a healthy balance
financial management in the NHS
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Summary

Financial management in context (Chapter 1)
The NHS is faced with a number of conflicting pressures. These include the rising demand for healthcare from an ageing population, developments in medical technology that are leading to the availability of new treatments, and a more questioning and informed attitude from service users. All these growing demands and expectations must be balanced against the limits upon the resources available to meet them. It is against this background that NHS bodies must manage their activities and achieve financial balance.

The aim of this paper is to help trusts and health authorities (HAs) identify the key factors that influence performance and the issues that need to be considered to meet this challenge successfully. The findings of the paper, which are summarised below, should also help the newly created primary care groups in England and local health groups in Wales to discharge their financial responsibilities.

Financial position (Chapter 2)
The most up-to-date audited financial information for a completed financial year is that for the year ended 31 March 1998, the audits for which were completed by September 1998. Financial forecasts by the NHS Executive (NHSE) and Welsh Office for the financial year ended 31 March 1999 have been included in the paper, but this information does not include the effects of year-end accounting adjustments and is unaudited.
In-year financial performance – England

Taken as a group, trusts incurred net in-year deficits of £104 million in 1997/98. This compares with an in-year deficit of £221 million a year earlier. The NHSE’s latest financial forecast for 1998/99 is an in-year deficit of £52 million.

HAs incurred net in-year deficits of £8 million in 1997/98, compared with in-year deficits of £238 million a year earlier. The NHSE’s latest financial forecast for 1998/99 is an in-year deficit of £27 million.

Cumulative financial position – England

At 31 March 1998, 126 trusts (30 per cent) had cumulative deficits of £304 million that were carried forward into 1998/99. The remaining 309 trusts (70 per cent) had cumulative surpluses of £513 million. The net surplus of £209 million at 31 March 1998 compares with a net surplus of £313 million a year earlier and a forecast net surplus of £157 million at 31 March 1999.
Eighty-six HAs (86 per cent) had cumulative deficits of £745 million that were carried forward into 1998/99. The remaining 14 HAs (14 per cent) had cumulative surpluses of £28 million. The net deficit of £717 million at 31 March 1998 compares with a net deficit of £709 million a year earlier and a forecast net deficit of £744 million at 31 March 1999.

In-year financial performance – Wales

Trusts incurred net in-year deficits of £9 million in 1997/98 compared with in-year deficits of £0.7 million a year earlier. The Welsh Office’s latest financial forecast for 1998/99 is an in-year deficit of £11 million.

Cumulative financial position – Wales

At 31 March 1998, 11 trusts (42 per cent) had cumulative deficits of £16 million that were carried forward into 1998/99. The remaining 15 trusts (58 per cent) had cumulative surpluses of £8 million. The net deficit of £8 million compares with a net surplus of £1 million a year earlier and a forecast net deficit of £19 million at 31 March 1999.

Four HAs (80 per cent) had cumulative deficits of £26 million that were carried forward into 1998/99. One HA (20 per cent) had a cumulative surplus of £1 million. The net deficit of £25 million compares with a net deficit of £14 million a year earlier and a forecast net deficit of £35 million at 31 March 1999.

Financial trend

In England, the in-year financial performance of health bodies has improved in recent years and total net in-year deficits have reduced significantly (down from £459 million in 1996/97 to £112 million in 1997/98). There has also been an improvement at Welsh HAs but not at Welsh trusts, where the in-year financial performance deteriorated in 1997/98.

In England and Wales, at both trusts and HAs, the year-on-year trend has been for more NHS bodies to have a cumulative deficit at the financial year-end. Thirty per cent of English trusts had a cumulative deficit at 31 March 1998, compared with 9 per cent three years earlier, while 42 per cent of Welsh trusts had a cumulative deficit at 31 March 1998 compared with 13 per cent the year before. At HAs, 86 per cent of English HAs had a cumulative deficit at 31 March 1998 compared with 72 per cent a year earlier, while 80 per cent of Welsh HAs had a cumulative deficit at 31 March 1998 compared with 60 per cent a year earlier.
Summary – England and Wales

The in-year financial performance of trusts and HAs in England and Wales in 1997/98 was a net in-year deficit of £132 million (0.4 per cent of total NHS spend), which is a considerable improvement on the previous year’s net in-year deficit of £474 million. The latest financial forecast for 1998/99 is for a net in-year deficit of £100 million.

At 31 March 1998, the cumulative financial position of trusts and HAs in England and Wales was a net deficit of £541 million (1.6 per cent of total NHS spend). This compares with a cumulative net deficit of £409 million a year earlier and a forecast cumulative net deficit of £641 million at 31 March 1999.

NHS bodies need to tackle these cumulative deficits because they reflect liabilities, for which cash funding will have to be found in future years. For example, provisions for the costs of clinical negligence are now included in the accounts of NHS bodies. At 31 March 1998, these provisions totalled £344 million. It should be emphasised that these provisions are not just accounting entries – when these liabilities are settled, cash funding will have to be found by the health bodies at the local level. While future calls on NHS cash resources are taken into account by the National Health Service Executive and the Welsh Office in determining each year’s settlement, the cash impact locally of all cumulative deficits needs to be addressed by NHS bodies.
Issues influencing financial management (Chapter 3)

No single issue determines good financial performance. Maintaining good financial health is the result of managing successfully many conflicting pressures, such as providing adequate emergency care, managing down waiting times and working together with other organisations in the local healthcare economy. Understanding and managing the major risks and uncertainties is the key to success.

In their responses to a survey questionnaire that was circulated to the chief executives of all HAs and trusts as part of the research for this paper, NHS bodies highlighted several key issues that they believe influence their financial performance:

- there must be strong working relationships between commissioners and providers. All parties involved in the local health economy must work collaboratively to address financial difficulties at the local level;
- less complex service agreements between commissioners and providers can help to improve financial management;
- HAs may sometimes need to radically review the services that they wish to commission;
- growth monies have been used to some extent by almost all HAs to deal with financial difficulties. Similarly, monies provided to trusts for capital spending have been used for revenue costs. However, using one-off monies in this way does not solve underlying financial difficulties and can result in a longer-term adverse impact upon services to patients; and
- reductions in management costs must always be achieved in a planned and controlled manner.

Achieving and maintaining financial balance (Chapter 4)

From audit assessments made in 1998, auditors report that the standards of financial management in the NHS are generally high. Four key conditions have proved successful in achieving financial balance:

- instilling a culture of strong financial awareness;
- creating good financial and business planning and budget-setting processes;
- maintaining a clear framework of financial control; and
- establishing effective monitoring and management information systems.
Instilling a culture of strong financial awareness

- Good financial management is not the sole preserve of the finance function. It is a corporate responsibility that is shared by all staff throughout organisations.
- The members of a trust or HA perform an important leadership role in securing effective financial management.
- A cornerstone of many financially well-run organisations is a strong working relationship between the chief executive and director of finance.

Creating good financial and business planning and budget setting processes

- Risks and uncertainties need to be identified, quantified and managed.
- Longer-term business plans play an important part in ensuring financial stability — yet the majority of current plans project only one year ahead.
- Longer-term plans must be supported by clear financial and activity plans.

- Annual budgets should be achievable and budgets aligned with forecasts of clinical activity.
- Budgetary systems need to motivate staff to achieve results, and include incentives to reward good performance and penalties for poor performance.

Maintaining a clear framework of financial control

- Effective systems of control are necessary to exercise good financial discipline. The 'minimum control standards' laid down by the NHSE and Welsh Office are an essential feature of corporate governance in the NHS and it is important that NHS bodies achieve them.
- Responsibility for controlling budgets should be devolved to those who take decisions about using resources. But where expenditure control fails, there may be a short-term need for the corporate centre of an NHS body to assume greater control to restore financial balance.

Cost improvement initiatives should be targeted on the areas that offer scope for the greatest improvement. Clinical processes should not be excluded from review.

Establishing effective monitoring and management information systems

- Well-presented, concise and up-to-date financial reports must be sent to the right people as soon as possible.
- Management information presented to board and authority members should combine financial and activity-related data.

Checklist for action

The questions at the end of each section of the paper, which for ease of reference are included in a centre pull-out checklist, are intended to prompt discussion and review by members of trust boards and HAs. The questions will also be helpful to the Commission’s appointed auditors in reviewing the adequacy of financial management at individual trusts and HAs.
Introduction

Why has this management paper been written?

1. This paper looks at the key influences that affect the financial performance of NHS trusts and health authorities (HAs) in England and Wales as they provide healthcare services. Some trusts and HAs have balanced competing financial and service demands more successfully than others, and the paper highlights good practices observed by the Commission. The paper does not purport to provide answers to all the difficulties encountered by health bodies at the local level. Rather, it aims to give practical advice that NHS bodies may wish to consider in trying to achieve and maintain financial balance.

