

A guide to finance for hospital doctors

July 2009



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The Audit Commission is an independent watchdog, driving economy, efficiency and effectiveness in local public services to deliver better outcomes for everyone.

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The Academy of Medical Royal Colleges promotes, supports and facilitates the work of the Medical Royal Colleges and their Faculties. It has a leading role in the areas of doctors' revalidation, training and education and aims to speak with a clear and sure voice on generic health care issues for the benefit of patients and healthcare professionals.

Medical training is very demanding. You may feel there is little room for any wider personal exploration of how the NHS works. But understanding how the money flows and some of the principles of financial management in the NHS will help you to deliver better patient care. It may also make your own professional life easier in the future – understanding a budget and how it can be managed will put you in a better position to determine the future of your service.

This guide, jointly prepared by the Academy of Medical Royal Colleges and the Audit Commission, is aimed at medical students and doctors in the early stage of their training. It stems from a joint statement in February 2009 by the Academy of Medical Royal Colleges, the Audit Commission, the Department of Health, the Royal College of Nursing, the NHS Institute for Improvement and Innovation and the Healthcare Financial Management Association that drew attention to the benefits that result for patients when clinicians get properly engaged in managing NHS money.

All doctors should understand at least the basics of NHS finance. This is not about turning doctors into accountants; it is about enabling doctors properly to engage with finance colleagues so as to make the best use of NHS resources for patients.

We hope that you find this guide useful. The case studies that it contains amply illustrate how such understanding and engagement can help to transform services.

Professor Dame Carol Black
Chair
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Summary	3
1 Introduction	9
2 How the money works in the NHS	12
3 Trust finance regimes	18
4 Managing a budget	27
5 Making the best use of the money available	33
Further sources of information	47
Glossary	49

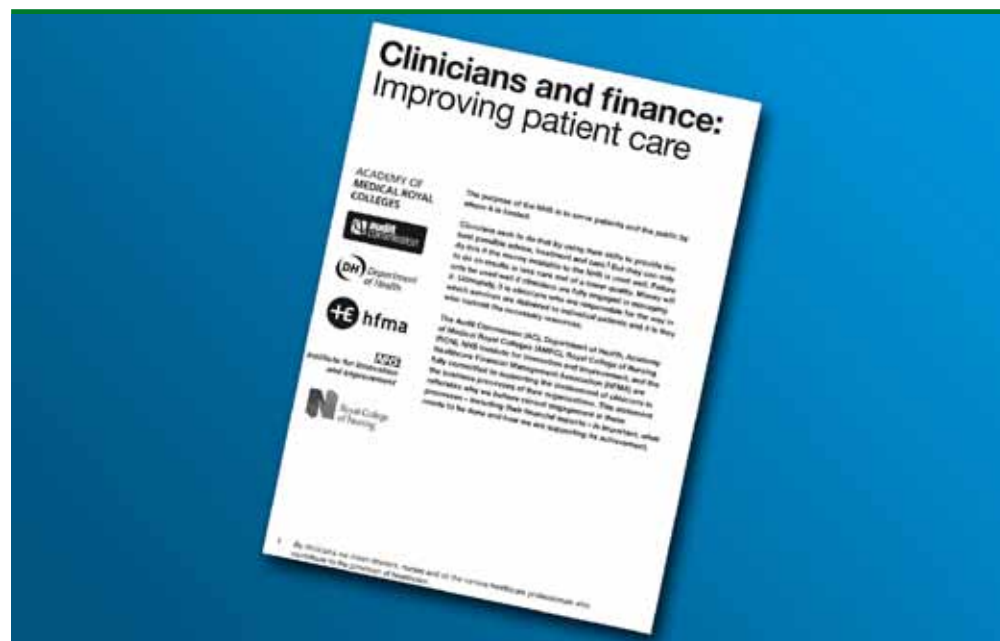
Summary

The purpose of the NHS is to serve patients and the public by whom it is funded. Clinicians seek to do this by using their skills to provide the best possible advice, treatment and care. But they can only do this if the money available to the NHS is used well. Failure to do so results in less care and lower quality. Money will only be used well if clinicians are fully engaged in managing it. Ultimately, it is clinicians who are responsible for the way in which services are delivered to individual patients and it is they who commit the necessary resources.

Clinicians and finance: improving patient care

In February 2009, the Academy of Medical Royal Colleges, the Audit Commission, the Department of Health, the Royal College of Nursing, the NHS Institute for Improvement and Innovation and the Healthcare Financial Management Association published a statement *Clinicians and Finance: Improving Patient Care*. The purpose of the statement was to draw attention to the benefits that can be obtained when clinicians are involved in the business processes of the NHS.

The statement, *Clinicians and Finance: Improving Patient Care*, drew attention to the benefits clinicians can obtain if involved in the business processes of the NHS.



Improving the quality of care and providing more responsive services for patients, as set out in Lord Darzi's final report from the NHS Next Stage Review, *High Quality Care for All*, can only be achieved if there is strong involvement of local clinicians in the management of the service. This includes having the understanding, the tools and the ability to manage resources effectively and use them well to the benefit of patients. This will empower them to lead change and improve services.

