hfma briefing

Contributing to the debate on NHS finance
May 2007

Better budgeting

Case studies: Basingstoke and North Hampshire NHS Foundation Trust, Mersey Care NHS Trust, South and East Dorset Primary Care Trust, King's College Hospital NHS Foundation Trust

Foreword

The NHS cannot afford to continue making the sort of losses that it did in 2005/06. Department of Health finance director Richard Douglas is undoubtedly right when he points out that many of the worst financial cases across the country exhibit a lack of basic controls. Budgeting is just one of a number of controls that we should expect to see in operation within an organisation. Indeed as a control it is without compare: no other single control measure, when combined with monthly reporting, covers the complete range of income, pay and non-pay expenditure. Across all areas, effective budgeting provides not a preventative measure, but an early warning of things going awry.

At the same time it drives a process of review that forces the organisation to consider its ability to improve efficiency, and provides a raft of management information upon which to make decisions. This makes it all the more surprising that we aren't better at budgeting than we currently are. As the Department's head of costing and classification Peter Donnelly pointed out recently: 'We [finance departments] need to make greater links between activity and resources' and, 'budget holders are turned off by incremental budgeting that bears little relation to the work they undertake'.

This guide takes the form of a general introduction to budgeting and a number of case studies, each of which highlights the progress that is being made in budgeting, and the benefits that this has realised. A common recognition throughout each of the case studies is the importance of clinical buy-in and ownership, when attempting to establish and monitor more realistic budgets, based on activity. So how far will the NHS be prepared to go? Service line costing is on its way, with exemplar sites likely to be used in the setting of the tariff in the future. Tariff will be based upon their cost structures, and their ability to deliver greater efficiency through better understanding of their costs. Are you sure that you can afford to be left behind?

Keith Wood, Chairman of HFMA's Financial Management and Research Committee

Acknowledgements

The articles in this publication were written by Seamus Ward, freelance journalist and contributor to *Healthcare Finance* magazine, following interviews with finance managers at the relevant organisations. The HFMA would like to thank the following for their time and help in producing this collection of case studies:

Steve Bolam, Lisa Thomas (Basingstoke and North Hampshire), **Neil Smith, Dave Sproson** (Mersey Care) **Paul Sly, Mark Orchard** (South and East Dorset), **Simon Taylor, Jonathan Rowell** (King's College)

Sponsored by COA CedarOpenAccounts

HFMA E-LEARNING

bringing the classroom to your desktop

HFMA E-LEARNING MODULES:

Introduction to Budgeting*

*Aimed predominantly at **helping budget holders and budget managers** fulfil their responsibilities, this module provides an introduction and overview to the whole subject of NHS budgeting.*

Introduction to NHS Finance in England

*Aimed predominantly at **Non Executive Directors and** as a general introduction for **all staff** in the NHS, this module is also relevant to **finance staff** new to the function.*

Introduction to Payment by Results*

*This module provides an introduction and basic overview of Payment by Results and how it will operate in the NHS in England. It is suitable for **NEDs, non finance staff and finance staff new to the NHS.***

Introduction to Practice based Commissioning

*This module aims to provide an introduction to Practice based Commissioning offering an overview to **non-finance staff and finance staff** who want to gain a better understanding of what PbC is, what it aims to do and how and why it is used.*

Introduction to Governance (Available from April 1st 2007)

*This module can provide an introduction to Governance offering an overview to **Non Executive Directors, non finance professionals and finance staff new to the NHS** who want to gain a better understanding of what Governance is and why it is important.*

* These modules have been developed in partnership with Leeds Teaching Hospitals NHS Trust.

Testimonials: Introduction to Budgeting

The Leeds Teaching Hospitals NHS Trust

'This programme undoubtedly ensures all our managers are financially trained to a consistently high standard…and ensures every pound of taxpayers money we spend, delivers value.'

Neil McKay, Chief Executive, The Leeds Teaching Hospitals NHS Trust

'Our aim is to empower managers at low as possible a level to ensure financial accountability across the organisation and right down to ward level.'

Neil Chapman, Finance Director, The Leeds Teaching Hospitals NHS Trust

'It's an excellent system. Anyone that can read and follow very simple instructions can use this system.'

Stacey Hunter, Matron, The Leeds Teaching Hospitals NHS Trust

Interested and **Want to find out more**?

For further information please visit **www.hfma.org.uk** and download a brochure or for a free e-learning demo please contact **Alison Myles** on **01380 830395**; **Alison.myles@hfma.org.uk**

hfma E-LEARNING

Introduction

Ask any accountant what a budget is, and you will get a reasonably simple response – usually, something along the lines of 'a budget is an organisation's plans expressed in financial terms'. In the NHS, as with other organisations, the reality is more complex than this simple statement suggests as the service moves to more sophisticated budgeting methods.

Traditionally, NHS organisations have simply rolled forward their previous year's budget into the new financial year, taking account of extra costs, such as pay awards and service developments, and deductions, such as efficiency savings. This historic or incremental budgeting has been the predominant method of budget-setting in the NHS, though some bodies have combined this with other techniques, like basing budgets on the amount of patients they see (activity-based) or building budgets from scratch (zero-based).

Zero-based budgeting, together with other complex forms of budget preparation, are being used increasingly as the NHS becomes more patient-led. Reform of financial flows and the implementation of Patient Choice, the financial turnaround programme and the introduction of new commissioners and providers have created a need for more detailed, accurate and timely information. In response, NHS organisations are moving to improve their budget-setting processes.

However, this has created a new set of challenges for NHS finance. The more sophisticated forms of budgeting are time-consuming and data can be difficult to pin down (though, with the right tools in place time can be saved, particularly in preparing, monitoring and reporting budgets). Training is essential, especially for non-finance staff such as budget- holders. They must play a more central role in budget-setting and monitoring if the new techniques are to accurately reflect and forecast income and expenditure, together with their organisation's plans and the priorities of the NHS as a whole.