2. The paper focuses on trusts and HAs: surprisingly, there is little published literature about how these bodies balance competing service and financial pressures successfully, and this paper aims to help fill this gap.

3. The paper looks at the financial position of NHS bodies in England and Wales and includes the most up-to-date audited financial information for a completed financial year at 31 March 1998. Since then, the Government has introduced a number of significant reforms that will affect the financial management of the NHS, including changes to the internal market, greater use of ringfenced or specific allocations, shared budgets with local authorities, clinical governance and the replacement of the GP fundholding scheme from 1 April 1999 by primary care groups (PCGs) in England and local health groups (LHGs) in Wales. The findings of this paper should help HAs, trusts, PCGs and LHGs as they discharge their new financial responsibilities. The Commission has prepared a separate paper on the operation of PCGs for publication in June 1999.

For whom has this paper been written?

4. This paper has been written principally for the members of trust boards and HAs as they scrutinise their organisations’ financial issues. It should prove helpful as a prompt to ask questions about financial management and performance, and adopting the good practices outlined in Chapter 4 will help trusts and HAs to achieve financial balance. It should also be useful to members by providing details of experience elsewhere and the approaches taken by other NHS bodies.

How should this paper be used?

5. The paper is designed to be used by trusts and HAs to help them to maintain and, where necessary, improve their financial management performance. Checklists of questions that members may wish to ask are included at the end of each section and are gathered together in a centre pull-out.
6. The paper uses case studies drawn from NHS bodies to illustrate current financial management practices. These practices do not, of course, represent the only approaches to particular issues, but they have been included as experiences that may usefully be shared with others.

The research behind this paper

7. This paper is based on the results of an extensive questionnaire that was issued in 1998 to all chief executives of HAs and trusts in England and Wales. Responses were received from 51 (50 per cent) of HAs and 206 (49 per cent) trusts. Field visits were made to 20 NHS bodies from all sectors of the NHS, and detailed discussions were held with chief executives and directors of finance.

8. An advisory group (Appendix) reviewed the findings of the study. The Audit Commission gratefully acknowledges its assistance. Thanks are also due to those organisations and individuals that responded to the questionnaire and to those who then discussed their experience in greater detail and provided examples of good practice. Responsibility for the contents of this paper, however, rests solely with the Audit Commission.

The structure of this paper

9. The first chapter puts financial management in the context of the overall performance of the NHS, and identifies who holds financial management responsibilities within an NHS body. Subsequent sections consider the current financial position of the NHS in England and Wales (Chapter 2), the main issues that influence financial performance (Chapter 3), what different NHS bodies have done to achieve and maintain financial balance (Chapter 4), and what else needs to be done to improve financial management (Chapter 5). A glossary of technical terms is included at the end of the paper.
## 1. Financial management in context

### Why is financial management important?

10. All organisations need good financial management if they are to meet their objectives effectively. In the NHS, good financial management is about securing the proper stewardship of public funds and utilising resources efficiently and effectively to improve the health of the population and to deliver patient care to high-quality standards.

11. For non-trading public sector bodies such as NHS trusts and HAs, the key financial task is to ‘live within their means’. Activities must be managed in such a way that the costs of the services provided are contained within the resources available. While this is a simple concept in theory, in practice it is not easy to achieve. NHS bodies have to contend with ever-increasing demands for better quality, as well as new and costly healthcare services.

12. Good financial management is central to achieving the core objectives of an NHS body. Without it, more resources may be used than are generated or allocated, with the inescapable consequence that subsequent budgets have to be cut and services reduced to bring the finances back into balance.

### Financial management responsibilities

13. Good financial management is often regarded as the sole responsibility of the finance function. But organisations that manage their financial affairs well take a much broader view of financial management than this. Instead, they regard financial management as a corporate responsibility that is shared by all staff, who need to have a good understanding of the cost of the activities under their control and of the degree of flexibility that exists to influence these costs.

14. Certain individuals have a greater share of financial responsibility than others. Getting to grips with the finances is a key task for the board members of HAs and trusts. In particular, the members of audit committees have an important role to play in promoting good financial management. The chief executive and director of finance also have special responsibilities for finance, including statutory duties for the satisfactory financial performance of their NHS body. The responsibilities of these individuals are considered in Chapter 4 of this paper.

### Statutory duties

15. The importance of good financial management is recognised in the statutory duties placed upon NHS bodies. HAs have a duty (set out in regulations issued under section 99(3) of the National Health Service Act 1977) to remain within an annual cash limit.
16. In the case of trusts, section 10 of the National Health Service and Community Care Act 1990 requires that ‘every trust shall ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to revenue account’. This is commonly known as ‘the break-even duty’. It means that, over a period of time, a trust must seek to achieve a balanced position on its income and expenditure account.

17. This balance is not expected to be achieved each and every year. There will be instances where costs incurred in one year are not recovered by income until a future year. But it is important that where, for example, a trust has a deficit on its income and expenditure account, it is aware of the underlying causes and has a realistic plan in place to restore financial balance. Good financial management means identifying the underlying causes of deficits quickly and tackling deficits within an appropriate period.

QUESTIONS

• Do board and authority members understand the critical role that good financial management plays in the successful management of the body?

• Are members satisfied that staff view financial management as a key part of their responsibilities?
2. The current financial position of the NHS

18. The NHS is the largest organisation in the country. It employs one million staff and spends about £34 billion annually in England and Wales. More than £1,000 is spent every second. This money is spent by more than 450 trusts and over 100 HAs in England and Wales. This chapter looks at the current financial health of these bodies. The most up-to-date audited financial information for a completed financial year is that for the year ended 31 March 1998, but forecasts from the National Health Service Executive and Welsh Office for the 1998/99 financial year are also included.

Trusts

19. Taken as a group, the in-year financial performance of trusts in England has improved over the last two years, reducing from an in-year deficit of £221 million in 1996/97 to one of £104 million in 1997/98. Final information for the 1998/99 financial year is unavailable, but the Welsh Office’s latest forecast in-year deficit for trusts in Wales was £11.2 million.

20. In Wales, the in-year financial performance of trusts has deteriorated from an in-year deficit of £0.7 million in 1996/97 to one of £9.0 million in 1997/98. As in England, final information for the 1989/99 financial year is unavailable, but the Welsh Office’s latest forecast in-year deficit for trusts in Wales was £11.2 million.

21. Turning to the cumulative position at the end of March 1998, 316 trusts reported a surplus while 137 trusts in England and Wales reported an overall deficit on their income and expenditure accounts.

22. In England, the cumulative deficits carried forward into the next financial year totalled £304 million. For six trusts, the cumulative deficit was more than 10 per cent of their annual total income. Total cumulative deficits are offset by cumulative surpluses amounting to £513 million [EXHIBIT 1].

EXHIBIT 1
English trusts: summary of cumulative surpluses and deficits at 31 March 1998 expressed as a percentage of annual income

One-hundred-and-twenty-six trusts carried forward deficits at 31 March 1998.

Source: NHS Executive data
23. In Wales, the cumulative deficits carried forward into the 1998/99 financial year by 11 trusts amounted to nearly £16.3 million. These deficits are offset by cumulative surpluses of £8.5 million at 15 trusts [EXHIBIT 2].

24. The percentage of trusts with a cumulative surplus at the financial year-end has steadily decreased in recent years, with more trusts going into deficit year-on-year. In England, 30 per cent of trusts were in deficit at 31 March 1998, compared with 9 per cent three years earlier [EXHIBIT 3, overleaf]. In Wales, a similar picture emerges, with 42 per cent of trusts in deficit at 31 March 1998 [EXHIBIT 4, overleaf] compared with 13 per cent a year earlier.

25. One of the contributory reasons for deficits in recent years has been a change in the way in which trusts have accounted for major liabilities, such as those arising from clinical negligence and early retirements. The aim has been to give a more accurate picture of the scale of the liabilities facing trusts, and to follow more closely the accounting practices that are used in other parts of the public and private sectors. In part, these moves to generally accepted accounting practice have given rise to deficits – for example, in England and Wales total provisions for the costs of clinical negligence included in trust accounts at 31 March 1998 were £175 million. Deficits should not, therefore, necessarily be seen as a sign of poor financial management or a lack of financial discipline. Indeed, deficits arising from making provisions for early retirements indicate that a trust has undertaken a rationalisation or restructuring programme and is working to improve its performance, rather than poor financial management.

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**EXHIBIT 2**

*Welsh trusts: summary of cumulative surpluses and deficits at 31 March 1998 expressed as a percentage of annual income*

Eleven trusts carried forward deficits at 31 March 1998.

Source: Welsh Office data
The percentage of English trusts in surplus has decreased year-on-year.

Source: NHS Executive data

The percentage of Welsh trusts in surplus has decreased year-on-year.