Efficient use of resources and good quality services go hand in hand

This is not about focusing on cost and cost alone. It is about how money can best be used to improve the quality of care, combining operational and clinical effectiveness. Efficient use of resources and good quality services go hand in hand.

Clinicians cannot do this alone. Finance and clinical staff must work in partnership. In the past, financial management was often seen as the preserve of the finance department, but this approach will not stand up to modern-day demands and expectations. It is not sufficient for finance skills to reside only within the finance department. However, finance staff have a vital role to play in supporting clinicians on financial matters, and by doing so enabling them to provide better care. To do that effectively there must be mutual understanding and cooperation.

The Academy of Medical Royal Colleges and the NHS Institute for Improvement and Innovation have been working together on the Enhancing Engagement in Medical Leadership project. As part of this project, a Medical Leadership Competency Framework has been produced which describes the leadership competencies doctors need to become more actively involved in the planning, delivery and transformation of health services. The framework includes resource management competencies.

All clinicians should understand the basics of NHS finance, the role that finance plays in their work and how they commit resources

What do doctors need to know?

Doctors do not need to have in-depth knowledge of financial issues, but should recognise and understand their role in committing resources and how good use of resources will contribute to better service provision

All clinicians should understand the basics of NHS finance, the role that finance plays in their work and how they commit resources. This should be part of a wider understanding developed through training and education of how the modern NHS works and how management processes, such as finance and measuring activity, can all have a direct bearing on the quality of patient care. At a minimum level, all doctors should have an understanding of:

- how money flows round the NHS, in particular how their organisation receives income when patients are treated (Chapter 2);
- the financial rules that exist in their organisation and the role of the finance department (Chapter 3);
- how budgets are set and managed (Chapter 4); and
- how to make the best use of the money available (Chapter 5).

Getting these basics in place will help as doctors move up the career ladder. The more senior the doctor, the more important it is that they understand the business and financial aspects of their service or department, be it in a hospital or in the community. In particular:

- Senior clinical staff should be familiar with the financing arrangements for their service and understand the basics of budgetary management.
- Clinicians should be encouraged to take financial responsibility for their service with the freedom to make changes and use the funds available to improve services – they should see this as a normal part of their role.

To help with this, doctors should receive prompt, reliable information presented in a way that they understand, which is useful to them and well-supported by IT, and for their involvement to be wider than simply being given a budget to manage. Doctors should also expect to receive appropriate training and support and be enabled, through increased knowledge, to contribute more widely on financial matters.

What is the purpose of this guide and who is it aimed at?

This guide is intended to support the objectives set out in *Clinicians and Finance: Improving Patient Care* by providing doctors with an easy-to-understand summary of the financial framework of NHS trusts and NHS foundation trusts (FTs). The guide is aimed at hospital doctors at the early stages of their career.

There are many examples where clinicians are closely involved in financial issues and where there is good engagement between finance and clinical staff, to the benefit of patient services. Recent experiences at 2gether NHS Foundation Trust illustrate what can be done when clinicians and finance staff work together to transform services (Case study 1). This guide includes further examples. The results speak for themselves – better patient care and a more efficient use of resources.

Doctors should also expect to receive appropriate training and support and be enabled, through increased knowledge, to contribute more widely on financial matters

Case study 1

Service redesign at 2gether NHS Foundation Trust

2gether NHS Foundation Trust provides mental health and learning disability services to the population of Gloucestershire. The FT received £60 million income in 2007/08.

During the 2006/07 and 2007/08 financial years, the FT undertook a project to redesign all of its existing Adults of Working Age services to better fit the emerging needs of the population. The aim was to completely reshape all of the current services by replacing the traditional community mental health teams with a more proactive service for the residents of the county.

The changes were led by clinicians but informed by the work of the finance team. This was done by clinicians and finance staff working together to plan services that would provide the best possible service and outcomes for patients. Models for service delivery were identified that met national guidance on service delivery, met the changing needs of its population and provided safe working practices for staff and patients. Finance staff provided detailed costing information so that a model was selected which met clinical requirements within the budget available. Resources were reallocated within the FT so that more services were provided within the community, including:

- specific recovery teams instead of general community mental health teams;
- increased provision of crisis and home treatment and early intervention teams;

- establishing an A&E liaison service;
- maintaining the level of assertive community treatment; and
- the establishment of new primary care and assessment teams.

The FT has judged the project to be a success as the redesigned service has resulted in equitable services that meet nationally recognised models of care across the county whilst also ensuring that each new team had robust staffing levels and associated non-pay budgets to enable better services to be delivered. Since 2006/07 there has been:

- an 86 per cent increase in crisis resolution face-to-face contacts; and
- a 337 per cent increase in early intervention face-to-face contacts.

The new service resulted in recurrent savings of £1.2 million (8 per cent of the original budget).