How are budgets currently drawn up in the NHS?

The predominant – though by no means exclusive – method of budget-setting in the NHS is historic or incremental budgeting. This uses the previous year's budget as its starting point. Non-recurrent spending from this period, such as time-limited posts, is deducted before adding the full-year cost of any required service developments, new staff or drugs (typically the budget for a new service is calculated on a zero basis and then added into the incremental budget). The budget is then adjusted for increases or decreases in activity, as well as the cost of mandatory cost pressures, such as national pay awards. Finally, savings from cost improvement programmes are deducted and the final budget is reached by adjusting for inflation (this can include uplift in income).

Acute trusts and strategic health authorities (SHAs) have generally used incremental budgeting, though SHAs' training and education budgets are 'set' by the contracts they negotiate with providers. The same goes for the commissioning arm of PCTs, which negotiate contracts or service level agreements with providers. PCTs also have a provider function, where budgets have mostly been put together on an incremental basis using the budgets devolved to the primary care trust by predecessor community mental health trusts or acute trusts that provided community services.

Some PCTs have zero-based individual provider services and many are moving to writing service specifications for their provider arms that form the basis of a service level agreement or contract that have providers' income attached. Contract schedules can include performance agreements down to HRG or specialty level.

Incremental budgeting risks perpetuating inefficiency, or even worse adding to the problem by failing to recognise changing operational constraints. A good example is the waiting list initiatives of the 1990s. A HFMA survey at the time found 80% of hospitals were planning additional theatre sessions over weekends to help cut waiting lists. All the hospitals had problems with bed numbers but only around 30% to 40% were putting in additional capacity. Where no additional capacity was introduced, patients operated on over the weekend occupied beds meant for elective patients scheduled for the beginning of the week, so the hospitals had to cancel operations on Monday and Tuesday. Using incremental budgeting, hospitals were walking into the trap of putting extra money into theatres to cover pay and other expenses (adding last year's number of sessions to the desired increase) without budgeting for the knock-on effect on bed occupancy.

Trusts involve budget-holders in the preparation of budgets to a greater or lesser extent. This is seen as one of the disadvantages of incremental budgeting as the budget-holders (who are, after all, accountable for balancing their income and expenditure) feel that

Zero-based budgeting, together with other complex forms of budget preparation, are being used increasingly as the NHS becomes more patient-led.

budget setting is something that happens to them. This lack of engagement can lead to resentment and a feeling that the budget is unrealistic – circumstances that can lead to overspending.

Incremental budgeting has other disadvantages. It can perpetuate inefficiencies by simply rolling forward spending without questioning its worth. Organisations wishing to change their priorities will be unable to use this form of budgeting and it is not well suited to the new NHS market environment.

Drivers for change

The public sector as a whole is moving to more sophisticated forms of budgeting and the NHS is no exception. Indeed, some of the drivers for change are so strong that many would argue the health service must adopt accounting techniques widely used in the commercial sector.

Reforms to create a patient-led NHS, such as payment by results and practice-based commissioning, are stimulating this change, together with the desire to put NHS finances on a firmer footing following the deficits of recent years. In many ways these reforms together with initiatives to address financial pressures have one thing in common – they demand organisations produce more complex sets of information that helps managers and clinicians tie finance to activity, staff numbers and skill mix, efficiency, effectiveness and the strategic aims of the organisation and the NHS as a whole.

In England, PbR is probably the most obvious driver for change. With money following the patient, trusts are no longer certain about their income and expenditure. And with a fixed tariff, trusts are unable to simply roll forward the previous year's budget without analysing whether their own costs are similar to the tariff. With income being calculated on the basis of tariff times activity, providers must become better at forecasting how many patients they will attract.

Financial pressures are also pushing the NHS towards more sophisticated budgeting methods. Incremental budgeting can perpetuate inefficiencies by assuming that, say, an orthopaedics department's budget should be last year's allocation plus inflation. Cheaper prostheses could be available, for example, or more patients could be treated as day cases but incremental budgeting does not necessarily create incentives to examine the reduction in costs these could produce.

The turnaround initiative and PbR have focused many minds in the NHS on the value for money of some services.

While inefficiencies may be undesirable at any time, they cannot be tolerated at times of financial difficulty. But with incremental budgeting, NHS organisations may not even be aware of where they are overspending. A more detailed build-up of how costs are incurred – pay, non-pay, overheads, corporate services and re-charges – will enable budget-holders, finance staff and senior managers to benchmark spending against similar organisations. Then, cuts can be made with a strong evidence base. Incremental budgeting is simply not consistent with the current emphasis on service re-design and lean thinking.

The turnaround initiative and PbR have focused many minds in the NHS on the value for money of some services. For example, a trust may have lost cataract surgery patients to a neighbouring NHS provider or a mobile independent sector unit under contract to the health service. Turnaround advisers might ask whether the trust should continue to provide the service. The trust may wonder whether income from the service covers its overheads. These questions will remain unanswered without more complex budget-setting and monitoring arrangements.

How can the NHS improve budgeting?

NHS organisations are moving towards, and in some cases have already introduced, more sophisticated methods of budgeting in response to the stimuli listed above. These techniques can be used in isolation or in combination to build up a detailed picture of how much they need to spend and how this relates to activity, income and service priorities.

Zero-based budgeting in its purest form begins with a blank sheet of paper. Obviously, an acute trust or PCT does not ask whether it should continue to be a provider or commissioner of health services – but it will have to decide what it needs to carry out its functions and cost each up.

Firstly, a department's objectives and priorities must be agreed, together with the quality and quantity of its services. This should include a thorough review of how and why services are provided and whether they could be done more cost effectively. Staffing levels, consumables, equipment and overheads required to deliver this plan must be identified and costed to produce a budget.