Source: Welsh Office data

26. However, while the size of reported deficits has increased because of changed accounting practices, such changes have been applied by all trusts and the fact that more trusts are going into deficit year-on-year reflects the financial difficulties that many of them face. Trust deficits have therefore been caused by a combination of the way that liabilities are now shown and a failure by trusts to contain expenditure within their income. ...the fact that more trusts are going into deficit year-on-year reflects the financial difficulties that many of them face.
27. The position has been complicated further at some trusts by the use of one-off transfers of funds to ease financial difficulties. The two most common methods have been to:

- cancel or defer capital spending from one financial year to a later one and instead use the monies provided on revenue and running costs; and

- use year-end ‘brokerage’, which is a way of redistributing resources on a short-term basis by the NHSE and Welsh Office to help NHS bodies to face their financial problems at year-end.

28. While using one-off monies as a short-term measure to solve immediate financial problems is tempting, this may be a means by which management avoids tackling the underlying problems and can result in a longer-term adverse impact upon services to patients [BOX A]. One-off monies do not solve underlying financial difficulties and are no substitute for management at the local level facing up to harsh realities at the earliest possible stage rather than deferring difficult, and often unpalatable, decisions to a later date.

**BOX A**

The use of non-recurring funds

A large teaching hospital had struggled to balance its budget for a number of years. Unable to secure additional funding from its main commissioners to bridge the gap between income and expenditure, it agreed with the NHSE to transfer money from its capital programme to support revenue expenditure. The underlying financial problem re-emerged the following year, when the NHSE again agreed a further, but smaller, transfer from the capital programme. To make up the shortfall, the trust agreed service restrictions with its main purchaser, allowing waiting times to lengthen.

Realising that the underlying problems had to be tackled, the trust and all the key commissioners and the NHSE agreed a three-year plan to bring income and expenditure back into balance. This involved injections of additional income, further cost reductions and a repayable loan from the NHSE. Letting the position drift on for so long severely affected both waiting times and capital investment. A start has been made in taking some harsh decisions about staffing and service provision.

Health authorities

29. The in-year financial performance of HAs in England has improved over the last two years, with an in-year deficit of £238 million in 1996/97 reducing to one of £8 million in 1997/98. Final information for the 1998/99 financial year is unavailable, but at 31 December 1998 the NHSE forecast in-year deficit for HAs in 1998/99 was £27 million.
30. In Wales, the in-year financial performance of HAs has also improved over the last two years, with an in-year deficit of £14 million in 1996/97 reducing to one of £11 million in 1997/98. As in England, final information for the 1998/99 financial year is unavailable, but the Welsh Office’s latest forecast for 1998/99 is an in-year deficit of £10.3 million.

31. In England, 86 HAs carried forward a total cumulative deficit of £745 million (including £316 million for long-term creditors, early retirement and clinical negligence liabilities), while 14 HAs reported a total surplus of £28 million. One HA had a deficit greater than 10 per cent of its annual income [EXHIBIT 5].

Source: NHS Executive data
In Wales, four HAs carried forward a cumulative deficit of £26 million, with one HA having a cumulative surplus of nearly £1 million. No deficits exceeded 2 per cent of a HA’s total income. [EXHIBIT 6].

In Wales, four HAs carried forward a cumulative deficit of £26 million.

EXHIBIT 6
Cumulative surpluses and deficits of Welsh HAs at 31 March 1998 as a percentage of total income

Four of the five HAs in Wales carried forward a deficit at 31 March 1998.

Source: Welsh Office data
33. Like the position at trusts in England and Wales, where the percentage with a cumulative deficit has grown year-on-year, the percentage of HAs with a cumulative deficit has also increased in the past two years [EXHIBITS 7 AND 8].

34. The financial year that ended on 31 March 1997 was the first financial year of the new HAs following the merger on 1 April 1996 of the family health services authorities (FHSAs) and district health authorities (DHAs). In addition, the basis of accounting for HAs changed fundamentally in 1996/97. From 1 April 1996, HAs were required to draw up their financial accounts on an accruals, rather than a cash, basis. This meant that from 1996/97, an HA’s accounts had to show the effect of liabilities that had been incurred in previous years.

**EXHIBIT 7**
Percentage of English HAs with a cumulative surplus or deficit at 31 March 1998
86 per cent of English HAs were in deficit at 31 March 1998, compared with 72 per cent a year earlier.

**EXHIBIT 8**
Percentage of Welsh HAs with a cumulative surplus or deficit at 31 March 1998
80 per cent of Welsh HAs were in deficit at 31 March 1998, compared with 60 per cent a year earlier.

*Source: NHS Executive data*  
*Source: Welsh Office data*
35. To illustrate this point, an HA may have incurred a liability in 1995/96 to pay £10,000 each year for ten years. Before 1996/97, the HA would have charged £10,000 in its accounts each year when payments were made. But under the new accruals basis applied from 1996/97, the HA would have included the full outstanding liability of £90,000 in its accounts for the first time. When examining the trend in the financial position revealed by HA accounts, therefore, it must be remembered that:

- comparisons with any years before 1996/97 are not possible because this was the first year of both the newly merged HAs and a different accounting basis; and
- the cumulative position on an accruals basis had not previously been established, nor were many liabilities disclosed fully because of the cash basis of accounting.

36. To summarise, the overall financial picture for HAs in England and Wales at 31 March 1998 was one of a deficit position. There are two main reasons for this, neither of which can be quantified with precision:

- changes in accounting practice – in particular, the inclusion for the first time of significant liabilities such as clinical negligence liabilities. In England and Wales, provisions for the costs of clinical negligence included in HA accounts at 31 March 1998 totalled £169 million. A further contributory factor in 1996/97 was the new requirement to disclose sums held on behalf of GP fundholders as creditor liabilities; and
- failures to contain expenditure within, and purchasing in excess of, available resources.

Summary NHS financial position

37. Interpreting an individual health body's financial performance and judging whether resources at the local level have been managed successfully can be obscured by the financial interdependency of HAs and trusts. For example, an HA can sometimes agree to meet the debts of a trust, thus allowing the trust to show a favourable financial position while effectively transferring any deficits to the HA. In other cases, an HA can refuse to underwrite formally a trust's debts, with the result that while the HA's finances may be strong, those of the trust may be less so. Nor is it acceptable for an NHS body to operate with significant surplus balances in its accounts. Any resources that are available but are not being used means less service provision than if these resources were being used. The key to successful financial management is to strike as close a balance as possible between expenditure and available resources.
For these reasons, it is helpful to bring together the cumulative financial position for trusts and HAs [TABLE 1]. The overall picture for the NHS in England and Wales at 31 March 1998 was a net cumulative deficit of £541 million. This equates to 1.6 per cent of total NHS spending in England and Wales.

### Financial recovery plans

All NHS bodies are required to have financial planning systems to help to determine priorities and future policy. Where a body is in deficit, the need to restore financial balance gives an added dimension to these financial plans, and it is usual to develop a financial recovery plan. One-half of HAs and 40 per cent of trusts that responded to the Commission’s questionnaire reported that they had financial recovery plans in place. Such plans were more prevalent in trusts that provide acute services than in ambulance and community trusts [EXHIBIT 9]. This finding is consistent with the number of trusts in deficit at these types of trusts.

#### TABLE 1

<table>
<thead>
<tr>
<th></th>
<th>Number in deficit</th>
<th>Per cent in deficit</th>
<th>Total surpluses (£m)</th>
<th>Total deficits (£m)</th>
<th>Total net surplus/deficit (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trusts</td>
<td>126</td>
<td>30 per cent</td>
<td>+513</td>
<td>-304</td>
<td>+209</td>
</tr>
<tr>
<td>HAs</td>
<td>86</td>
<td>86 per cent</td>
<td>+28</td>
<td>-745</td>
<td>-717</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-508</td>
</tr>
<tr>
<td><strong>Wales</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trusts</td>
<td>11</td>
<td>42 per cent</td>
<td>+8</td>
<td>-16</td>
<td>-8</td>
</tr>
<tr>
<td>HAs</td>
<td>4</td>
<td>80 per cent</td>
<td>+1</td>
<td>-26</td>
<td>-25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-33</td>
</tr>
<tr>
<td><strong>Total cumulative deficits in England and Wales</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-541</td>
</tr>
</tbody>
</table>

*Source: NHS Executive/Welsh Office data*
Conclusion

40. The NHS has to achieve a difficult financial balancing act. It spends about £34 billion each year in England and Wales and has to ensure that this money is spent for the purposes intended by Parliament and that financial balance is achieved year-on-year. But achieving and maintaining financial balance at an individual NHS body can be problematic. Many NHS bodies have managed this task successfully, but it is becoming more difficult as demands for healthcare grow. It is also a task that requires constant vigilance by NHS staff. Chapter 3 looks at some of the key factors that influence financial performance.