‘We have completely transformed our approach to the delivery of community mental health services’ said Dr Chris Fear, Associate Medical Director for Working Age Adults at the FT. ‘The provision of costing information was enlightening and gave us a basis for making decisions about what level of service we provide and where. The changes we’ve made have resulted in improvements in services as well as increased efficiency. It has been a huge morale boost for the team.’

Source: Audit Commission

1 Introduction

Why is it important for doctors to understand NHS finances?	10
What does this guide cover?	11

Managing both the service delivery and the finances can be empowering and can lead to change and the improvement of services

Why is it important for doctors to understand NHS finances?

1 Improving the quality of care and providing more responsive services for patients as set out in Lord Darzi's final report from the NHS Next Stage Review, *High Quality Care for All*, can only be achieved if there is strong involvement of local clinicians in the management of services. This includes having the understanding, the tools and the ability to manage resources effectively and use them well for the benefit of patients. **Managing both the service delivery and the finances can be empowering and can lead to change and the improvement of services. There is evidence that when clinicians do not engage in financial management the outcomes are poorer and will not enable the NHS to meet the challenges it faces.**

2 In contrast, there are many examples where clinicians have led change and improved services, through taking greater responsibility for managing the money available to them. This is not about focusing on cost and cost alone, but how best money can be used to improve the quality of care, combining operational and clinical effectiveness. Efficient use of resources and good quality services go hand in hand.

3 These trends represent a major shift in the balance of financial power and authority within the NHS, with implications for financial stability and the future relationship between clinical leaders, finance professionals and general management. The Audit Commission, the National Audit Office and the Public Accounts Committee have all emphasised the need for clinicians to become more involved in their organisations' financial management and to take greater responsibility for the resources they deploy. The Audit Commission has also highlighted a lack of engagement of clinicians in the core business processes of NHS organisation as an important contributory factor in financial failures.

4 Doctors need to understand the importance of finance, the work carried out by finance staff and how this links to clinical activity undertaken. Such knowledge will provide them with increased power in terms of helping to decide, along with service managers, where scarce resources should be allocated and used – for example, when they are planning how to meet new local health challenges or considering how best to use the resources available to improve services.

Q It's not my job to look after the money. I became a doctor to cure the sick and not count the beans. Shouldn't I be left to do my job and the finance people left to do theirs?

Financial management is a key aspect of general management and it is the responsibility of all managers, not just finance staff. It is important that clinicians and all staff that commit resources (for example by ordering equipment or requesting scans) understand the implications of their decisions. Clinicians cannot properly manage services without understanding the finances.

What does this guide cover?

5 We are not expecting all clinicians to have an in-depth knowledge of financial issues, but all clinicians should recognise and understand their role in committing resources and how good use of resources will contribute to better service provision. To help with this the Audit Commission and the Academy of Medical Royal Colleges have worked together to produce this guide. Its purpose is to explain some of the main elements of NHS finances. It is aimed at hospital doctors at the beginning of their medical career and is relevant for doctors working in both NHS trusts and NHS FTs.

6 This guide covers:

- the flow of funding within the NHS and some of the key accountability and governance arrangements;
- the finance regimes under which NHS trusts and FTs operate;
- how budgets are set and managed; and
- how NHS trusts and FTs can ensure they are making the best use of the money available and thereby deliver the best possible outcomes for patients.

Q NHS finances are incredibly complex. How can medical staff hope to get to grips with it in the time available?

Financial information needs to be presented so that busy clinicians can understand it and, as a result, manage their services properly. This would include information like budget monitoring reports, the cost of the services being provided, and the income generated for the trust. Many clinicians have good financial understanding and this could be used to the advantage of the NHS.

2 How the money works in the NHS

Introduction	13
NHS funding	13
PCT commissioning	15
Payment by Results	15

Introduction

7 This section of the guide sets out how the money flows around the NHS. It:

- covers how the Department of Health and NHS bodies are allocated funding;
- describes what primary care trust (PCT) commissioning is; and
- explains the primary system of hospital funding, Payment by Results (PbR).

