# Financial forecasting in the NHS

**July 2016**

**Best practice in difficult financial times**

shaping healthcare finance …

## Contents





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# Introduction

**NHS organisations are responsible for spending taxpayers' money to ensure that patients have access to high-quality healthcare, free at the point of need. As this is taxpayers' money, there is an absolute requirement to demonstrate that the money is used well and for its intended purpose.**

**Every NHS organisation also has a specific statutory duty to make 'proper arrangements for securing economy, efficiency and effectiveness in its use of resources' or 'exercise its functions effectively, efficiently and economically' [1].**

**To be able to meet this requirement, each organisation needs to determine the activities it will deliver or commission in any particular period and establish the associated resource implications or budget – not just in terms of money but also in relation to staffing, equipment, supplies and so on.**

**Planning and budgeting takes place in two areas – revenue and capital – which are then brought together in an overall plan. Being able to produce an accurate operational and financial plan and then to estimate how the organisation will perform in financial terms against that plan – a key responsibility of NHS finance directors – is more important than ever.**

**This briefing will focus on the second part of this equation, forecasting – how financial performance is estimated, predicted and reported within the NHS. The resulting prediction is subject to both national interest and media focus. This briefing will set out:**

- **What is a financial forecast?**
- **The current financial context**
- **Forecasting as a necessity**
- **Forecasting as an opportunity**
- **Basic principles of good forecasting**
- **Steps in preparing a forecast**
- **Trends in forecasting.**

**It also includes a number of case studies to illustrate how the theory is applied in practice and how some organisations tackle the challenges of forecasting.**

1 Sections 14Q, 26 and 63 of the *NHS Act 2006*/Schedule 3 of the *Health and Personal Social Services (Northern Ireland) Order 1991*/s175 of the *National Health Service (Wales) Act 2014*/ s15 *Public Finance and Accountability (Scotland) Act 2000*

## What is a financial forecast?

Simply defined, a financial forecast is a prediction of what the financial performance or position of the organisation is going to be at some determined point in the future. It is distinct from a budget, which is a quantified plan for where an organisation wants to go.

In the NHS, forecasts are routinely made in relation to the end of the current financial year (and milestones within the year) and the medium to long term (two to five years) as part of the annual planning cycle.

Much like weather forecasting, the business of financial forecasting has become more sophisticated and evidence-based, but is still prone to unanticipated events and unforeseen outcomes of known events.

The problems with forecasting can be summed up in the now infamous words of former US secretary of defence Donald Rumsfeld: 'There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.'

The more precarious the financial position, the more important it is to be able to accurately predict how close to, or far from, what was planned the organisation will be at the end of the financial year (the short term) and the financial outturn in the longer term (as reflected in longer term plans).

## Financial context – 2015/16

In 2015/16, the NHS in England struggled to stay within the resources made available to it – with the real possibility of a breach of the Department of Health's expenditure limit. It has been a particularly challenging year in both operational and financial terms for all types of NHS providers (foundation and non-foundation trusts). In its May 2016 board report[2], NHS Improvement stated that the NHS provider sector had finished the year with a deficit of £2.45bn for the financial year ending 31 March 2016. This was £461m worse than revised plans and £340m worse than the initial plan.

Having said that, earlier in the year, the worst case run rate forecast was that the year-end deficit would be £2.8bn, so the actual position was an improvement on that.

The picture for the devolved nations, while not quite as stark as that for England, still reflects a system that is under extreme financial pressure. A report to the Welsh Assembly health and social care health committee[3] showed an overall forecast deficit of up to £142m at the end of November 2015. However, the Welsh government is forecasting that the actual position will be £50m-£60m less than this.

Organisations within both the Northern Irish and the Scottish health systems have relied historically on non-recurrent funding to balance their positions and continue to face annual efficiency targets.