QUESTIONS

- Are members aware of the current financial position of the trust or HA?
- Do members know how the financial position has changed over time?
- Are members aware of the underlying causes of deficits?
- Are members satisfied that realistic plans exist to achieve and maintain financial balance?

EXHIBIT 9
Existence of financial recovery plans at trusts

Financial recovery plans were found most frequently at acute trusts.

<table>
<thead>
<tr>
<th>Number of trusts</th>
<th>Ambulance</th>
<th>Combined acute</th>
<th>Community</th>
<th>Non-teaching acute</th>
<th>Teaching acute</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>0</td>
<td></td>
<td>10</td>
<td>25</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>25</td>
<td>0</td>
<td></td>
<td>10</td>
<td>20</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>20</td>
<td>0</td>
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<td>10</td>
<td>15</td>
<td>10</td>
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<td>15</td>
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<td>10</td>
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<td></td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>5</td>
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<tr>
<td>5</td>
<td>0</td>
<td></td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Audit Commission
3. Issues influencing financial management in the NHS

41. The Government has set a clear direction and a challenging future agenda for the NHS in its White Paper, *The New NHS* (Ref. 1), which was issued in December 1997. The opening chapter of the White Paper makes plain that:

‘...the NHS needs to make better use of its resources.’ [paragraph 1.22]

Good financial management within each trust and HA is an essential ingredient in turning this statement into reality.

42. But the objective of getting the finances right and maintaining good long-term financial health is just one of several key objectives for health bodies. NHS bodies must also meet other important service objectives, such as providing adequate emergency care and keeping waiting lists short. In consequence, financial management cannot be viewed in isolation. Different objectives are interlinked and generating improvements to meet one objective may worsen performance in another. To help trusts and HAs to meet these different challenges, the Commission has published many major reports since it assumed responsibility for auditing the NHS in 1990 [BOX B].

**BOX B**

Examples of Audit Commission reports on key NHS issues

Many reports have examined important managerial challenges in the NHS.

**A Short Cut to Better Services (1990)** (Ref. 2)

Shifting appropriate treatments to day surgery can enhance patient care and release much-needed resources. Focusing on a ‘basket’ of procedures, the report showed how gains in quality and cost-effectiveness can be made.

**NHS Estate Management and Property Maintenance (1991)** (Ref. 3)

The use and management of NHS estates need to be improved and the maintenance service could be more efficient and customer-oriented. The study illustrated how resources could be released to deal with the maintenance backlog.
Lying in Wait (1992) (Ref. 4)
Efficient bed management can deliver higher-quality care and improved patient throughput while using fewer beds. The study demonstrated how the best hospitals are achieving improvements through better management of admissions, placements, stays and discharges.

By Accident or Design (1996) (Ref. 5)
Faced with big increases in demand and shortages of qualified staff, this report identified the steps that need to be taken to improve the provision of care to all who are currently examined or treated in A&E departments. The study also examined how these requirements could change as alternative settings for the provision of emergency care develop.

Cover Story (1999) (Ref. 6)
Locum doctors provide an important service to many NHS trusts and account for approximately 8 per cent of medical staffing expenditure. But locum use could be reduced through better planning and management, and trusts can reduce their expenditure by using NHS locums where possible, and by working in partnership with a small number of locum agencies.

...locum use could be reduced through better planning and management...
43. A key task of financial managers in the health service is to recognise the issues that are the critical drivers in, and barriers to, effective resource management at the local level and to manage these factors in a balanced way. Financial managers need to assess and quantify business risks and to devise strategies to counter those risks.

44. As part of its research for this management paper, the Commission circulated a comprehensive questionnaire to the chief executives of all trusts and HAs in England and Wales. The responses to this questionnaire identified several key processes and actions that have consistently proved successful in helping NHS bodies to achieve financial balance; these are discussed in Chapter 4. But in their responses to our questionnaire, NHS bodies also highlighted a number of other issues that, in their view, have influenced their financial performance [EXHIBIT 10]. These are discussed in the rest of this chapter.

EXHIBIT 10
Questionnaire responses: external issues influencing financial performance
NHS bodies identified several key factors that affect their financial health.

Source: Audit Commission
Commissioner/provider relations

45. The purchaser or commissioner/provider distinction remains an important organisational feature of the NHS. The Government is currently reshaping the internal market introduced by its predecessor, but the essential distinction between the two roles is being retained. The nature of this relationship is seen by NHS bodies as having an important effect upon financial performance. Questionnaire responses show that commissioners are more positive than providers about these relationships [EXHIBIT 11].

46. Where difficulties have arisen in relationships between commissioners and providers, respondents reported that the most commonly used and successful methods to solve problems were regular meetings between the parties and jointly sponsored staff working on particular issues of concern. The need for NHS bodies to manage the changes that will arise from the NHS White Paper and its subsequent legislation, can offer important lessons [CASE STUDY 1, overleaf]. In particular, all parties involved in the local health economy need to work together to address financial difficulties.

EXHIBIT 11
Relations between commissioners and providers
Commissioners are more positive about relations than providers, as shown in the response to the questions.

Source: Audit Commission
CASE STUDY 1

Different ways of resolving problems

Example 1: Wakefield HA
As part of the response to severe financial difficulties, the chief executives of the HA, acute and community trusts, together with the regional director of finance, set up a group to oversee the financial performance of the local health economy. The result was a better understanding of the financial and other pressures affecting the NHS at the local level, which engendered a spirit of co-operation in tackling common problems, and provided a foundation to improve the financial position of the local health economy.

Example 2: South and West Regional Office, NHSE
The regional office successfully used an external facilitator to analyse expenditure on patient services and the performance of local health economies. The data from the independent source was then used to help to resolve disputes between commissioners and providers. Both commissioners and providers jointly funded the work and agreed in advance to accept the result. One of the most positive aspects of this approach was that the debate about resources was focused upon the data presented and away from individuals’ subjective views of the past.

47. The background of key decision-makers was also felt to be an important factor in relationships. Not surprisingly, decision-makers with experience of both commissioning and providing healthcare services were seen as offering benefits to working relationships in the context of financial management [EXHIBIT 12].

48. The clear message for NHS managers is that giving staff the opportunity to work in both commissioning and providing areas is beneficial to the overall management of the service. This is one of the factors to be taken into account when developing job descriptions and advising staff on their future career development.
A Healthy Balance

Checklist for action
Questions for trust board and health authority members

Please pull out and copy

In its management paper, *A Healthy Balance: Financial Management in the NHS*, the Audit Commission identified issues to help trust board and health authority members to ask questions about their financial management and performance.

These questions have been drawn together in this pull-out section to assist in the consideration of the key issues, to stimulate discussion, and to help to identify priorities and who should take the lead in addressing them.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Priority/Lead Person</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FINANCIAL MANAGEMENT IN CONTEXT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Do board and authority members understand the critical role that good financial management plays in the successful management of the body?</td>
<td></td>
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<tr>
<td>2. Are members satisfied that relevant staff view financial management as a key part of their responsibilities?</td>
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<tr>
<td><strong>CURRENT FINANCIAL POSITION</strong></td>
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<tr>
<td>3. Are members aware of the current financial position of the trust or HA?</td>
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<tr>
<td>4. Do members know how the financial position has changed over time?</td>
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<tr>
<td>5. Are members aware of the underlying causes of deficits?</td>
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<tr>
<td>6. Are members satisfied that realistic plans exist to achieve and maintain financial balance?</td>
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<tr>
<td><strong>ISSUES INFLUENCING FINANCIAL MANAGEMENT IN THE NHS</strong></td>
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<td></td>
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<tr>
<td>7. Are there good relations between commissioners and providers?</td>
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<tr>
<td>8. Is the current relationship between major commissioners/providers having an adverse effect upon the financial performance?</td>
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<tr>
<td>9. If so, has action been taken to improve matters?</td>
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<tr>
<td>10. Is the complexity of service agreements having an adverse effect upon financial performance?</td>
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<td></td>
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<tr>
<td>Question</td>
<td>Yes/No</td>
<td>Priority/Lead Person</td>
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<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>11. If so, is there scope for changing the nature of the service agreements?</td>
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<tr>
<td>12. Does the HA need to reappraise radically how it decides which services it should commission?</td>
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<tr>
<td>13. Has the HA used growth monies to fund existing financial problems?</td>
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<td></td>
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<tr>
<td>14. If so, do members know why, and was this part of a longer-term strategy to achieve and maintain financial balance?</td>
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<td></td>
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<tr>
<td>15. Has the HA/trust achieved management cost reductions in a planned manner with due regard to minimising the risk of weakened financial control?</td>
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<tr>
<td><strong>ACHIEVING AND MAINTAINING FINANCIAL BALANCE</strong></td>
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<tr>
<td>16. Is there a pervasive culture of financial awareness and responsibility?</td>
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<tr>
<td>17. Does the board/authority lead by example in discharging its financial leadership role?</td>
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<tr>
<td>18. Does the audit committee review internal financial control effectively?</td>
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<tr>
<td>19. Are members satisfied that there is a strong working relationship between the chief executive and the director of finance?</td>
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<tr>
<td>20. Does the HA/trust have longer-term commissioning or business plans?</td>
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<tr>
<td>Question</td>
<td>Yes/No</td>
<td>Priority/Lead Person</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Are longer-term commissioning or business plans supported by financial</td>
<td></td>
<td></td>
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<tr>
<td>and activity plans?</td>
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<td></td>
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<tr>
<td>Are commissioning or business plans supported within the context of the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>local healthcare economy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are annual budget allocations realistic and achievable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do budget estimates align closely with clinical activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there incentives in the budgetary system to reward good performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and penalise poor performance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an effective system of internal financial control in place?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the 'minimum control standards' laid down by the NHS Executive /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welsh Office being achieved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are delegated financial and managerial responsibilities aligned?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are cost improvement initiatives targeted on the areas offering scope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for greatest improvement opportunity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are financial monitoring reports well presented, up to date and sent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to the right people?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the management information presented to board and authority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>members combine financial and activity related data?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Experience of key decision-makers
Experience of working both as purchaser and provider offers benefits.