NHS funding

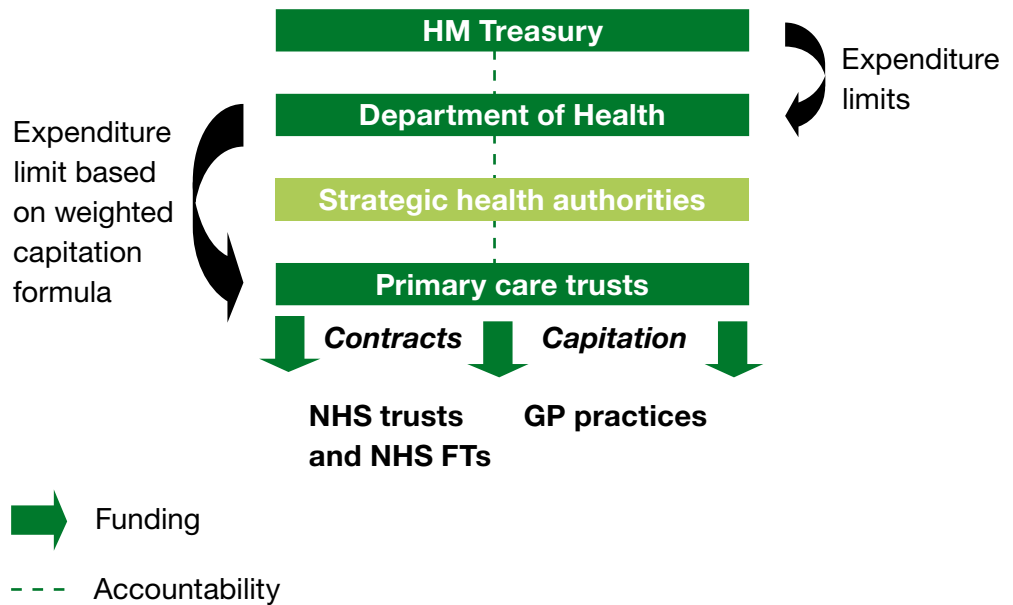
8 HM Treasury sets the expenditure for each government department, including the Department of Health, as part of its Comprehensive Spending Review process. Comprehensive Spending Reviews cover a three-year period, with the latest, in 2007, setting spending plans for 2008/09, 2009/10 and 2010/11. Comprehensive Spending Reviews are reviewed and considered by parliament twice a year in the budget (in the spring) and in the pre-budget report (in the autumn). Expenditure on the NHS is approximately 8 per cent of the gross domestic product.

9 The Treasury sets limits for Department of Health revenue expenditure (day-to-day items such as salaries and running costs) and capital expenditure (typically for purchasing large items which have a usable life of over one year, such as buildings and equipment).

10 The Department of Health provides funding directly to the ten strategic health authorities and local health bodies known as PCTs. PCT spending accounts for around 90 per cent of NHS expenditure.

11 The Department of Health allocates revenue funding to PCTs according to a weighted capitation formula. The aim is for PCTs to be able to commission similar levels of health services for populations in similar need. In December 2008, the Department of Health published details of the funds that will be available to PCTs in the 2009/10 and 2010/11 financial years. Like the funding that is allocated to the Department by HM Treasury, the Department of Health sets limits for the revenue expenditure for all PCTs. The formula for allocating funds to PCTs is constantly reviewed and is a topic that is much debated.

Figure 1: NHS revenue funding flows



Source: Audit Commission

12 The arrangements for capital funding are different. PCTs are required to bid each year for the capital funds they require through their strategic health authority and funding for these plans will be provided by the Department of Health subject to affordability within a national total. NHS trusts and FTs are expected to use internal sources of funds (such as proceeds from asset sales) and loans to fund capital schemes. Any borrowing is subject to limits. For very large projects, NHS trusts and FTs may consider financing them via a private financing initiative contract with the private sector.

13 Each year the Department of Health issues an operating framework which sets out the key priorities for the following year and the financial rules that will operate. For NHS organisations this is one of the most important documents they receive as it helps them to plan and prioritise how to use their resources. The framework is usually published in December and relates to the financial year starting the following April.

PCT commissioning

14 PCTs are responsible for leading their local health economies. Their primary function is to commission healthcare for their local population. This can be from NHS trusts, FTs, themselves (or other PCTs) or from the independent sector. Commissioning requires PCTs to consider their priorities and how to deliver more and better quality services within their financial allocation, resulting in improved health outcomes for patients.

15 NHS trusts and FTs receive most of their income through the commissioning process with PCTs and other NHS trusts. NHS trusts also receive a small amount of funding directly from the Department of Health and from other sources, such as local authorities and charitable donations, as well as being funded for carrying out research and training.

16 Commissioning at PCT level can be seen as relatively remote from individual patients and clinicians. In recent years it has been seen as important to engage GPs in commissioning as they are close to patients and have the scope to design and commission more responsive services for local needs. Practice-based commissioning has been developed with the aim of making the NHS more patient centred by extending choice in elective care and by empowering primary care professionals to commission services more specifically on behalf of patients. Under practice-based commissioning GPs can take on the commissioning and financial responsibility for large parts of PCT budgets and change the patterns of service provision.

Payment by Results

17 PbR was introduced in 2003/04 and is a rules-based approach for paying for acute and specialist hospital services in the NHS. It is a key part of the current reform programme in the NHS and was designed to directly link the payments that healthcare providers receive to the activity they undertake. PbR was intended to underpin patient choice (which aims to enable patients, in conjunction with their GP, to decide where and how care is provided) by enabling the money to follow the patient.

18 PbR covers the majority of acute inpatient, outpatient and A&E activity. PbR exclusions include activity such as transplants, some specialist services and activity where the number of treatments performed nationally is low. There are plans to extend PbR to cover mental health and community care.

NHS trusts and FTs receive most of their income through the commissioning process with PCTs and other NHS trusts

The introduction of PbR has had major implications for NHS organisations

19 A national rate, or tariff, is set annually for each type of service, with services classified by health resource groups (HRGs).¹ Commissioners are then required to pay for healthcare provided to their residents at this tariff. This system replaced an approach of locally negotiated block contracts, based on compromise between providers' costs of providing services and what commissioners could afford to pay. The introduction of PbR means that income received by providers better reflects the volume and complexity of healthcare provided. The price of those services and procedures outside the scope of PbR remains subject to local negotiation.