The challenges faced by the NHS during 2015/16 are well documented and include external pressures such as difficulty in recruiting permanent clinical staff and an unprecedented number of people attending accident and emergency departments (a

> 'Under the current pressures of austerity, growing demand and escalating costs, looking backwards is far from the most urgent task for NHS managers. Their urgent priority is to chart a firm course forwards: defining a clear, ambitious, but realistic path through the obstacles and barriers.
>
> 'The overwhelming imperatives are to plan the best possible deployment of the scarce resources to maximise their impact, and then to deliver this plan by steering the organisation effectively. Applying a disproportionate amount of these precious resources to describe in great detail the territory from which the organisation is just emerging is both wasteful and misleading.'
>
> ***Leadership of Whole Systems*, King's Fund**

2 https://improvement.nhs.uk/news-alerts/nhs-providers-working-hard-still-under-pressure/

3 www.senedd.assembly.wales/documents/s47516/PAC4-01-16%20P5%20Letter%20from%20Welsh%20Government%2010%20December%202015.pdf

*Historically, finance teams have tended towards optimism in financial plans and pessimism in financial forecasts*

rise of 2.9% against 2014/15 levels according to NHS Improvement). However, NHS finance staff have a key role in ensuring that forecasts are transparent, accurate and as comprehensive as possible and that the difference between what is forecast and what actually happens is a small as possible.

### Forecasting as a necessity

In these difficult financial times, finance professionals must continue to act with integrity and objectivity when developing budgets and forecasts and reporting the actual position against them.

In England, the Department of Health and its arm's length bodies (ALBs[4]) require detailed plans from all NHS organisations. The requirements were set out in *Delivering the forward view: NHS planning guidance 2016/17- 20/21*[5] published in December 2015.

The guidance sets out a requirement for each NHS organisation to produce two separate but related plans:

- A five-year sustainability and transformation plan (STP), place-based and driving the implementation of the *Five-year forward view*
- A one-year operational plan for 2016/17, organisation based but consistent with the STP (seen as year one of the five-year plan).

The planning requirements therefore mean that individual NHS organisations must be able to forecast their financial position for five years[6]. There is also now a clear link between eligibility for receipt of sustainability and transformation funding and performance against operational and financial targets which means that it has never been more important to have accurate forecasts of both financial and operational performance so early action can be taken if performance is not on target.

Health systems within the devolved nations are also taking steps to increase the focus on longer term planning and consequently longer term forecasting.

The Welsh health system has recently moved to a three-year integrated medium-term planning cycle and break-even requirement, and the Scottish health system also works to a rolling three-year local delivery planning cycle. At present, the health and social care system in Northern Ireland is still working to a one-year planning cycle.

### Forecasting as an opportunity

In this environment of financial pressure and longer term plans, a robust and methodical approach to financial forecasting is increasingly important. Entities must be able to produce financial forecasts that are credible and based on an impartial consideration of all known factors.

Historically, finance teams have tended towards optimism in financial plans and pessimism in financial forecasts – the balance between these two is crucial and should be struck by the organisation as a whole, not just the finance team.

In 2013, the Association of Chartered Certified Accountants (ACCA) published *The importance of strategic financial leadership in the UK public sector in a time of financial austerity*[7]. The study found that organisations in the public sector in the main prepare 'broad-brush' multi-year financial projections that are often of limited use and represent extrapolations of the past while having little in the way of underlying strategies.

In the same year, the National Audit Office[8] described financial management in government as having a 'fairly narrow role and not consistently central to a department's decision-making or strategic decision'.

Whilst neither of these reports focused solely on the NHS, it is clear that these findings may well be familiar within some NHS finance departments. Indeed the findings are in line with those reported in the

4 NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission, Health Education England, National Institute of Health and Care Excellence and Public Health England

5 www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

6 NHS Improvement issues economic assumptions for the next five years on a regular basis. These assumptions should form the basis for economic forecasts – https://improvement.nhs.uk/resources/economic-assumptions-1617-to-2021/

7 www.accaglobal.com/content/dam/acca/global/PDF-technical/public-sector/tech-tp-tiosfl.pdf

8 www.nao.org.uk/report/financial-management-in-government-2/

Chartered Institute of Management Accountants (CIMA) publication[9] in 2007 that looked specifically at financial forecasting within the NHS. It reported that the most common approach to forecasting remained an extrapolation of current results.

While there continues to be increased media attention on revenue outturn forecasts, NHS bodies are also required to prepare capital expenditure forecasts. Traditionally, NHS bodies have struggled to spend up to their capital resource limits, and have been criticised for poor capital expenditure planning and forecasting. In essence, the principles of both revenue and capital expenditure forecasting are the same.

Accurate capital forecasting will become more and more important as the capital resources available to the NHS reduce. This is reflected in NHS Improvement's proposed Single Oversight Framework[10] which introduces the possibility of capital control totals for NHS provider bodies.