Zero-based budgeting has a number of advantages – expenditure is transparent and based on actual costs. Traditional ways of working are challenged, making

it more likely a trust can drive through efficiencies, and there is a stronger link between budgets and the organisation's activity plans, objectives and priorities. It is often used to pinpoint the costs of a new service but those that use zero-based budgeting for established services may only have to perform the exercise once every three years.

Finance staff are keen on zero-based budgeting but they point out that it is time-consuming and most organisations will not be able to spare the staff to do it. Sophisticated information systems are needed to generate the data and these are not always present in NHS organisations.

The risk with zero-based budgeting is a department or directorate's final budget might be higher than the income they receive. If additional funding cannot be found, the budget will have to be trimmed, causing frustration for budget-holders. Some trusts have tried to avoid this by zero-basing but setting a clear spending limit from the outset. This area is further explored within the following case studies.

The introduction of flexible budgets is being led by PbR. This is a form of zero-based budgeting and involves looking at where costs are being incurred based on the work being done – for example, an orthopaedics department might assume it will do 2,000 knee replacements. It knows its costs (2,000 prostheses, plus theatre time, drugs etc) so it can work out its expenditure budget for all 2,000 operations and the unit cost for each procedure (divide total cost by 2,000). The budget can be flexed in year to reflect changes in activity.

Budgeting will be improved if it is based on accurate forecasting of activity and precise figures for pay and non-pay costs based on realistic numbers (for staff, skill mix, equipment and accommodation). This bottom-up approach can be combined and reconciled with top-down budgeting, where an organisation's board can set an overall budget based on its strategy and national priorities.

To achieve this combined approach, non-finance staff must be included in the process – from chairman and chief executive down to budget-holders and clinicians. The key is to convince non-finance staff that budgets are not the preserve of the finance department. Accountants do not recover deficits but facilitate the recovery of deficits. Indeed, in its July 2006 report, Learning the lessons from financial failure in the NHS, the Audit Commission said financial failure was often linked to a board that left the recovery of the organisation's finances to the finance director alone. This was compounded by clinical disengagement from management of the organisation and weaknesses in the availability of information, particularly in financial monitoring and forecasting of the year-end position.

According to one finance director: 'Management accountants help budget holders develop the budget but there must also be clinical buy-in – if the doctors and nurses in a specialty don't support the budget it is doomed.'

Another adds: 'The problem is the expertise is in the finance function when it needs to be outside in the departments. However, it would take a brave finance director to devolve their finance department so collaboration is the way forward. This means getting business managers to construct the budgets within a professional framework provided by the accountants. The budget then has to relate to what they do day-to-day to make monitoring successful. Otherwise it's nothing more than a box-ticking exercise for the business manager.'

Anecdotally, finance directors report that when budget-holders and clinicians have been involved in the budget-setting process, departments are more likely to stay within their spending limits. They add that the budget-setting process turns up more realistic efficiency savings when frontline staff are involved.

Activity based budgets and trading accounts

With Monitor pressing the need for trading accounts by specialty, how can activity based budgets support this development?

There is an argument that each speciality should operate as an operating division and have its own business plan, which would include a realistic budget based on planned patient activity and associated costs and income, which would be used to guide/control expenditure inline with actual activity, in order to deliver a small surplus.

It is recognised that the above model will rely on agreeing appropriate cost allocations from support departments, an area further explored within the following case studies, and that agreement of the cost allocation methodology, as with trading accounts and activity based budgets requires full engagement with the clinicians.

This joined up approach will align budgets, expenditure

Budgeting will be improved if it is based on accurate forecasting of activity and precise figures for pay and non-pay costs based on realistic numbers.

and income and enable clinicians to take ownership of the budgets and profit/loss position and enable them to make informed decisions based on accurate and timely management information.

Conclusion

The current reform programme in the NHS – introducing greater links between finance and activity and encouraging a greater understanding of the business of healthcare – makes a more sophisticated approach to budgeting essential, not optional. The following case studies describe how four organisations have set about improving their budgeting process. They identify a number of common challenges, issues and benefits. But perhaps the over-riding common theme is the need to involve clinicians and budget holders in the budgeting process. Only by doing this can the benefits of better budgeting be fully realised.

Only by involving clinicians and budget holders in the budgeting process can the benefits of better budgeting be fully realised.

Case study 1:

Basingstoke and North Hampshire NHS Foundation Trust

Budgeting at Basingstoke and North Hampshire NHS Foundation Trust had been based on the traditional model of rolling forward the previous year's budget and uplifting for development (such as employing a new oncology consultant for example) and adjusting for non-recurring waiting list activity. But this approach, while simple and relatively quick, is limited and like many of its peers the trust has moved towards more sophisticated budget-setting processes.

Many of the disadvantages associated with traditional budgeting were to be found at the trust. Lisa Thomas, its head of financial planning and development, says budget-holders such as ward sisters and departmental managers did not have much faith in the accuracy of their budgets. Trust management had little of the information needed in the increasingly patient-led NHS – how did spending relate to activity and income and did rolling over budgets each year perpetuate inefficiency? It also had some serious concerns it could not respond to about equity across the organisation

In recent years, the trust has made a more explicit link between activity and budgets but first it carried out a rebasing exercise on its spending plans. Although this had elements of a zero-based approach to budgeting, like most of its NHS peers North Hampshire recognised it did not have the time or resources to perform a genuine zero-based budget.

The exercise was first performed in late 2004/early 2005 as the trust set its 2005/06 budget. This was carried out in the context of the need to tackle a £4.3m deficit from 2004/05. The trust, which became a foundation hospital in December 2006, has three main divisions – elective, emergency, and maternity and child health. Each has its own clinical director, manager and accountant.