20 The introduction of PbR has had major implications for NHS organisations. Both hospital providers, and particularly PCT commissioners, face greater financial risk and reduced financial control. With the price set nationally, contract negotiations focus on the volume of activity to be provided. Without the protection of fixed value block contracts, providers need to maintain a certain level of activity and ensure that costs do not exceed the national tariff in order to remain financially viable.

21 Conversely, commissioners are required to pay for activity at the national tariff and bear the financial risk of increases in hospital activity, which they can only partially control.

Q Surely total NHS funding depends on political priorities which change from year to year and we just have to accept that don't we?

This is true for the overall amount spent on the NHS each year, but not for what each individual NHS trust and FT receives. Under PbR income for individual hospitals largely depends on the level of activity they undertake and the complexity of that activity. Income increases as the number of patients treated increases. There are moves to make additional payments to hospitals to reward the provision of quality services. The money available to trusts, therefore, is increasingly related to the quantity and quality of the work of clinicians.

¹ HRGs are standard groupings of clinically similar treatments that use similar levels of healthcare resources. They are underpinned by diagnosis and procedure classification systems which reflect current clinical activity performed in the NHS.

How the money works in the NHS

22 PbR requires good quality data on costs and clinical activity to be available. Trusts and FTs use activity data for billing purposes (every recorded patient admission will lead to the commissioning PCT being charged according to the treatment carried out). They may also make decisions on savings and investment in individual specialties, based in part on their cost position and on the income they receive.

PbR requires good quality data on costs and clinical activity to be available

23 In turn, PCTs make payments based on activity data provided by each trust. They need to know that it is accurate – that the treatment invoiced was the treatment provided and for the correct patient.

3 Trust finance regimes

Introduction	19
Financial governance and accountability	19
The financial duties and targets of NHS trusts and FTs	23
The role of the finance department	24
Financial planning	26
Board reporting and forecasting	26

Introduction

24 This section of the guide provides an overview of:

- **NHS financial governance and accountability arrangements;**
- **the financial duties and targets of NHS trusts and FTs;**
- **the role of an NHS finance department; and**
- **board reporting and forecasting.**

Financial governance and accountability

25 Governance can be defined as the rules, processes and behaviour that affect the way in which powers are exercised. It is, therefore, concerned with how an organisation is run, how it is structured and how it is led.

The board

26 Every NHS organisation has a board. The board of an NHS trust is made up of executive directors and non-executive directors who are collectively responsible for promoting the success of the trust by directing and supervising its affairs. NHS trust boards can have a maximum of 12 directors, excluding the chairman, comprising up to seven non-executive directors and no more than five executive directors. All directors are required to act in the best interest of the trust and comply with statutory requirements. Each director has a role in ensuring the probity of the organisation's activities and financial affairs and for contributing to the achievement of its objectives in the best interest of patients and the wider public.

27 Each board will have a chairman and a chief executive. Chief executives of NHS organisations have special financial responsibilities as the accountable officer for the NHS body concerned. As accountable officers, chief executives are responsible for ensuring that their organisation operates efficiently, economically and with probity, and that they make good use of their resources and keep proper accounts.

The existence of an independent audit committee is a key element of the board ensuring that effective internal control arrangements exist

28 Arrangements for NHS FTs differ slightly from NHS trusts. An FT has two boards: a board of directors and a board of governors. The board of governors is not involved in matters of day-to-day management. Their main function is to work with the board of directors to ensure that the FT acts in a way that is consistent with its terms of authorisation and to help set the strategic direction.

29 Each NHS FT can decide on the size and shape of its board of governors in the light of their local circumstances, within certain minimum parameters. The chair of an FT is the chair of both the board of governors and the board of directors. This ensures that views from governors are considered by the directors. Governors are responsible for appointing the chairman and non-executive directors.

Audit committee

30 Every NHS board is required to have an audit committee. This reflects established best practice in the private and public sectors. Its membership solely comprises of non-executives (although others are invited to attend) and this provides the basis for the committee to operate independently of any decision-making processes and to apply an objective approach in the conduct of its business. The main focus of an audit committee's work relates to internal control matters, such as the safeguarding of assets, risk management, the maintenance of proper accounting records and the reliability of financial information. The existence of an independent audit committee is a key element of the board ensuring that effective internal control arrangements exist.

Annual report and accounts

31 NHS trusts and FTs are required by legislation to produce annual reports, which must be published with either the full set of audited annual accounts or with the summary financial statements. The annual report gives an account of the organisation's business over the financial year. The annual report must be approved by the board before presentation at a public meeting. The deadline for such a meeting is the end of September following the end of the relevant financial year.