## Basic principles for effective financial forecasting

However sophisticated an organisation's forecasting methodology, there are some basic principles that should always be followed in the production of financial forecasts.

***Start with a foundation in fact***

The forecast must be grounded in factual data. This could be:

- Actual financial performance to date (probably the most commonly used)
- Historical financial performance over the previous year
- Historical financial performance (appropriately profiled) over more than one year
- Actual activity information
- Historical activity information
- The normalised position, which is the historical performance adjusted for non-recurrent items
- Actual population profile data
- Agreed budgets and business plans for new developments
- Detailed costing information, particularly where the impact of new or different service arrangements are under consideration.

The best forecasts will use a mixture of all of this factual data. They will also take account of financial adjustments traditionally made at the year-end, such as provisions, partially completed spells, adjustments to inventories and impairments, so that there are no surprises when comparing actual performance with forecasts.

***Align to strategic plans of the organisation***

This becomes particularly important when looking at a medium- to long-term period when changes to services are more than likely to occur.
For NHS organisations in England, the development of STPs and the decisions around the transformational footprint of the organisation could have far reaching implications for financial forecasts – for example, when looking at potential partnerships that may evolve as a result of place-based planning and the introduction of long-term contracts aligned with different ways of delivering services.

***Be cognisant of external factors***

These can be demographic factors that will lead to service redesign, environmental or political factors – for example, changes in policy driving service provision. They can also be something as simple as the season – a common feature of NHS financial forecasting is an adjustment for activity and consequently a cost surge in certain months. They can also be more complex – for example, growth either in relation to local or regional demographics or in relation to market share.

In addition, the impact of national and local policy changes will need to be reflected appropriately. National examples include the introduction of the apprenticeship levy[11] from April 2017 and, harder to predict, the outcome of the junior doctor negotiations.
Local examples could include local authority strategic and operational

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9 www.cimaglobal.com/Documents/ImportedDcouments/tech_techrep_in_year_fin_forecasting_in_NHS_0807.pdf

10 https://improvement.nhs.uk/resources/have-your-say-single-oversight-framework-consultation/

11 The apprenticeship levy will come into force on 1 April 2017. It will be a charge of 0.5% of an employer's pay bill. However, there is a £15,000 allowance for employers, which means the levy will only be paid on employers' pay bills over £3m. See www.gov.uk/government/publications/apprenticeship-levy for the proposed arrangements for collecting the levy

*It is good practice to compare in-year forecasts to outturn and understand the reasons for any differences*

plans, such as a change in the provision of social care or the plans of local care home providers to open or close new operations in the area.

***Adjust for anomalies***
A good forecast will look behind the factual foundation to identify one-off items, either in the past or future, that will have an impact on the forecast position. This can be a particular issue as the year-end approaches in relation to non-recurrent income or funding.

Anomalies that can be forecast are likely to be external factors such as the opening of a care home in the area. A current anomaly is the outcome of the referendum on the UK's membership of the European Union; other elections may also affect forecasts.

***Include risks and consider more than one possibility***
Every financial forecast includes an element of risk assessment. Risks can arise from many sources – for example, the assumed level of patient activity, staff and agency costs or the timing of new service developments.

These risks should be clearly stated, quantified where possible and their impact on the financial position assessed. The forecast should take into account both the likelihood of the risk transpiring and its financial effect. A highly remote risk with a major impact should be noted but probably not built into the forecast, whereas a probable risk with a small impact should be included.

The key is to be open and transparent about the assumptions made at all levels of the organisation and reflect them in reports to the organisation's governing body or board.

Risk assessments are particularly important in volatile areas such as cost improvement schemes or commissioning for quality and innovation (CQUIN) payments. The rigour of considering the best case, the worst case and possibilities in between brings a level of confidence to a forecast. It is unlikely that all identified risks will be realised but a number will be critical to the organisation and it is important to recognise the associated financial impact in the forecast.

***Review forecasts against actuals***
Forecasting is an iterative process, so to judge the quality of the forecast, time must be spent 'closing the loop'. This involves routinely comparing actual income and expenditure with what was forecast and planned, then describing both to the finance and performance committee (or equivalent) and to the governing body or board with an explanation of any differences.

It is also good practice to compare in-year forecasts to outturn and understand the reasons for any differences. A monthly bridge analysis may be helpful here, to support internal understanding and reporting to the regulator.