The trust rebased all its budget; costing all staff spending. 'We produced a staff costing sheet based on payroll information and we worked with the budget holders to get more detail,' Ms Thomas says. 'Some trusts have staff costing spreadsheets that they run all year but that was not common practice here. We took the cost of everybody in post at month six and linked it to activity and income. It was not in the culture to look at the budget in that detail and as it was all done on spreadsheets it created quite a lot of work.'

Traditional budgeting has created a few issues around pay, mainly about incremental drift. 'The NHS typically has members of staff who work in trusts for long periods of time, which means they are at the top of the pay scales. The budgets were set at the mid point for their grade creating a difference between budget and actual costs of staff in some areas. This was particularly the case in pockets of services like child health. Similarly, as we rolled over budgets it meant we didn't always ensure individual budget lines and budgets reflected reality in terms of skill mix changes, particularly as we move towards more qualified staff on wards,' Ms Thomas adds.

The high number of workers the trust has recruited from overseas created a further anomaly. For example, it has a high number of ancillary staff from Poland who opt out of the NHS pension scheme, but rolling forward budgets does not take account of the sub-sequent reduction in employer's contribution (14%).

Since it was founded in actual staff establishment and pay expenditure, the rebasing exercise has given the trust more realistic budgets. Under the trust's devolved structure the divisional accountants worked alongside budget holders to quantify the pay bill, while the budget holder confirmed the establishment including vacancies and staff in post. All vacant posts were funded at the mid incremental point together with the average pay enhancements for the grade.

The resulting figures were then put into a larger division-wide spreadsheet to produce a total pay position.

Though the focus was largely on pay, the trust carried out a similar exercise on non-pay spending in order to create a recurrent baseline. This was based on actual spending per item with budget holders or divisional managers agreeing proposed baseline budgets with their management accountants. There were four outcomes to the non-pay rebasing:

- the budget stayed the same;
- part or all of the budget was released and vired within the cost centre or division;
- additional funds were requested; or
- part or all of the budget was released to the division's recovery plan.

The final proposed divisional budgets were then reviewed and agreed by the trust board.

> 'We produced a staff costing sheet based on payroll information and we worked with the budget holders to get more detail.'
>
> **Lisa Thomas**

Despite a difficult year for the finance department – when it had four interim directors of finance – the trust carried out a similar exercise for its 2006/07 budget (this time using projected 2005/06 outturn based on actual year-to-date figures at the end of November 2005). Ms Thomas says to some extent, this was made easier by the hard work that had been done in the previous year. This year (for 2007/08 budget) the trust is trying to do things differently.

'Spreadsheets are time consuming and produce copious amounts of paper. Errors tend to appear so we are trying to do things within our financial system. There are two types of accountant in the world – those who like to have the biggest spreadsheets and those that don't. I am one of those that don't. I think anything that is done in the financial system is far more robust and reliable, and we can manipulate and present the information in far more user friendly ways. With spreadsheets you have human error as you are looking at thousands of lines – you might miscode three lines worth £70,000 each and only find out in April.'

Clinical engagement has been key to the rebasing exercise. 'As a trust we are fortunate to have a clinical body that is engaged in finance and that recognises the need for what we are doing, though they might not necessarily agree with the answer we come up with,' she says.

However, the trust tries to improve staff buy-in by ensuring cost improvements are bottom up as part of a rolling programme of review and are deducted from budgets before they are finally signed off. 'It doesn't help budget holders if you set their budget and then come in later with a cost improvement target. If you reduce it at the start it helps them gain ownership of the budget,' says Ms Thomas. 'The clinical director and divisional manager can then decide what areas they are going to target to make that saving and how they are going to work together to achieve it.'

And she adds the trust is hoping to use its freedoms as a foundation trust to reward those departments that have a surplus, perhaps by giving them access to additional capital funds. 'Until we start to take these things on board some clinicians will feel they can talk till they are blue in the face but they will still have to find 3.5% savings on their budgets. Where is the incentive to get involved and engaged with the reforms?'

The trust's development of service line reporting has generated a great deal of interest among its consultants. 'They are fully on board with looking at ways to maximise income and expect us to report earnings per consultant,' Ms Thomas adds.

However, while income it receives via the tariff is at spell level, reference costs are based on finished consultant episodes. So, in order to compare costs with income the tariff received must be split down to the FCEs that generated the payment.

'We need to do this as if you want to apportion income over divisions the spell may cover two divisions so you need to apportion each a fair share of income to cover the costs they incurred,' Ms Thomas adds.

The trust is now looking at software systems to help it run profit and loss reports at healthcare resource group level and procedural level at least quarterly and ideally monthly. It feels this will satisfy Monitor's requirements on reporting service line performance but it also hopes that service line reporting will allow the trust to move to more targeted cost improvement plans.

'We should be able to highlight services that are making contributions (profit) and those that are not,' says Ms Thomas. 'That is not to say we don't recognize the need for the non surplus making services – as a DGH we need to provide a service for our local population. It will however allow us to closer identify which services we need to look at and understand the drivers of those costs. It may be as simple as not collecting data correctly or the service we provide is expensive but it's of high quality.'

'It doesn't help budget holders if you set their budget and then come in later with a cost improvement target. If you reduce it at the start it helps them gain ownership of the budget.'

Lisa Thomas

Case study 2:
Mersey Care NHS Trust

Mersey Care NHS Trust set its budget for 2006/07 not only with the aim of reducing a £2.5m deficit but also with one eye on the planned introduction of payment by results into mental health services at some point in the future.

The trust launched its 2006/07 budget-setting programme in December 2005 by sending detailed guidance to all budget-holders. For budgeting purposes, income and expenditure was set at 30 November levels (actual figures though any known developments were included). These were adjusted later to reflect the position at 31 March 2006.