32 All NHS bodies have a statutory duty to produce annual accounts. These documents are the main way in which they discharge their accountability to taxpayers and service users for their stewardship of public money. The form and content of the accounts is set by the Secretary of State for Health, (or Monitor in the case of FTs) but is largely consistent with generally accepted accounting practices. The accounts comprise the following four primary statements:

- an income and expenditure account, which records the income and costs incurred by the trust during the year;
- the balance sheet, which provides a snapshot of the organisation's financial position (its assets and liabilities) at the end of the financial year;
- the cash flow statement, which summarises the cash flows of the organisation during the accounting period; and
- the statement of total recognised gains and losses, which provides a summary of all the organisation's gains and losses.

33 The accounts are accompanied by notes to the accounts, a statement on internal control, the directors' statement of responsibilities and the auditors' report. The notes to the accounts provide additional details on the entries in the primary statements as well as additional disclosures, such as specific accounting policies that the hospital has adopted in preparing its accounts.

34 The format of accounts for NHS FTs is broadly similar to that specified for NHS trusts. However, FTs have more discretion over the exact format and content of their annual accounts.

The role of audit

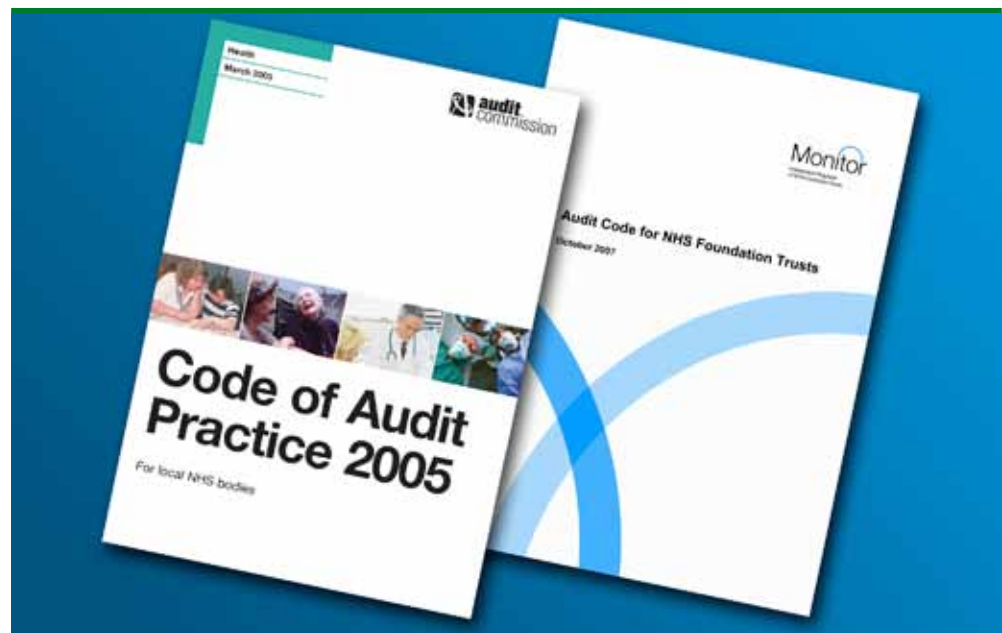
35 Internal and external audit are important elements of governance which all NHS organisations must have in place. Internal audit is an independent appraisal function established by, and operating to, agreed standards set by management. Internal auditors report to the audit committee on the systems of governance, risk management, internal control and value for money. This means the scope of the work can be wider and cover a number of non-financial areas.

36 Internal auditors are sometimes confused with external auditors. The Audit Commission appoints external auditors to NHS trusts. They are either employees of the Commission or one of the accountancy firms. The board of governors of FTs appoint their own external auditors.

All NHS bodies have a statutory duty to produce annual accounts

37 External auditors are required to comply with professional audit standards and the relevant Code of Audit Practice (there are different codes for NHS trusts and NHS FTs). Both codes set out the scope of the work auditors should carry out. Auditors are required to audit and give an opinion on the organisation's annual accounts.

The Codes of Audit Practice set out the scope of auditors' work.



Standing orders, standing financial instructions and schemes of delegation

38 Standing orders set out how a trust should conduct its business. The key financial elements are the standing financial instructions and the scheme of delegation. Model versions of these documents are issued by the Department of Health and are locally adapted and approved by NHS boards.

Standing financial instructions

This document details the financial responsibilities, policies and procedures adopted by a trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and with government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

Scheme of delegation

This is a schedule setting out where responsibility lies for decision making within the organisation. Some decisions will be reserved to the board and the scheme of delegation sets out the management arrangements in place to enable responsibility to be clearly delegated to senior executives.

Q Why should doctors bother to get to grips with the finances?

This is a real opportunity for clinicians. Being involved in the financial management of an organisation will bring increased power in terms of helping to decide where resources should be allocated and how they could be used better.

The financial duties and targets of NHS trusts and FTs

39 NHS trusts have a range of statutory and financial duties, the key one of which is to break even. That is, their expenditure must not exceed their income taking one financial year with another. Taking one financial year with another is generally interpreted to mean over a three (or exceptionally a five) year period. NHS trusts are also required to keep spending on capital and the cash they hold within certain limits. NHS trusts are required to report their performance against statutory duties and targets in their annual accounts.