Complexity of service agreements
49. The percentage of trusts’ income that is accounted for by their main commissioner varies significantly. Trusts provide most of their services to a single commissioner; and most questionnaire respondents attributed between 70 and 80 per cent of their income to their main commissioner. Those trusts with more complex service agreements are often specialist providers; they tend to experience more volatility in income and show a higher incidence of financial recovery plans.

Source: Audit Commission
50. One way of trying to provide more certainty of income when financial problems have arisen is to move away from contracts or service agreements that are related to the numbers of patients to block agreements, where funds pass from commissioner to provider for a specified range of care that is not linked directly to individual patients. However, the breaking of direct links between patients and funds has both advantages and disadvantages. On the one hand, total income is known in advance and so planning can be undertaken with reasonable certainty. But on the other hand, less pressure to identify a particular treatment’s costs and hence income, accepting more patients than have been planned for, providing more expensive treatments, or being inefficient in the use of resources can all lead to expenditure outstripping income and financial problems.

51. At one trust, a critical examination of the range of services required, how and where they should be provided, and what can be done to maximise the healthcare from the available resources has led to simpler forms of service agreements [CASE STUDY 2].

CASE STUDY 2
Southampton University Hospitals NHS Trust
Southampton University Hospitals Trust worked closely with GP fundholders to simplify contracts and developed only one type of contract for all the GP fundholders in the city. Prior to this, the Trust entered into separate contracts with 26 separate GP practices, two consortia, a multifund and a total purchasing practice. Very few of these contracts were the same, each having different mechanisms to handle changes in the volume of activity, and containing different ceilings at which marginal rates were applied for under- and over-performance against contract targets. This complex structure required extensive monitoring and a great deal of time to negotiate with each practice.

Conscious of the urgent need for a simpler system, the Trust agreed with the local GP fundholding forum to consolidate the existing contracts into one global agreement for all Southampton GP fundholders. A budget subgroup of the fundholding forum, with representatives from each geographic locality, agreed a standard contract model. Provided the agreed volumes of activity are carried out, the overall agreement ensures that the Trust will earn sufficient income to cover its costs in total, although individual GP practices may have variances against their indicative targets. Aspects of this less complex form of commissioning are being considered by a number of primary care groups.
Health authority funding

52. The financial performance of a local health economy depends upon the decisions taken by HAs about the services that should be commissioned from providers. Introducing radical changes can be a slow, difficult and expensive process. However, if resources are to be matched to need and services matched to resources, the traditional approach of making marginal changes in the way that funds are used may not be appropriate. HAs may need to consider developing different approaches [CASE STUDY 3].

CASE STUDY 3

Wiltshire HA’s approach to tackling a long-running financial deficit

Wiltshire HA faced a significant historical budget deficit, which had been masked for a number of years by the receipt of non-recurring funding and the use of reserves. To overcome its financial problems, the HA developed an approach called ‘fair shares’.

To give a framework for allocating available resources, the HA identified its likely income for the next five years. Then using the same principles as the national funding formula on which the HA is funded, it split the likely income between geographical localities. This enabled the HA to compare current levels of expenditure with the national norm and, more importantly, to quantify what the level of resources within each locality should be, using the national criteria. Local planning groups were then established, supported by local GPs and non-executive directors of the HA, to agree the level of resources within each locality.

The HA recognises that the effect of these actions has been to share the problems within the local health economy, and that financial balance for trusts may be difficult in the early years.

53. HAs are funded using a formula which is based on health needs that are drawn from a range of demographic factors. Every HA has a target or equity funding position. Each year, in addition to changes in funding for inflation, further changes are made to move HAs closer towards target funding. The aim is for increased resources to allow services to be more closely matched to the needs of the community.
54. HAs below target funding have received more growth money than others and report improvements both in service delivery and financial performance. Analysis over the last three years of how these additional resources have been used shows that the majority of HAs have used at least some of these funds to help to resolve financial problems [EXHIBIT 13]. This undermines the objective of redistributing resources in order to better match the needs of the local community.

Requirements for management cost reductions

55. In recent years, there has been significant pressure on health bodies to reduce their management costs. Respondents to the questionnaire felt that this pressure has had a significant, and often adverse, impact on the financial performance at trusts and HAs [EXHIBIT 14]. Management costs must always be reduced in a planned and controlled manner, with due attention given to the risks of weakened financial control that may result from such action.

EXHIBIT 13

Use of growth monies

Most HAs receiving growth monies have used these resources to varying degrees to deal with financial problems.

Source: Audit Commission
EXHIBIT 14

Impact of management cost reductions

Questionnaire respondents felt that management cost reductions had often had an adverse impact on financial performance.

QUESTIONS

- Are there good relations between commissioners and providers?
- Is the current relationship between major commissioners/providers having an adverse effect upon the financial performance?
- If so, has action been taken to improve matters?
- Is the complexity of service agreements having an adverse effect upon financial performance?
- If so, is there scope for changing the nature of the service agreements?
- Does the HA need to reappraise radically how it decides which services it should commission?
- Has the HA used growth monies to fund existing financial problems?
- If so, do members know why, and was this part of a longer-term strategy to achieve and maintain financial balance?
- Has the HA/trust achieved management cost reductions in a planned manner with due regard to minimising the risk of weakened financial control?
4. Achieving and maintaining financial balance

56. All NHS bodies need good financial management if they are to meet the demanding challenges set by the Government in its White Paper, The New NHS (Ref. 1). From their assessments in 1998 at the last round of NHS audits, auditors report that the standards of financial management at NHS bodies in England and Wales are generally high and no accounts of a trust or HA received a qualified audit opinion.

57. Both from the field visits that we have made in preparing this paper and from the responses and practical suggestions to our questionnaire, it is clear that a number of key processes and actions have consistently proved successful at NHS bodies in helping to achieve financial balance [EXHIBIT 15].

58. There can, of course, be no certainty that copying these actions will always guarantee success or secure a sound financial position. Steps to improve the financial performance of NHS bodies must take into account the underlying culture, history and attitude of the organisation and the people involved at the local level. But creating the right conditions and implementing good management practices will help to avoid the situation that can arise in practice when things go badly wrong and financial management fails [BOX C].
ACHIEVING AND MAINTAINING FINANCIAL BALANCE

BOX C

When financial management fails

The trust was established with adequate initial funding, but the economic pressures from the internal market soon revealed that achieving and maintaining financial balance would be difficult. One factor contributing to financial difficulties was, and remains, the dilapidated state of the estate. Tackling the ongoing problem of backlog maintenance has drained the trust's resources.

A chief executive was in post for several years and managed the trust efficiently and effectively with a good appreciation of the financial position. The director of finance and the chief executive formed a good working relationship. However, the chief executive resigned and his replacement did not have a good understanding of finance. This, coupled with conflict with the medical staff, soon resulted in considerable strain within the management team. The chair also found it difficult to restore a clear sense of direction to the trust. The result was a management team and board without a common vision of what they were trying to achieve.

What followed was a deterioration of financial results over several years. Cost improvements were achieved only with great difficulty, and there was a poor understanding of the key factors that influenced costs. One of the characteristics of its financial problems was that by month six of the financial year, the trust was already adrift from budget, both against profiled actual spending to date and the projected year-end position. This meant that months 7–12 always involved a struggle to restore financial balance. The trust found it hard to identify clearly the underlying costs of services and to link these explicitly to income from contracts. It was difficult to provide hard evidence that price matched cost and, indeed, work by internal audit has since shown that there were significant gaps between cost and income on individual contracts. This meant that the trust was not in a position to know where it had been failing to obtain the income required to cover its costs.