The trust's overall budget for the year (£182m) was set by the trust board by adjusting the 2005/06 financial plan to account for anticipated and agreed changes in recurrent and non-recurrent income and expenditure during the year (2006/07).

The 2005/06 financial plan had been established following an exercise that confirmed the significant financial pressures faced by the trust. Budget-holders, such as department heads or ward managers, and members of the finance team reviewed and agreed staffing levels and non-pay budgets. In all, the exercise identified recurrent cost pressures of £5.2m and a further exercise for 2006/07 confirmed recurrent cost pressures of £5m.

The exercise was a form of zero-based budgeting – 'pure' zero-based budgeting begins with a blank sheet of paper. Staffing levels, consumables, equipment and overheads required to deliver this plan must be identified and costed to produce a budget. In contrast to 'pure' zero-based budgeting, Mersey Care set a ceiling for each directorate's spending. The 2006/07 financial plan detailed each directorate's budget (control total), against which they could set their own pay and non-pay budgets net of local income assumptions (for activity such as private patients, overseas visitors and other forms of income generation). Directorate finance managers drew up budgets for this local income together with budgets for related expenditure.

Essentially, directorates could build up their spending plans from scratch but these had to be reconciled with their control total. Apart from increasing understanding of how funds were spent, this approach allowed directorates to move money around within departments, for example to redesign services. It also avoided one of the pitfalls of zero-based budgeting – that desired spending can be higher than income.

The trust admits that staff reaction was mixed. The budgeting approach had made cost pressures transparent, but some departments had to live with the fact that some cost pressures were not fully funded. Rising fuel prices were an example of significant pressures in 2006/07 with directorates having to find an additional 0.5% cash-releasing efficiency saving to fund it and other pressures.

Budget-holders also had to produce a staffing list based on their month seven (30 October 2005) budget statements. Commitments not currently on the payroll, such as long-term sickness and extended maternity leave, were identified. Vacancies were reviewed as part of the zero-basing exercise and those deemed necessary funded at the mid-point of the pay scale. This created a funded establishment for each directorate.

Non-pay budgets were also thoroughly reviewed to ensure they were cost-effective before they were agreed. Costs were estimated at actual costs using 2005/06 outturn prices. Unavoidable, non-recurrent costs, including a £30,000 rent on a property in Liverpool, were also included.

The trust had strict rules about service developments or new cost pressures. A business case had to be made for developments or cost pressures that were not funded – that is, those that had not been agreed by commissioners or being funded internally through service redesign. If no funding was identified, the matter was sent to the trust's board for a decision.

Each directorate was asked to identify cash-releasing efficiency savings of 2% (in line with Department of Health guidelines) and these were agreed by service director, service manager, business manager and finance manager. These recurrent savings were then removed from each directorate's budget and a financial planning accountant reconciled directorates' pay and non-pay budgets to their income streams. Once the budgets were completed, they were signed off by budget-holders.

This year the trust is also looking to the future. Not only is it training its budget-holders in order to improve their financial skills, it is also working to develop its costing mechanisms in advance of the arrival of payment by results by developing business units. Until now, only 'direct' costs, such as nursing and

Essentially, directorates could build up their spending plans from scratch but these had to be reconciled with their control total.

non-pay costs, have been reported to budget holders. But it will identify other costs, such as overheads and medical services (the trust has a separate budget for medical staff that is not yet allocated directly, although it intends to do so from 2007/08), and re-charge these to each of the business units.

The new costing system, assigning medical and overheads to service lines, is operating in shadow form in 2006/07 to make the transition smoother. To support this process, the trust is hoping to introduce a database to produce staff cost information and introducing measures to improve its performance management. Activity plans are agreed with PCTs and it now reports activity and key performance indicators to the board and directorates, thus making the link between finance (including reference costs) and activity.

'We are bringing in the indirect and overhead costs so that we can report the true cost of providing the service to budget holders,' says Dave Sproson, the trust's head of financial management.

'Having this information on a monthly basis instead of annually, allows for a continuing debate about efficiency and value for money. This process will be enhanced by the production of indirect or overhead benchmarking information. Getting the budgeting right is the first step towards financial control and management as well as service line reporting and trading accounts.'

'Getting the budgeting right is the first step towards financial control and management as well as service line reporting and trading accounts.'

Dave Sproson

Case study 3:
South and East Dorset Primary Care Trust

In 2003/04 and 2004/05 South and East Dorset Primary Care Trust* reported year-end deficits of £0.4m and £2.4m respectively. The Audit Commission concluded that the trust's arrangements for setting and monitoring budgets were not fit for purpose. It added: 'Cost centre budgets were significantly misaligned with actual expenditure or contained unidentified potential savings. No cost centre budget reports were issued for a period of several months and arrangements for monitoring expenditure were ineffective.'

Yet within a year the trust had achieved a remarkable turnaround both in its financial fortunes and control of its spending by overhauling its budgeting process.

During 2004/05 Mark Orchard* was appointed as deputy director of finance and was handed the task of strengthening commissioning reporting to the trust board. In December 2004, Paul Sly* joined the organisation as director of finance and information and immediately embarked on the tall order of 'turning the ship around'.

As expected, the 2005/06 external audit planning process identified the financial health of the trust as high risk. However, the Audit Commission subsequently conducted a detailed review of financial management arrangements and concluded that the trust had made fundamental improvements in the way it set and monitored cost centre budgets and forecast full year spending. The trust ended 2005/06 with a planned surplus of £1.5m, which included delivery of £2.4m savings. At the 2006/07 mid-year point, the trust was on target to deliver further savings of £1.1m.

Key to this turnaround in financial fortunes was a comprehensive zero-based budgeting exercise undertaken early during 2005/06 covering the trust's £183m revenue budget.