40 FTs' financial duties differ from those of NHS trusts and are set out in the terms of their authorisation as set out by Monitor (the independent regulator of FTs). For example, FTs have no statutory duty to break even, but must instead achieve the financial position set out in their financial plan. Achievement of the financial plan, as measured achievement of EBITDA,¹ is one of the areas that Monitor look at in their assessment of risk to determine the level and depth of monitoring that an FT will be subject to.

41 All NHS organisations are required to pay invoices to non-NHS suppliers within certain time limits.

Q In the past, the finance director kept money in his back pocket to help manage the year-end position. Why isn't this done anymore?

It is true that there used to be various methods that finance directors could use to achieve financial balance at year-end, such as moving money from capital to revenue. However accounting rule changes have resulted in a reduction of the flexibilities available. This is a good thing as it promotes proper accountability in budget holders and places less reliance on accounting adjustments.

¹ Earnings before interest, tax, depreciation and amortisation.

The role of the finance department

42 The finance department is led by a finance director, who has corporate responsibilities as an executive director on the board. They are qualified accountants who are responsible for financial governance and assurance of the trust. One of their main roles is to present and communicate information on the financial implications of strategic and operational decisions to the board. The size of the finance department will depend on the size of the organisation and whether any of the finance activities have been outsourced. Sue Jacques, Director of Finance at County Durham and Darlington NHS Foundation Trust, describes the role of her finance department.

Sue Jacques is Finance Director at County Durham and Darlington NHS Foundation Trust. The FT has an annual income of £320 million and 5,500 members of staff, 45 of whom work in the finance department.

'I see my finance department as having two main functions. I think this is typical for most NHS finance departments. The first is to prepare financial statements for external purposes, such as the annual accounts for parliament and the financial monitoring returns and plans for Monitor who regulate the activities of the FT. This work is carried out by senior finance staff who are qualified accountants. The transactions that underpin those statements, such as the payment of salaries, fees and expenses, payments to suppliers, invoicing, and debt collection are managed by more junior staff. The second relates to providing management information, accounts and advice to the board and clinical departments and budget holders to aid decision making. This work is carried out by the management accountants.

However, the role of a finance department also extends beyond these areas. They include: safeguarding the FT's assets through the implementation of procedures and systems; ensuring compliance with regulatory and statutory obligations; ensuring proper procedures and cover are in place for matters such as insurance; cash management; and controlling the FT's bank accounts. Finance staff also provide assistance with the preparation of business plans, assess proposed capital developments, liaise with PCTs and other outside bodies on financial contractual matters, and prepare and monitor budgets and financial forecasts for the FT.

In my FT we focus on ensuring that financial skills and expertise do not only reside in the finance department. In my opinion an excellent organisation will ensure that financial management skills are present throughout the organisation, with financial responsibility being devolved to those who have responsibility for delivering the service. The finance department has a key role in facilitating this; in supporting clinicians and managers on financial matters, and in providing finance training to service managers and budget holders.'

43 For clinicians, most contact with the finance department will be with management accountants (also known as directorate accountants, finance managers or financial analysts). In some organisations these posts will be situated within the finance department, but in others they will be situated within the directorates they provide finance advice to.

Q I have worked for 20 years to get where I am in my profession. Why should I have to listen to a part-qualified, junior member of staff? What can finance staff do to support me with my financial management role?

It's about recognising each other's skills and experiences. It will pay dividends to spend time with your finance contact and to help them to understand the services you provide. They can become powerful allies and can support you to manage the service and help you to make changes. You could ask your finance contact to review the financial information provided to you to see if it can be more tailored to your needs and provided on a more timely basis and to ensure that they are familiar with the services delivered so that they can gain a better understanding of what drives your costs and the issues you face. Finance staff should be seen as enablers of change, rather than a barrier.

44 Some finance directors have additional responsibilities as well as their financial ones. These can include information, facilities and estates and procurement.

Q What is procurement and why can't I spend my budget where I like?

Procurement is the process of purchasing goods and services from an external supplier. It involves tendering, which is the process of bidding and negotiating for a contract. Because NHS organisations are spending taxpayers' money, they are subject to controls on how they conduct their purchasing activities. Anything they buy must be of benefit to the public, and it must provide the best value for money at the time. Purchasing also has to be done in a fair and open way. UK and European laws define how things must be done and procurement is subject to audit and scrutiny. Each trust and FT will have developed its own internal procurement rules and procedures and these will be contained in its standing financial instructions.

The financial plan will be developed alongside the strategy of the trust so that priorities and assumptions around activity levels are consistent

Financial planning

45 Preparing a financial plan or strategy is a key activity for finance staff. It is an important document that sets the financial direction of the organisation. Financial plans can be prepared covering different time frames. The most common is the medium-term financial plan that typically covers a three to five-year period. In the plan organisations estimate how much income they expect to receive over the period in question, the likely expenditure on revenue items and an estimation of capital funding requirements. The financial plan will be developed alongside the strategy of the trust so that priorities and assumptions around activity levels are consistent. The plan should also include an element of scenario modelling, so that the financial impact can be assessed should one of the variables change (for example the tariff for a particular treatment). Some organisations involve clinical staff and stakeholders in the financial planning processes, particularly in decisions about the financial direction and the prioritisation and allocation of scarce resources.