If differences arise as a consequence of one-off items, such as non-recurrent funding, then this is probably not something that can be anticipated in the forecast. However, if differences are as a direct result of slippage or something else that has happened more than once, the forecast process needs to be reviewed and revised to ensure that such changes are taken into account.

***Ensure ownership by the organisation***
It is crucial that financial forecasting is completed in collaboration with clinical and other operational staff – for example, HR and estates staff. They should understand the forecast and how it has been derived and have input into the assumptions and risk factors considered.

A financial forecast produced entirely by a finance team working in isolation from the rest of the organisation lacks both credibility and organisational context. The forecast should be as important as reporting

the monthly position at all levels of the organisation and should be subjected to the same performance management rigour.

***Relate the forecast to the local health economy***
Having produced a cohesive plan across the local health economy, forecasting must take into account the individual forecasts of local partners. For example, it is no good a provider forecasting additional activity to be paid at full price if the relevant commissioner isn't in agreement.

Similarly, decisions about readmission and other contractual adjustments can have a material impact on the final year-end position. Regular, comprehensive and honest discussion is needed between commissioners and providers.

## Steps to good financial forecasting

Taking into account the principles outlined above, there are a number of key enablers involved in producing a financial forecast. Organisations need to take a holistic approach to all of the elements to improve the sophistication of financial forecasting. These can be split into three stages, as illustrated in the diagram.

***Inputs***
*Processes*
This represents the agreed mechanism for determining the forecast, to ensure consistency across different service areas. This could include a standard template that all areas complete, where they highlight their forecast achievement of cost improvement programmes (CIPs), to ensure that this is built into the overall forecast.

*Data*
This is the information that drives the final figures. It can be financial, such as general ledger, budgetary information, inflationary uplifts. It should also include non-financial information such as activity data and demographic data where this is available.

*Roles*
This is a clear understanding of who has responsibility for each part of the overall forecasting process; focusing particularly on the role of finance and non-finance staff – for example, operational staff having responsibility for highlighting new pressures to their service as a result of changes in national guidance such as National Institute for Health and Care Excellence (NICE) guidelines.

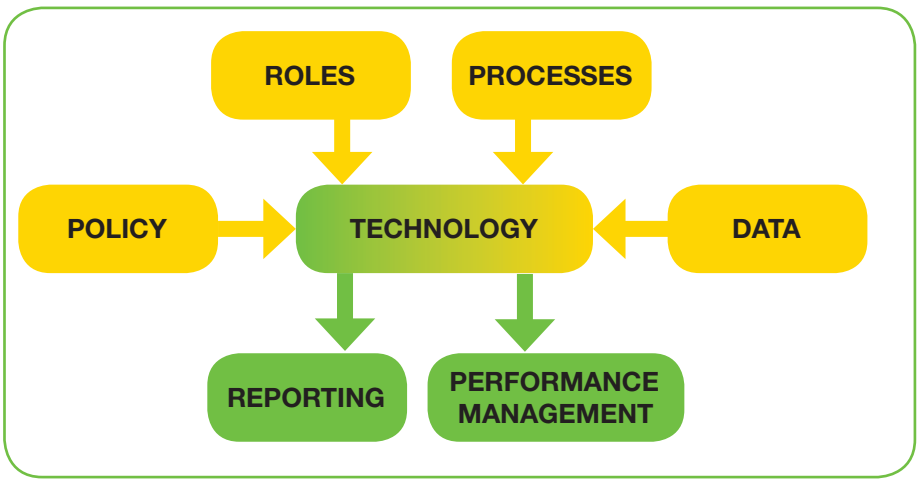
*Policy*
This sets out the overarching rules for the forecasting process including the timelines, frequency, review processes and deadlines. These should be documented as part of finance procedure notes.

***Technology***
A number of 'off-the-shelf' financial systems deliver detailed financial forecasting. Typically these work within the organisation's budgetary management system, and use both general ledger and budgetary information to produce detailed forecasts at account code and cost centre level. Such packages provide bottom-up financial forecasting.

Alternatively, organisations without such technology often extract general ledger and/or budgetary information into spreadsheets and adjust and manipulate it at a higher level to produce financial forecasts.