'All cost centre budgets were initially reconstituted over a period of two months on the basis of actual 2004/05 expenditure and projected 2005/06 forecasts, taking account of LDP (local delivery plan) commitments,' Mr Orchard says.

'Importantly, the director of finance led this exercise, and together we held individual meetings in the field with each budget manager to review their financial position. This process of "eyeballing" each budget manager in their own backyard allowed us to quickly establish the real and full extent of the challenge. It sent out a clear message – and corporate acceptance – that the trust had a financial problem.'

Previously, due in part to the lack of financial information made available to budget managers at the trust, financial accountability had become divorced from operational decision-making.

Budget managers were challenged to identify local cost improvement or savings schemes for the corporate good. Attitudes changed as the 'this is how we've always done it' approach was eroded quickly and all existing levels of spend were being challenged. Realistic, but at the same time challenging, base budgets were agreed on a line by line (account code) basis, net of agreed savings. Baselines were built up to areas of spend or departmental (cost centre) level with an overall summary position agreed by each budget manager. Importantly, agreed budgets also include formalised income targets, where appropriate. These provide the necessary flags to ensure the trust collects all the income it is due – this has not always been the case.

Agreed savings were extracted from base budgets as schemes were identified and transferred to a central 'savings plan' cost centre. Budget managers held only their residual net funding; reducing any temptation to move away from agreed positions. Budget managers were vigorously performance managed against the net baseline. Formal quarterly review meetings, again led by the director and deputy director of finance, focused on delivering the agreed bottom-line contributions.

Mr Sly (who left the PCT at the end of 2006 to become finance director at Bournemouth and Poole Primary Care Trust) believes that key to the success in this approach was the level of 'buy-in' achieved with all budget managers across the system. This was achieved through:

- Involving them 'shoulder to shoulder in the budget setting process from the very outset';
- Allowing them to 'own their budgets' with minimal intervention or journal adjustment by finance without their prior approval. This was the key to enabling accountability;
- Roll-out of budget manager training workshops and awareness sessions, accompanied by a succinct and understandable local handbook;
- Servicing them with a timely, accurate and comprehensive suite of information (with full drill

'Budgetary control, not surprisingly, must be exercised through budget managers. It is these individuals that commit the trust resources needed to provide patient services. For every pound spent someone is responsible, and everybody needs to understand that.'

Paul Sly

down facility to transaction level detail). 'This allowed confidence to be built-up on both sides,' he says; and

- Ongoing support from finance colleagues, complemented by the formal quarterly performance reviews. 'This was about holding people to account and getting financial disciplines embedded in the culture of the organisation,' he says.

'The whole process allowed finance to chip away at the common misconception that finance is the sole responsibility of the director of finance,' Mr Sly continues. 'Budgetary control, not surprisingly, must be exercised through budget managers. It is these individuals that commit the trust resources needed to provide patient services. For every pound spent someone is responsible, and everybody needs to understand that.'

Alongside the main budget review exercise, the trust introduced a new financial management system from April 2005. Before this, for historic reasons, the trust had employed two separate general ledgers concurrently, which significantly delayed the month-end closedown routine and over-relied on cumbersome and labour-intensive spreadsheet analysis.

It also rationalised cost centres (which included reducing them in number from 357 to 181 – some of which had been used to capture annual transactions totalling less than £10,000). By amending the financial coding structure to accurately reflect the trust's organisational structure and operational activities, it gained immediate reporting efficiencies.

The month-end closedown routine was cut to three working days, giving budget managers and the board timely and accurate information. The standard of reporting to the trust board was improved in line with best practice – a significant element of which was driven directly from the new financial management system.

The trust also introduced risk-pooling arrangements with neighbouring Dorset PCTs, where appropriate. South and East Dorset PCT had previously accepted full financial risk as lead commissioner for several volatile pan-Dorset commissioning streams (including NHS continuing care and high-cost, low-volume activity, such as bone-marrow transplants and blood products). The finance team was strengthened to deliver the turnaround agenda.

Reflecting on the process, Mr Orchard concludes: 'Whilst finance can provide an important steer, none of this could have been achieved without the support and engagement of staff across all levels of the organisation. Both Paul and I are immensely proud to have been part of the turnaround at South and East Dorset.'

**South and East Dorset Primary Care Trust merged with North Dorset Primary Care Trust and South West Dorset Primary Care Trust on 1 October 2006 to form the new Dorset Primary Care Trust. Paul Sly and Mark Orchard have recently moved to become finance director and deputy finance director at Bournemouth and Poole Primary Care Trust.*

'Whilst finance can provide an important steer, none of this could have been achieved without the support and engagement of staff across all levels of the organisation.'

Mark Orchard

Case study 4:
King's College Hospital NHS Foundation Trust

While robust budgets are a key element of financial recovery, they are worthless if the information on which they are built is incorrect. With a deficit of £2.7m in 2004/05, King's College Hospital NHS Foundation Trust decided it needed better data if it was to implement a successful recovery plan.

So, in April 2005 it launched an activity-based costing project, which is now being used to inform its budget-setting.

The trust has previously used the traditional incremental method of budget-setting (essentially last year's budget plus uplift minus cost improvements) but in future will increasingly move to setting budgets based on expected activity. Simon Taylor, the trust's chief financial officer, says any trust would be uncertain of the consequences of any actions it takes if it does not understand its costs.

The trust has divided its specialties into care groups, which include women's and children's services, liver and renal, critical care and surgery and dentistry, and each is seen as an autonomous business unit. The initial stage of the activity-based costing process was to meet with senior managers in each care group, including clinical directors and general managers, to explain the initiative. This was followed up with further meetings that involved business and finance managers and clinicians where the care group's expenditure budget was examined line by line to allocate costs.