During the years of struggle, the financial situation was contained with help from the HA, but problems came to a head when directors, including the director of finance, began to leave. The trust failed to attract a suitable candidate when it tried to recruit a new director of finance, so the period of stop-gap measures went on much longer than intended. During this period, the board did not increase its scrutiny of the financial position.

KEY ISSUES FOR BOARD MEMBERS TO ADDRESS

• Ensure good financial awareness at the top (para 61).

• Establish good working relationships between CEO and DoF (para 62).

• Give direction from the board (para 61).

• Identify the underlying causes of financial problems (para 17).

• Understand costs, and relationship with income (para 13).

• Do not rely on short-term fixes (para 27).
When financial management fails

The basics of bookkeeping were also neglected over a period of several years, with the result that disputes over sums due from commissioners were not resolved in a timely manner. They were included in the income figures reported to the board, but were not accompanied by warnings about the degree of uncertainty surrounding the income figures. During the eventual resolution of these disputes, the trust had to write off over £1 million of income.

The bank-nurse function was tendered and a new contract put in place. As the existing arrangements were closed down, £800,000 of unforeseen invoices were found in the system, which had accumulated over several months. This served to highlight weaknesses in the internal monitoring and control systems at the trust. These problems were compounded by further breakdowns in the monitoring system and resulted in an under-accrual in the accounts of £1 million. A lesson learnt by the trust was that non-finance staff should not be required to administer a finance-based system, such as notifying and accruing for the costs of bank and agency staff, without receiving good training and support.

The trust also failed to account properly for the costs arising from clinical negligence and had to make late adjustments to the final accounts.

The result of these financial failures was that an expected deficit of £1 million was being reported to the board up to 31 March, but after adjustments for the above items, the final position was a deficit of over £5 million.

The board proved to be ineffective in critically examining the financial information that it received. The information was presented without sufficient attention being drawn to the uncertainty surrounding important elements of the income. Slowness in dealing with income items in dispute, loss of control over the costs of bank and agency staff, and failure to account effectively for clinical negligence all contributed to the board being seriously misled as to its true financial position.

Once the full extent of the financial failures became known, there were changes in senior staff and non-executive board members. Revised monitoring systems and clearer financial reporting arrangements to the board have since been put in place.

KEY ISSUES FOR BOARD MEMBERS TO ADDRESS

- Ensure effective operation of basic financial controls (paras 77–8).
- Ensure effectiveness of financial monitoring systems (paras 85–9).
- Identify liabilities promptly (para 17).
- Ensure accurate figures are reported to the board (para 85).
- Question critically information reported to members (para 85–9).

Note: Paragraph references are to where the issue identified is discussed further within this paper.
Culture of strong financial awareness

59. Good financial management is not the sole preserve of the finance function. It is a corporate responsibility that is shared throughout organisations. There must be an all-pervasive culture of financial awareness and responsibility in an NHS body, which is backed up with effective information systems. Those incurring expenditure in a trust will include the medical, nursing and other staff who take decisions about the nature of care and treatment for patients. It is these people who have to exercise professional, managerial and financial skills in a co-ordinated way to achieve the best possible service delivery [EXHIBIT 16, overleaf].

60. But while good financial management is a shared responsibility, certain groups of people carry a greater burden of responsibility than others.

Trust board and authority members

61. Members of a trust or HA perform an important leadership role in securing effective financial management. All board and authority members have a duty to ensure that arrangements are in place for proper financial governance. To fulfil these responsibilities, members need to review accurate and timely information about the current financial position, and about the underlying financial health of the body. The behaviour adopted by the board or authority strongly influences the degree to which an organisation as a whole responds; how the board or authority approaches and resolves difficult financial issues is critical because of the message it sends to the rest of the body. Members must lead by example, working together as a team but being prepared to adopt a questioning, and constructively critical, approach until they are satisfied that they understand both the present financial position and future financial prospects. Often it is helpful for a non-executive director to take a special interest in financial management in order to review performance critically and call others to account; the members of audit committees have particular responsibilities in this respect. The extent to which board and authority members currently discharge their financial leadership role varies, as indicated in the responses to the Commission’s questionnaire [EXHIBIT 17, overleaf].
The director of finance bears a particular responsibility for keeping the board and authority members informed about financial performance.

EXHIBIT 16

Financial management in context

Financial management is the responsibility of a wide range of staff and is an integral part of ensuring that the overall aims of the body are met.

Source: Audit Commission
Exhibit 17

Discharging the financial leadership role

Current arrangements by which boards and authorities monitor financial performance vary.

![Graph showing financial position and outlook discussed regularly at board meetings, all decisions taken by the board identify the financial consequences, and are signed off by the director of finance, all executive directors have financial targets, and a non-executive director is nominated to take a special interest in financial performance. Source: Audit Commission]

Chief executives and directors of finance

62. The chief executive is the ‘accountable officer’ and responsible ultimately for the finances of an NHS body. Chief executives are answerable for financial performance through the chief executive of the NHS in England and the director of the NHS in Wales to the respective Secretaries of State. Both the chief executive and the director of finance have statutory duties for the financial performance of the body. A cornerstone of many financially well-run organisations is a strong working relationship between these two postholders. Both officers must possess a clear understanding of, and interest in, all aspects of NHS finance and the factors influencing the financial performance of the body concerned. The director of finance bears a particular responsibility for keeping the board and authority members informed about financial performance, ensuring that the financial information that is presented is comprehensible, timely and accurate. Detailed advice on the role of the director of finance can be found in The Role of the Director of Finance in the NHS, issued by the NHS Executive in 1993 (Ref 7).

Budgetholders

63. These include a range of professionals including clinicians, nurses, professional and managerial staff. All need an appreciation of what influences the overall financial performance of the body, as well as a good knowledge about those factors that affect their own budgets. Perhaps the most important attributes are a willingness to understand the constraining influence that finance has upon behaviour and activity and to accept responsibility for controlling budgets.
NHS bodies that are managed successfully time and again stress the importance of creating a culture of financial awareness in all parts of the organisation. While board members, the chief executive and the director of finance all have key financial roles to play, responsibility for financial discipline needs to be more widely spread and accepted by all staff. The usual way is by circulating written guidance in the form of standing orders, financial instructions and clear job descriptions, sometimes supplemented by induction courses and other types of training [CASE STUDY 4].

Good financial and business planning and budget-setting processes

A central element of good financial management is a planning process that enables organisations to look ahead and set priorities for the short, medium and longer-term. Risks and uncertainties need to be identified, quantified and managed. In the NHS, the emphasis until recently has been more upon the annual contracting and funding round than on longer-term financial and business planning. One of the features of the changes being introduced into the NHS is a move to longer-term service agreements between commissioners and providers, which should result in more stable funding flows.

CASE STUDY 4

Financial management training at Sunderland City Hospitals Trust

The Trust has set up a directorate structure that places financial accountability upon those responsible for taking spending decisions. Each directorate includes a business manager who is also responsible for managing the devolved budget.

There is a regular series of training events for business managers and senior medical staff, lasting up to two days each month, covering the latest policy and management issues facing the Trust. The director of finance has an input to each of these sessions. Feedback from the staff involved is that they are better equipped to carry out their financial management responsibilities.
66. Only a minority of NHS bodies responding to the Commission’s questionnaire has developed long-term plans. Fifty-five per cent of HA purchasing plans and 75 per cent of trust business plans cover only one year ahead [EXHIBIT 18].

67. If long-term plans are to be of real benefit and not simply a wish-list for the future, they need to be supported by clear financial and activity plans. While the majority of HAs and trusts have such supporting information for their longer-term plans, a significant number do not, leading to the risk of a mismatch between the body’s objectives and the finances and facilities to deliver them [EXHIBIT 19, overleaf].

68. Most HAs and trusts include detailed financial and activity plans to support their purchasing and business plans. But it is of concern that 30 per cent of HAs’ purchasing plans did not include a detailed financial plan, and 40 per cent did not include a detailed activity plan. The coverage was more comprehensive at trusts where nearly 90 per cent of business plans included financial details. It is also noteworthy that only 3 per cent of business plans included detailed staffing plans, a very low proportion considering that such a large proportion of NHS spending is on staff.

69. If plans are to reflect accurately the available resources, then they need to be agreed between commissioners and providers. This needs to be done to a greater extent than is currently the case [EXHIBIT 20, overleaf].
EXHIBIT 19
Extent to which HAs’ purchasing plans and trusts’ business plans are supported by detailed financial and activity plans
The majority of HAs and trusts have purchasing and business plans supported by other detailed plans, but a significant proportion do not.

EXHIBIT 20
Commissioner support for trusts’ business plans
For plans to reflect properly the available resources, commissioners need to support trusts’ business plans.