Best practice would suggest that where historic or current financial

*Where historic or current financial information is being used as a basis for the forecast, this should be derived from the general ledger*



*A rolling forecast creates an ongoing cycle of planning, conducting, evaluating and updating operations and their impact in financial terms*

information is being used as a basis for the forecast, this should be information derived from the organisation's general ledger.

Clearly, this basis is not appropriate where the services provided by the organisation are anticipated to be markedly different in the future than they have been in the past. In such cases alternative sources of information – such as agreed revenue and capital consequences of developments, forecast activity information, cost details of similar services – would be more appropriate.

***Outputs***

*Reporting*

This sets out who receives financial forecast information, how often and in what format:

- Is it in the form of a narrative monthly report to the board or is it a detailed analysis available to all budget holders?
- Is information in chart, graph or tabular form?
- Is only the most likely case scenario reported or are a number of different possible options given?
- Does the forecast information reconcile to the information provided to regulators? If not, why not?

*Performance management*

In this context, this is the process by which managers throughout the organisation are held to account for what the forecast is telling them about the likely performance of their area of responsibility and the organisation as a whole.

There needs to be clear understanding of how the forecast has been reached and what the key factors are in determining the forecast position, in order to use this information to inform strategic and operational decision making across the organisation.

## Trends in financial forecasting

It is clear that recent policy developments, together with the increasingly challenged financial position, have increased the focus on forecasting. Across private sector firms forecasting has seen a shift which is likely to be increasingly mirrored in the public sector. This shift can be summarised under five areas:

***Increase in rolling/dynamic forecasting and use of run rates***

A rolling forecast creates an ongoing cycle of planning, conducting, evaluating and updating organisation-wide operations and their impact in financial terms. It is updated on an ongoing and consistent basis, allowing a forecast to be produced at any time. Dynamic forecasting allows the forecast to be adjusted for changes – for example, slippage of cost improvement plans and the impact on the run rate.

***Improved ownership and transparency of forecasting***

There is a real potential here to improve collaborative working within and between NHS organisations, by harnessing the expertise and knowledge of service managers regarding future developments and risks in their areas, in the short and medium term. A financial forecast that is widely understood and owned by the organisation is a vital part of strategic planning and decision-making.

As NHS bodies and local authorities work more closely together to integrate health and social care, it will be important that forecasts are developed together by the different statutory bodies. This will involve agreeing a common timetable for forecasting and reporting and a common basis for financial reporting. For example, that all historic financial data is reported on an accruals basis and that all performance/activity data is reported to the same point in time.

***Levering technology***

Finance within the NHS has already harnessed technology in

the development of patient-level information and costing systems and service line reporting, to improve the understanding of cost drivers and drive out inefficiencies. Using this information to feed financial forecasting tools is the next logical development.

***Improved communication across the business***

Robust financial forecasting improves the finance department's knowledge of the organisation and vice versa. Forecasts can prompt challenging conversations around current performance and future direction, as well as providing assurance to boards in relation to the level of financial control operating in the organisation.

***Longer term forecasting***

In the main, financial forecasting within health organisations has focused on an in-year forecast, with the result at the end of each financial year being, necessarily, the main focus.

However, as we have seen both in England and some of the devolved nations, health bodies are being asked to look to a three- or five-year timeframe. Indeed, it could be argued that a truly effective healthcare system would look to a much longer timescale in order to anticipate the health and social care needs of the next generation, and build systems to meet those needs.

The movement to longer term forecasting will be more necessary in the context of longer term contracts and multi-year tariff rules. Some of the new models of care being developed in England are considering new contracting and payment arrangements that are much longer term (up to 15 years) than the NHS has seen before.

There is a risk that as the financial position of the NHS is currently so tight, and whilst the national tariff is set on an annual basis, the focus will remain on the in-year forecast. As a matter of best practice, NHS bodies should maintain a longer term (five-year) plan and forecast against that.

There is therefore a growing interest in the use of modelling and simulation, principally as a way of looking at the healthcare implications of changes in care pathways or the impact of new technologies.

However, this information can also be used to consider the financial implications of future changes. For example, the simulation software tool SIMUL8 was used by the NHS Ayrshire and Arran health board to model the relative benefits of different options for reconfiguration of unscheduled care services.

This process highlighted major potential problems with the existing configuration's ability to cope with clinical shortages, changes in working times and the requirements of new technology.