Generally, costs were allocated using activity drivers such as length of stay, theatre minutes per procedure and cost and volume of diagnostic tests. These showed how much of a given resource (such as ward nursing, drugs, junior doctors' hours) was required to deliver a certain level of activity. Since costs are based on activity, budgets can flex to reflect increases (or decreases) in activity in-year by accurately reflecting activity and income earned in each care group.

However, in some cases the activity drivers were not appropriate – for example, intensive care has three levels of dependency with greater or lesser levels of nursing needed. In neonatal intensive care ITU nurse/bed ratios were 1:1, HDU 1:2 and SCBU (special care baby unit) 1:4 so using length of stay to cost nursing services would be inaccurate. Costs for these services are now allocated on the basis of weighted bed days, automatically pulled from the care group's IT systems on a monthly basis to reflect these levels of dependency.

Such fine tuning came from the involvement of clinicians, which Mr Taylor says is a cornerstone of the process. 'Clinicians are heavily involved, particularly with regard to developing the allocation methodologies. And it is much easier to get their involvement in the budget setting process if they can see it as part of an overall service strategy, which is underlined by robust cost and income data.'

Jonathan Rowell, King's chief income and costing accountant, says: 'Primarily it's a costing system and budgeting is a secondary result of the work we have done. But activity-based costing is starting to allow us to do a sense check on whether people's expenditure budget is appropriate or not.

'We are able to say, "this is your level of activity and these are your unit costs for this activity" which is now starting to inform the setting of expenditure budgets,' he says.

In theory, if the unit cost for a procedure was £1,000 and the care group planned to perform 50 procedures in a year, the budget would be £50,000 (before adjustments for cost improvements, for example). 'At the moment we are not planning to move away from the traditional expenditure budget entirely but clinical engagement and buy-in is difficult as people say they see no resemblance to the activity they are doing. Once we get agreed activity plans for next year we will be using activity-based costing to build up information on how much that activity should cost each care group,' Mr Rowell continues.

However, he acknowledges that activity-based costs can bear little resemblance to the expenditure budget because activity-based costs also include indirect costs and overheads. For example, the cost of a hip operation will include things that the surgical department has direct responsibility for, such as the surgeon, (which are covered by their expenditure budget) but there are other costs they have no direct control over, such as radiology or pathology (which are not).

This can be overcome by setting target contributions by care groups based on their controllable costs. Improvements to this level of contribution can be retained by the care group concerned for reinvestment in the service.

> 'We are able to say, "this is your level of activity and these are your unit costs for this activity" which is now starting to inform the setting of expenditure budgets.'
>
> **Jonathan Rowell**

Mr Rowell says the trust's activity-based costing system is useful when budgeting for new services. 'We find it useful in the development of strategy, planning and modelling. The tendency has been for developments to be slightly haphazard, with individuals pressing their own cases, and the trust having difficulty in strategically assessing conflicting bids consistently.

'However, at the end of last year, each care group looked at their costs and income and tried to model a five-year strategy that included any developments they wanted to make. We used our activity-based model to cost those developments, so each care group now has a clear financial strategy for the first time. People can pull activity-based costing information from the system and use it as a basis to model any developments, and senior management can use it to prioritise those deemed most important.'

'Getting clinicians to help identify the true costs of what they are doing, whether it be at an individual patient level or at a service line level, is an important step in improving efficient care delivery and, eventually, outcomes to patients.'

Simon Taylor

But perhaps the biggest benefits of the activity-based costing project are the links with reporting by service line or patient level. This is particularly important at the moment with Monitor's push to ensure all foundations measure and report service line performance.

'The key benefit of going to a patient level is that it highlights to a clinician the variability of costs that occur either as a result of different clinical practice or problems in process flows, for example lost theatre time,' says Mr Taylor. 'Clinicians find it a lot easier to remember particular events when they are associated with an individual patient, particularly if they are given the information promptly.'

Mr Rowell adds: 'We are also starting to develop activity-based costing as more than merely a measure of contribution and profitability. We are moving towards using budgeted expenditure and planned activity to come up with standard costs, which could be done at healthcare resource group or procedural level. When we get it right it will be a powerful tool to speak to clinicians about – we will talk to the people responsible for individual procedures about costs and why they differ. Plans are well underway with this.' Indeed, activity-based costing has already flagged up some inefficiencies that have been addressed. Since the project started, length of stay within the trust's acute medical care group has fallen by 15% releasing approximately £3m a year.

Mr Taylor believes that patient-based costing heralds a significant change in the way healthcare budgeting is performed and will lead to a much higher level of clinical involvement in the process. 'Getting clinicians to help identify the true costs of what they are doing, whether it be at an individual patient level or at a service line level, is an important step in improving efficient care delivery and, eventually, outcomes to patients,' he adds.

HFMA Publications and Training Packages

Introductory Guide to NHS Finance in the UK (8th Edition)

This new, fully updated edition of the introductory guide is designed to give its users a solid grounding in and practical understanding of NHS finance. It is written in simple, straightforward language and will appeal to anyone who wants to get to grips with how the NHS works. The guide focuses on the policy and organisational framework for the NHS in England but includes chapters that highlight the key differences in Northern Ireland, Scotland and Wales.

Effective Governance in Healthcare: an Introductory Guide (2nd edition)

This guide provides an easy to read but comprehensive introduction to governance in the NHS that will be an invaluable reference source to anyone with an interest in this high profile area. It will be particularly relevant to managers and board members involved in establishing an effective assurance framework that integrates all the different governance strands.

Patients' Monies and Belongings (2nd Edition)

All trusts (foundation, NHS and primary care) have a responsibility both to safeguard patients' property and to limit their own liability in the event of loss or damage. They also have a responsibility to ensure that patients are aware of and can access any statutory financial assistance available for health related costs. This publication outlines good practice guidance in relation to handling patients' monies and personal belongings and describes the main social security and other benefits available to them.