Source: Audit Commission
70. All plans, whether for the short- or longer-term, need to be communicated and then monitored throughout the organisation. It is common for trusts to be structured into clinical groupings called either divisions, directorates or care groups. Most of these sub-parts of trusts have business plans, but over 40 per cent did not include financial details. In these cases, the effectiveness of the plan as a management tool may be reduced.

71. As well as developing long-term plans, some NHS bodies use formal reviews during the year to help to identify issues that are likely to have an effect on the body in the future. These are then quantified and built into budget estimates and future plans [CASE STUDY 5].

CASE STUDY 5
Cardiff Community Trust in-year reviews
Cardiff Community Trust undertakes a comprehensive mid-year review of its external environment to identify changes that may have a future impact on the Trust as well as undertaking a major in-depth risk assessment of each directorate. The reviews focus on financial risks, which allows the nature and extent of the risks to be discussed at an early stage with directorates and built into the forthcoming financial year budget plans. Early identification of the risks allows time for the Trust to respond to these changes in a measured way.

72. Underpinning long-term plans is the annual budget, which has a controlling influence over all the activities of the HA or trust. Detailed budgets are an important part of an effective financial management system, and should flow from long-term plans. Without consistency between these plans and the annual budget, the strategic objectives of the organisation are unlikely to be achieved.

73. Most NHS organisations use a mix between incremental budgeting, where budgets are adjusted only at the margin year on year, and zero-based budgeting, where some elements are re-examined in their entirety each year. It is important that budgets reflect in monetary terms the aims and objectives of the NHS body, matching forecasts of clinical activity and flexing during the year to reflect changes in the demand for services. Only 30 per cent of trusts responding to the Commission's questionnaire felt that budgets aligned fully with activity forecasts, while a further 60 per cent reported that they aligned partly. To help to develop clinical ownership of budgetary targets the linkages between activity and money need to be improved.
74. Budgetary systems also need to motivate staff to achieve results. Budgets need to be realistic and achievable, but the budgetary system also needs to include incentives. Examples of these are the ability for budget managers to carry forward underspending from one year to another, or to use savings in one area to pay for developments, such as new equipment, in another. Conversely, the budgetary system also needs to include penalties. These might include the carrying forward of overspendings from one year to another, and explicit action against staff who continually fail to achieve budgetary targets. Less than one in five trusts had arrangements in place to carry forward budget variances from one year to another [EXHIBIT 21].

75. As well as aligning financial budgets with activity targets and having the right incentives, the budgetary system also needs to be, and be seen to be, fair. While differential efficiency targets may be appropriate — relying, for example, on greater savings from non-clinical areas — the rules must be clear from the start. Asking one part of the organisation to bail out another late in the year may undermine the credibility of the whole budgetary system [BOX D].

EXHIBIT 21

Budgetary incentives and sanctions
It is important that budget monitoring systems include incentives and sanctions that reward good, and penalise poor, financial management.

BOX D

Setting realistic budgets
At an acute trust, the majority of cost improvement targets had previously been found from non-clinical areas. Despite this, these areas were again asked to find further in-year savings to provide the resources for overspending clinical areas.

A failure to budget accurately for clinical expenditure at the start of the year undermined budgetary targets and demotivated non-clinical budget managers, who resented the unfairness of the cuts they had to make.
76. A prime purpose of financial management in the NHS is to enable decisions to be taken on an informed basis about the nature of the services to be provided. Once these decisions have been made and translated into budgets, an effective monitoring system, which includes both service and financial information, should provide accurate information to show progress against priorities. One way for the process to be successful is for commissioners and providers to work together to determine how services should be prioritised, developed and funded [CASE STUDY 6].

CASE STUDY 6

Avon HA determining priorities

Avon HA has agreed a framework for decision-making in respect of how services within the HA should be funded, developed and prioritised. In drawing the framework together, the HA sought input from professional advisory groups and the local community. The framework covers four broad areas:

- protocols for treatment and criteria for access to services;
- funding levels;
- introducing new drug therapies; and
- consideration of exceptional cases.

Protocols for treatment and criteria for access to services

Criteria have been developed in discussion with trust clinicians, HA staff and GPs that are based upon evidence of effectiveness and outcomes as well as the day-to-day experience of individual clinicians. These criteria or protocols provide a framework against which individual clinicians exercise their clinical judgement. The criteria are reviewed by the HA on an annual basis.

Funding levels

Recognising that the level of funding that is allocated each year to a service determines how many people will be able to have access to that service, the HA has involved trust staff and GPs (and in future PCGs) in decisions about priorities and funding levels. As the HA considers its broad approach to priority-setting for the following year, these judgements are considered carefully and the implications of proposed decisions are made clear.

The introduction of new drug therapies

The HA works closely with the Prescribing and Therapeutic Committee and, on occasions, the District Medical Advisory Committee, to seek advice on the introduction of new drug therapies before making decisions on which new therapies should have the highest priority. In taking these decisions the HA recognises that every new development is competing for funding with existing services and other potential service developments.

Consideration of exceptional cases

Where an individual (or carer) feels aggrieved by a purchasing decision of the HA, an appeals procedure has been established to determine whether exceptions to the general purchasing policy should be allowed.
Clear framework of financial control

77. NHS bodies need to maintain an effective system of controls if they are to exercise good financial discipline. By incorporating effective controls into their financial systems, generally referred to as internal financial controls, HAs and trusts can be confident that their transactions will be properly processed and that errors will be detected promptly.

78. The NHS has been at the forefront of corporate governance initiatives in the public sector in recent years. From the 1997/98 financial year, directors must confirm that the organisation has an appropriate system of internal financial control. This means that the 'minimum control standards', as laid down by the NHS Executive and the Welsh Office, have been in existence within the organisation throughout the financial year [BOX E].

<table>
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### Key financial controls 1998/99: minimum control standards

Minimum control standards have been specified under five headings:

**The control environment**
- Standing orders are in place.
- Standing financial instructions are in place.
- There is a fraud and corruption policy and response plan in place.
- There is an audit committee in place.
- There is a remuneration committee in place.
- There is an adequate internal audit function.
- There is a mechanism in place to facilitate control over the acquisition, use, disposal and safeguarding of assets.
- There is a budgetary control system in place.

**Identification and evaluation of business risks**
- There is an annually produced business plan.

**Information and communication**
- There are systems in place that produce reliable financial information and proper accounting records.
- There are controls in place concerning the security of financial systems and data.
- The 'millennium' impact on the organisation's significant and fundamental financial systems has been assessed and, where required, contingency plans have been prepared.

**Control processes**
- Procedure notes are in place for all significant and fundamental financial systems.
- Financial systems are subject to internal audit coverage.
- There has been adherence to the mandatory requirements contained within the current NHS Executive costing guidance.

**Monitoring**
- The audit committee reviews and monitors internal financial control and the implementation of agreed control improvements.
- The board regularly receives and reviews financial and performance reports.

*Source: NHS Executive/Welsh Office Manual for Accounts*
ACHIEVING AND MAINTAINING FINANCIAL BALANCE

79. It is a fundamental principle of good financial management that health bodies 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, either on-line or on a regular basis, and is able to take action quickly should there be evidence of unexplained or unauthorised variances.

80. There may be instances where expenditure control does fail and there is a need for the centre to assume greater control. Such moves should be for the minimum time needed to restore financial balance [CASE STUDY 7].

81. Some NHS bodies adopt a policy of challenging expenditure decisions continually as a means of reinforcing the pressure upon budget holders not to exceed allocations [CASE STUDY 8, overleaf].

It is a fundamental principle of good financial management that health bodies should aim to devolve responsibility for controlling budgets as closely as possible to those who take the decisions about using resources.

CASE STUDY 7

Dorset Community Trust – using short-term expenditure controls

Following the merger of two smaller community trusts in 1993, the newly formed Trust struggled to come to terms with financial difficulties in the new organisation. The position was made worse by a lack of financial information and a weak management structure. The Trust sought to resolve its financial problems through a major redundancy programme. The situation came to a head in 1996/97 when the Trust reported a deficit of £1.7 million, a significant part of which was caused by redundancy payments, although the underlying position was still not one of recurring financial balance.

Faced with a major financial crisis, the newly appointed director of finance immediately re-centralised all expenditure controls. Any non-staff expenditure over £300 was authorised personally by the chief executive. Simultaneously, the accounting information and systems were improved to provide reliable financial information. Once the position had stabilised, decision-making was transferred back to the newly created directorate structure.

Using short-term expenditure controls was necessary as part of an overall package of measures to restore financial balance and the Trust has now established itself as a financially stable organisation.
CASE STUDY 8

Challenging expenditure decisions

Different ways can be used to review decisions to incur expenditure.

Example 1
Cardiff Community Trust used its audit committee to challenge items of expenditure. The message got through very quickly to staff that their expenditure decisions would be reviewed by board members.

Example 2
All external advertisements to fill vacancies are first approved by the chief executive at Trafford Hospitals Trust. While very few requests are rejected, the process encourages staff to think carefully about the need for and requirements of every post before automatically filling the post.