The simulation came into its own during public consultation, when the sponsors of the change were able to demonstrate the impact of different models of care live to public audiences.

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## Checklist for good forecasting

- Do you have a documented forecasting process from beginning to end?
- Have you automated the forecasting process as far as possible?
- Do you understand the key drivers for your organisation's performance and include them in your forecast?
- Are you using all available relevant information to prepare your forecast?
- Are you involving clinicians in your forecasting?
- Is your forecast understood and agreed at the highest levels in your organisation?
- Does your forecast include a list of key assumptions?
- Do you have a normalised forecast that strips out any one-off and non-recurrent items and focuses on the underlying 'normal' performance?
- Has your forecast appropriately considered risk?
- Does your externally reported forecast reconcile with internally produced information?
- Is there an escalation process within your organisation for the results shown in forecasts?
- Do you regularly review and update your forecast?
- Do you review your forecasts against actuals and understand the reasons for any differences?
- Do you evaluate the reasons why the forecast may not be accurate to determine whether any of those reasons should be built into future forecasts?
- Do you use forecasts as part of routine performance management? ■

## Glossary

■ **Bottom-up financial forecasting** This is a method of forecasting that starts with activity plans and works out the income that will be generated from that activity and the associated costs. In the commercial sector, bottom-up forecasting is based on sales forecasts, while the alternative top-down forecasts start with the market and calculate how much of the market share that entity can command. Bottom-up forecasting tends to be more conservative.

■ **Bridge analysis** This is a method of analysing and illustrating in a chart the difference between two results. In the case of forecasting, it is a way of showing the reasons that the actual position differs from the forecast. It is also known as a waterfall chart.

■ **Dynamic forecast** A dynamic forecast takes account of all of the variables affecting the outturn position. Therefore, if there is a reduction in staff numbers in one department it will take account of that, but also the impact on other departments that might see increases in workload. Like the rolling forecast, the dynamic forecast is updated each period for a number of periods ahead.

■ **Run rate** This is a way of extrapolating current results to predict future results. At its most basic, it would mean multiplying quarter 1 costs by four to predict the year-end costs. To be useful, run rates should be adjusted for seasonality and other known movements.

■ **Rolling forecast** This forecast is for a fixed number of periods ahead rather than the traditional forecast to a fixed point in time (usually the financial year end). Therefore, if the rolling forecast period is a year, the forecast reported in May 2016 would be to May 2017.

# Case study 1

Good forecasting follows on from accurate budgeting based on realistic contracts which all parties have signed up to. For **Hambleton, Richmondshire and Whitby CCG** the budget is based on historic information adjusted for known changes set out in the planning guidance, known changes to commissioned services by local providers, changes to the demographics in the area and QIPP plans. However, it is always important to bear in mind that the future is uncertain and it is the actions taken when the unexpected happens which are as important as the accuracy of the forecast.

As the finance team do not actually incur the expenditure, it is imperative that budget holders and clinicians are 'bought in' to the budget setting process. As the financial year progresses it is the finance and contracting team's role to identify where the actual expenditure is deviating from budget and where it might deviate in the future in the forecasts. Working with clinicians the finance team can identify the reasons for the gap and everyone, working together, can try to identify a solution to the problem.

As the CCG's forecast expenditure equates to income for provider bodies the CCG is in constant dialogue with them. Hambleton, Richmondshire and Whitby CCG has one main provider with whom they have an open and honest relationship. The two organisations share their forecasts and assumptions, and understand the reason for each other's position, each organisation can therefore manage any risk associated with their forecast.

Whilst the CCG uses the data produced through the Secondary Users System (SUS), there is a 6 week delay in this information so its relationship with its main provider allows it to identify issues early and therefore start working on a solution as soon as possible.

Each month the CCG's finance and contracting team and budget holders sit down together and work through the current financial position on a line by line basis and use this and the budget to forecast whether they are on target or not. They assess the risks to each line of the financial report and assess the best, worst and probably scenarios, it as an assessment of those risks which is used to provide the forecast position for the governing body.

When reporting to the governing body, it is the role of the Chief Finance Officer to be open and honest and to report an accurate position along with any assumptions made or risks associated with the position. In these current financially difficult times, there is pressure to report the 'right' answer and be more optimistic about what is achievable. The Chief Finance Officer, supported by the governing body, needs to be secure that the reported position is as accurate as possible even if this is telling a difficult message. It is then everyone's responsibility to find a solution to the challenges; these cannot be resolved by finance teams alone.