Public Sector Business Cases using the Five Case Model: a Toolkit

This HFMA Toolkit is designed to help organisations produce good quality business cases that take account of all relevant financial and non-financial considerations. It provides a systematic and objective approach to all stages of the business case process from Strategic Outline Plan (SOP) to Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC). The Toolkit is based on the 'Five Case Model' recommended by the Office of Government Commerce and is designed to sit alongside the Treasury's Green Book.

Training Packages:

- **NHS Finance in a Nutshell Brochure 2nd Edition**
- **Payment by Results in a Nutshell Brochure 2nd Edition**
- **Business Cases in a Nutshell**

These packages are ready-made one-hour presentations that give an overview of NHS Finance, Payment by Results, Business Cases and how they operate in the NHS in England. It has been written to meet the needs of a general non-financial audience including clinicians and non-executive directors. It can also be used as part of an overall training programme, at an induction day or public meeting.

The package consists of a smart presentation folder containing acetates, a CD-Rom (for Power Point use) and detailed notes for presenters. There are also two copies of a booklet that reflects the topics covered in the presentation.

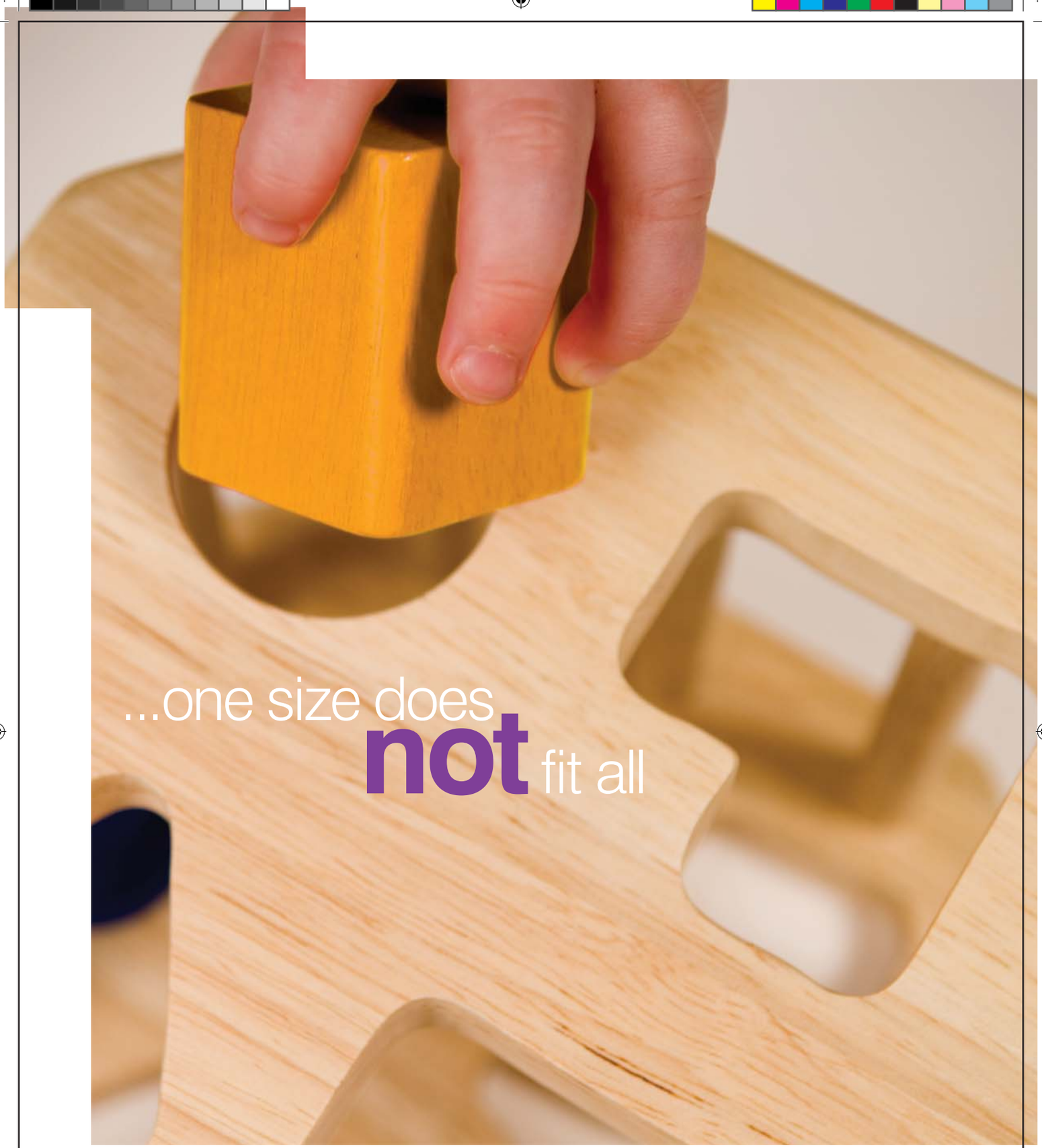
TO VIEW ALL HFMA PUBLICATIONS AND TRAINING PACKAGES OR TO PLACE AN ORDER:

Please go to **www.hfma.org.uk**

OR Telephone the publications team on **0117 929 4789**

the **voice** of healthcare finance...

hfma



Over 130 NHS organisations are working collaboratively with **COA**, ensuring continuous **efficiencies** and **improvements** are achieved. **You could be too.**

For further information on how your organisation can benefit,
please contact us on **www.cedaropenaccounts.com** or **08451 60 55 55**
COA, Munro House, Portsmouth Road, Cobham, Surrey KT11 1TF United Kingdom

COA
CedarOpenAccounts