Non-staff-related expenditure is also subject to scrutiny. Certain categories of expenditure need to be approved by the finance department before being processed by the in-house supplies function, which also actively challenges expenditure proposals.

82. A feature of the NHS in recent years has been an annual requirement to improve efficiency. An important element has been to achieve cost improvement programmes (CIPs) – that is, to reduce costs by a percentage which is set by the NHS Executive and the Welsh Office. The intention is that these 'savings' are then recycled throughout the NHS to finance new treatments. The majority of work undertaken as part of CIPs takes place within trusts with relatively low levels of input from commissioners.
83. Very few trusts seek to reduce costs simply by across-the-board budget reductions. The majority prefer to use a mix of across-the-board reductions and the targeting of specific areas. The areas that are most frequently targeted are management cost reductions, skill and grade mix review, the contracting out of services, and estate rationalisation. There has been a tendency to focus cost improvement initiatives more towards functional areas that are more easily measured, rather than clinical processes. This view is highlighted further in an analysis of the areas where questionnaire respondents thought that CIPs had been the most successful [EXHIBIT 22].

84. Exhibit 22 shows that, while most trusts have achieved success in directing cost improvement programmes at functional areas, those that have also looked for cost reductions in relation to the delivery of services to patients have also been successful. Since the majority of money spent within the NHS is spent on clinical processes, these are likely to offer the opportunity for further efficiency improvements.

EXHIBIT 22
Success of cost improvement programmes in different types of activities within trusts
Cost improvement initiatives have tended to focus on functional areas.

Note: MSEE refers to medical and surgical supplies expenditure.
Source: Audit Commission
Effective monitoring and management information systems

85. Good quality monitoring and management information is essential if an organisation is to manage its finances effectively. There is no single model format for financial reports, as this will depend on local needs. But, as the Commission reported in its management paper, *Taken on Board*, published in 1995 (Ref 8), reports to board and authority members should always:

- be well-presented, concise and concentrate on the key facts. Badly presented reports can make it difficult for those with financial responsibility to see the wood for the trees;
- be up to date. Out-of-date information can mislead, causing people to reach the wrong decision and possibly allow a bad situation to get out of hand; and
- be sent as soon as possible. Each member should receive regular budget reports, that are tailored to their particular needs.

86. If members of HAs and trusts are to meet their financial responsibilities, the information they receive must be sufficient to cover the key areas but be kept to a manageable level and be comprehensible. 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.
87. For NHS bodies, the management information presented to trust boards and HAs needs ideally to combine both financial and activity-related data, along with narrative explanation. Over 80 per cent of HAs reported that members receive regular financial and activity data, but less than 15 per cent said that they integrate this into a single report for the authority’s meeting. In addition, only one-third of trusts explain financial variances from budgets in service delivery terms. Monitoring reports at trust board and directorate level tend to be dominated by financial information, which users do not always find useful [EXHIBIT 23].

88. The clear message from Exhibit 23 is that, while financial information is seen as being very useful to trust boards and directorates, other management information that could be equally as useful is reported to boards only infrequently. The effectiveness of trust boards and directorates could be improved by also providing them with data on cost improvement programmes, patient waiting times and other critical success factors.

89. Financial reports presented to boards and HAs could also be better in terms of improving the integration of financial and activity data and to explain more fully the implications of budget variances. Where possible, reports should also contain comparable information to allow comparisons to be made with similar organisations, previous years and national standards.
QUESTIONS

- Is there a pervasive culture of financial awareness and responsibility?
- Does the board/authority lead by example in discharging its financial leadership role?
- Does the audit committee review internal financial control effectively?
- Are members satisfied that there is a strong working relationship between the chief executive and the director of finance?
- Does the HA/trust have longer-term commissioning or business plans?
- Are longer-term commissioning or business plans supported by financial and activity plans?
- Are commissioning or business plans supported within the context of the local healthcare economy?
- Are annual budget allocations realistic and achievable?
- Do budget estimates align closely with clinical activity?
- Are there incentives in the budgetary system to reward good performance and penalise poor performance?
- Is there an effective system of internal financial controls in place?
- Are the 'minimum control standards' laid down by the NHS Executive/Welsh Office being achieved?
- Are delegated financial and managerial responsibilities aligned?
- Are cost improvement initiatives targeted on the areas offering scope for the greatest improvement opportunity?
- Are financial monitoring reports well presented, up to date and sent to the right people?
- Does the management information presented to board and authority members combine financial and activity related data?
5. Conclusion

90. The NHS has a clear duty to manage its resources to the best effect, and the management of its financial resources is a key element in providing effective healthcare services. As this management paper shows, NHS bodies in England and Wales face a range of formidable challenges in achieving this task. Generally, they are meeting those challenges well, and auditors report that the overall standards of financial management at both trusts and HAs are consistently high.

91. There is no single key to success, but better financial management is likely to result where trust board and authority members:

- identify and manage the different, and often competing, pressures upon resources;
- appreciate the critical role that good financial management plays in the overall success of the body;
- instil a culture of strong financial awareness at all levels of the organisation;
- lead by example in their consideration of financial matters;
- accept that financial management is a key responsibility for staff at all levels, and that attention needs to be given to ensure that staff are trained properly;
- seek to delegate financial decisions to those responsible for decisions that commit resources, while being themselves informed of the overall financial position;
- assure themselves that robust financial planning, budget-setting and monitoring processes are in place;
- receive appropriate information on a regular basis; and
- are willing to take what at times can be harsh decisions about staffing and service provision where financial problems arise.

92. Questions that members and senior officers may wish to consider to satisfy themselves that their approach towards financial management is appropriate are included in the centre pull-out checklist included in this paper.
References

Glossary

**Accountable officer**
Nominated officer at each NHS body, normally the chief executive, who carries personal responsibility for financial management.

**Bank-nurse system**
System of holding nurses on call to replace shortages due to illness, training or unfilled vacancies.

**Brokerage**
Means of transferring funds for a short period, normally at the end of the financial year, from those NHS bodies with surplus resources to those requiring resources.

**Commissioner**
NHS body, usually a health authority, that is purchasing healthcare services for its population.

**Cost improvement programmes (CIPs)**
Cost reduction, or efficiency improvement, targets set each year by the NHS Executive/Welsh Office for each NHS body.

**Cumulative financial position**
Outcome of income compared with expenditure, taking account of all previous years’ financial results.

**In-year financial performance**
Outcome of income compared with expenditure, ignoring any impact of the previous years’ financial results.

**Local health groups (LHGs)**
Welsh equivalent of PCGs (see below).

**Non-recurring funds**
A one-off allocation of funds normally to solve quickly a financial problem.

**Primary care groups (PCGs)**
Groupings of general practitioners, primary healthcare professionals and others acting as a subcommittee of a health authority for the purchase of primary health services for the local community.

**Provider**
NHS body, usually a trust, but can also be another public sector body such as a local authority social services department or a private sector supplier of services.
Appendix: Members of the advisory group

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Former Deputy Director of Finance, NHS Executive

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Former Deputy Director of Finance, Southampton University Hospitals NHS Trust

Geoff Watkins
Health Financial Management Division, Welsh Office
The Audit Commission has produced a number of reports covering issues related to management in the NHS. The following may be of interest to readers of this report:

**Cover Story**
The Use of Locum Doctors in NHS Trusts

**First Assessment**
A Review of District Nursing Services in England and Wales

**A Life in the Fast Lane**
Value for Money in Emergency Ambulance Services

**Protecting the Public Purse**
Ensuring Probity in the NHS – Update 1998

**First Class Delivery**
Improving Maternity Services in England and Wales

**The Coming of Age**
Improving Care Services for Older People

**Anaesthesia Under Examination**
The Efficiency and Effectiveness of Anaesthesia and Pain Relief Services in England and Wales

**Comparing Notes**
A Study of Information Management in Community Trusts

**Goods for Your Health**
Improving Supplies Management in NHS Trusts

**What the Doctor Ordered**
A Study of GP Fundholders in England and Wales

**By Accident or Design**
Improving A&E Services in England and Wales

**Form Follows Function**
Changing Management Structures in the NHS and Local Government

**Lying in Wait**
The Use of Medical Beds in Acute Hospitals

**NHS Estate Management and Property Maintenance**

**A Short Cut to Better Services**
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The NHS is faced with the challenge of meeting increasing demands on its services. These include the growing healthcare needs of an ageing population, developments in medical technology that are leading to the availability of new treatments, and a more questioning and informed attitude from service users.

All these growing demands and expectations must be balanced against the limits upon the resources available to meet them. It is against this background that NHS bodies must manage their activities and achieve financial balance.

The Audit Commission has written this paper to help members of trusts and health authorities to identify the key factors that influence performance and the issues that need to be considered to meet this challenge successfully.