**Thanks to Debbie Newton, chief financial officer, Hambleton, Richmondshire and Whitby CCG**

## Case study 2

**South Eastern Health and Social Care Trust**, Northern Ireland has taken a number of steps in recent years to improve its financial forecasting methodology. In the past, the trust used a grossed-up figure of expenditure in the year to date. Steps have included:

- Introducing written procedures for how the general ledger actual position to date is used as the starting point for forecasting and how this information is then developed to produce the overall forecast
- Developing a standard template for the calculation of forecasts at sub-directorate and directorate level. Aggregation to organisation level provided the information reported externally in monitoring returns
- Incorporating within the template run rate adjustments for expenditure and savings. For example, the forecast is adjusted for the impact of winter pressure escalation activities and the downturn of beds in the summer months
- The forecast is adjusted at sub-directorate level by estimates for new/emerging pressures. These are discussed and agreed with operational managers to ensure a full buy-in to the figures being included, and has been key to building the credibility of the financial forecast across the organisation
- The forecast position is reported before and after the impact of ongoing savings plans. This allows budget holders to assess the underlying position of their areas, as well as determining the impact where savings plans are non-recurrent in nature
- The directorate forecast is discussed fully on a monthly basis at a formal meeting with operational teams; agreement is sought that the forecast represents a best estimate of the likely position of the directorate at the end of the financial year
- The forecast includes narrative around key risks to the position and key assumptions in arriving at the figure. This narrative is provided by the operational teams
- Each directorate is given a target forecast position at the beginning of the financial year, and any slippage on this is reported as part of the monthly forecasting cycle. There are agreed processes for the escalation of issues that are affecting directorate positions.

**Thanks to Wendy Thompson, director of finance, HSC Business Services Organisation**

# Case study 3

Rather than using its own data to drive an assessment of financial performance, **Tameside and Glossop CCG** uses patient-level activity data submitted by all secondary care providers to the DSCRO (Data Services for Commissioners Regional Office) central data warehouse via software managed by Civica.

The CCG uses a combination of SQL scripts and financial modeling templates (developed in-house) to interrogate this rich source of data on a monthly basis.

The output of this exercise is a set of detailed activity/cost models for each provider that allows for the following questions to be answered:

- For each secondary care provider contract, can a full analysis of current year to date and forecast positions be assessed?
- If there are unexpected variances, where (within which point of delivery) do they occur – emergency, elective or outpatients?
- Within each point of delivery, which specialty is over- or under-spending?

Having identified any significant queries, the CCG then works with its key stakeholders to investigate and address the issues accordingly. In the first instance, this will be with local providers to ascertain whether the query is isolated or will affect future periods. Reasons for variances include: coding issues with provider data; one-off isolated procedures (critical care with organ support); change to treatment pathways; public health initiative; and case mix.

The CCG also works very closely with GPs, local authorities and patient groups. It needs to have a clear understanding of how any variances are likely to impact on the care of its patients, so using trend analysis, past, present and future activity/cost profiles are created and provider forecasts are adjusted accordingly. Given the six-week time lag for main provider returns to become available, the CCG receives daily urgent care data sets to identify immediate issues and act as an early warning system.

From 1 April 2016, Tameside and Glossop CCG has been working with Tameside Metropolitan Borough Council as a single commissioning function. This has brought two sets of reporting frameworks together. The combined body produces joint reports for its respective management teams. Any significant shifts in activity and/or risks are highlighted to the management team, who will make judgement calls as to whether additional resource may be required. All of the reports are red, amber or green rated, based on the likelihood of a risk manifesting itself, as well as the likely impact of that risk. Something with a high risk but very small impact would be rated as less of an issue than a low risk but hugely impactful issue.

The CCG's lead provider continues to produce its own forecasts for its board. While there will be differences between the reports, these are known and understood so that the reporting across the health economy is consistent.

A single health and social care finance report has provided the opportunity to show the full impact of costs and activity for the community from the perspective of both the NHS and social care and demonstrate how they inter-relate.

**Thanks to deputy chief finance officer Tracey Simpson and senior management accountants Lee Butler and Darren Gregg**

Pictured: the single integrated finance team of CCG/council colleagues

# Case study 4

John Williams, assistant director of finance at **Chesterfield Royal NHS Foundation Trust**, acknowledges that the trust's forecasting is not perfect. It is, however, conducted in the general ledger, with a number of positive results:

- It enables automated reporting
- It allows detailed analysis to be done efficiently
- Actuals, forecasts and budgets are easily compared
- Forecasting at a granular level engenders ownership by budget holders
- The process is auditable.

Each month an extract from the general ledger is put into Excel. Months form the column headings; every cost centre account code combination populates the rows (income and expenditure). Actual income and expenditure are pre-populated; all other months are initially blank. These figures are populated by the finance team, with support, information and knowledge received from clinical/divisional teams.

Once complete, the Excel file is uploaded to the ledger (forecasting universe), enabling detailed analysis at a number of levels – ranging from the overall trust and divisional positions to a forecast of expenditure on agency staff or specific consumables. The forecasting information is automatically included in financial management reporting. This means the same information is used across all areas of the trust and when reporting externally to regulators.

Each month, the trust's actual financial performance is compared with the plan (budget) and the most recent forecast (usually the previous month's forecast). Attention is focused on actual spend and income rather than what was planned or any variance to plan, because when this was tried it overcomplicated the task.

The team found that the approach creates one language and reduces misunderstandings when discussing, for example, internal recharges and savings. In terms of cost improvement plans, only real cash reductions are included. The management accounts team meets together weekly to discuss any issues/queries and challenge and agree assumptions. This means all forecasts are reported in a consistent way for ease of understanding by the trust's leadership team.

Forecasting information is discussed with budget holders and the team plans to incorporate the forecast into individual budget statements as soon as possible. Consideration is also being given to the use of forecasting to support service line reporting – for example, in terms of forecasting service line contribution.

Consideration is also being given to scenario planning within the ledger. Currently only one forecast is included in the ledger but this could be expanded to include different scenarios. This is done outside of the ledger system.

Importantly, the trust's income forecast is shared and regularly discussed with commissioners to ensure there are no material differences in forecasting assumptions and to prevent any year-end surprises. This joined up approach enables the resolution of data quality issues early on, translating into confidence in relation to the year-end position.

Dr Roger Start, divisional director and trust cancer lead clinician, says: 'Budgetary forecasting is vital to divisional and departmental leadership teams. Just like weather forecasting, the information allows proactive, timely responses to predictable and unforeseen events as these develop in any given locality.'

**Thanks to assistant director of finance John Williams**

## Case study 5

Forecasting does not always need to be a look very far ahead. At **Hertfordshire Partnership University Foundation Trust**, the finance team produce a 'flash forecast' on the second Tuesday for the month just ended.

This is an early forecast of income and expenditure for the month, which is circulated to the executive team. It acts as an early warning of emerging issues two weeks ahead of the production of the actual results. It means that action can be taken to resolve problems at any early stage, which is vital in these difficult financial times.

As a mental health provider, the trust has a block contract, which means that income is relatively straightforward to forecast – although adjustments have to be made for CQUIN elements of the contract which are either cost and volume or performance related.

Pay is the trust's largest cost and the forecast is made up of three elements – staff pay, bank costs and agency costs. The first two are relatively straightforward to forecast, as the payroll information is available ahead of the month end. Agency costs are harder to forecast as these are reliant on the systems for hiring agency staff being followed. However, producing this early forecast is useful to flush out issues with that system and has helped strengthen controls in this area.

Of the rest of the trust's expenditure, a further challenge is to forecast overheads in those areas where costs do vary, such as IT spend, consulting and marketing/communications.

To produce this forecast a set of questions has been developed for the accountant responsible, which the corporate division will work through at the end of each month.

This reporting, which has been in place for several months, is now relied upon by the executive team and used routinely. Within the finance team, it has helped force our understanding of the variability of the key expenditure areas and the associated cost drivers. By then focusing on those cost drivers, it has helped get a much earlier sense of how costs are moving and what actions need to be taken.

Hertfordshire's executive director for finance, Keith Loveman, says: 'For me the flash forecast means I can take a day-one view of the financial position to the executive for discussion, and we can take decisions on any actions much earlier. The flash has proven to be robust and reliable and has also led to much more forward-focused discussion, which is very positive in approach.'

**Thanks to Paul Ronald, deputy director of finance**

## About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

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

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