46 Financial plans are prepared by the finance department and should be approved by the board. Financial plans are continually updated, with additional information being added as more facts are known. The financial plan forms the basis of the annual budget.

Board reporting and forecasting

47 NHS boards need financial information to manage their organisation effectively. As the financial performance of NHS bodies will fluctuate during the year, this information has to be accurate and timely so that boards can take corrective action where necessary. Financial performance will be monitored on a monthly basis via a board finance report, which will include financial information such as the current financial position, a forecast of the year-end position, the balance sheet and a statement on cash. The format, content and frequency of such reports will vary from organisation to organisation and will be specified by the board. Many NHS organisations now place board reports on their website.

4 Managing a budget

Introduction	28
What is a budget?	28
Budget setting	28
Managing a budget	29

Introduction

48 This section of the guide is about the processes involved in managing a budget. It:

- **explains what a budget is; and**
- **describes what is involved in setting and managing a budget.**

What is a budget?

49 A budget is a detailed statement setting out anticipated expenditure and income, normally for a 12-month period. Once an organisation has set its overall strategy and its service and financial plans, these need to be translated into a budget. Setting a budget in this way will ensure that resources are allocated in line with the organisation's aims and objectives.

50 Budgets can be set for a number of purposes and at a number of levels. An overall budget will be developed for the entire organisation, including budgets for both capital and revenue expenditure as well as income. This will be a summarisation of the budgets developed at a directorate and service level. The level at which budgets are set will depend on the extent to which responsibility for managing a budget has been devolved. Budget holders, who have the necessary authority to take and implement decisions about how resources are utilised, need to be identified. In healthcare clinicians have a key part to play because their roles require them to commit the majority of resources within the organisation through the clinical decisions they make.

Budget setting

51 Most NHS bodies use a combination of budget setting methods. The most common is an incremental approach, where budgets are rolled forward from one year to the next and adjusted for known or expected developments and inflation. This approach has the advantage of being relatively quick and easy. The main disadvantage of this method is that errors are rolled forward. Some organisations use what is known as zero-based budgeting where the budget is built up from scratch each year. This is often more robust as it challenges assumptions made in previous years. However, it is much more time consuming than incremental budgeting. In reality many bodies use a combination of both these methods.

52 As budgets reflect expected spending over a specific period of time, part of the budget-setting process involves breaking down the budget into monthly profiles. The purpose of profiling a budget is to show the expected pattern of income and expenditure over a period of time, so that it can be compared with the actual pattern over the same time period. A properly profiled budget is an important aid to maintaining financial control as it will help to identify unplanned variations in income and expenditure in a timely manner, enabling remedial action to be taken.

Managing a budget

53 Once a budget is set and the financial year has started, the budget needs to be managed. Good budget management is achieved where:

- budget holders are held to account for managing their budgets;
- reports, to monitor performance against budgets, are accurate and provided regularly to budget holders on a timely basis;
- monitoring reports do not just contain financial data but are linked to information about performance and service improvements; and
- variations against budget are identified and investigated, and corrective action is taken.

54 Finance staff should work with clinicians and budget holders to ensure that the monitoring information they provide is tailored to their needs. Financial training should be provided to help clinicians and budget holders understand budgets and monitoring reports.

The purpose of profiling a budget is to show the expected pattern of income and expenditure over a period of time, so that it can be compared with the actual pattern over the same time period

Q Isn't the micromanagement of costs time consuming and therefore costs money rather than saves it?

Managing a budget is not about micromanagement of costs. It is an important management tool that, when used alongside activity information, provides a clear picture of what the service is doing and how much it costs.

Financial management is about explaining and accounting for what has happened in the past and forecasting income and expenditure in the future

55 Figure 2 gives an example of what an NHS trust's general ward expenditure budget statement, for the second month of the financial year, might look like. It is divided into three main headings:

- Month – this compares the actual level of spend incurred by the general ward during the second month with the amount of the budget allocated for that month.
- Year to date – as this example relates to month two of the financial year, the year to date column provides a comparison of the total amount the department has actually spent in two months with the ward's budget for the same period.
- Full year – this compares the year-end forecast, (what the general ward's year-end spending position is judged to be) with its budget for the full financial year. The figures are identical because in this example the budget holder expects that by the end of the year the ward will spend no more or less than the budget.

56 Financial management is about explaining and accounting for what has happened in the past and forecasting income and expenditure in the future. Using budget statements, budget holders should be able to identify the areas where they have spent less (underspent) and spent more (overspent) than their budget. They can begin to understand why variances, in terms of under or overspends, have occurred and, where appropriate, take action. To properly understand the financial picture, budget holders will also need information about the level of activity undertaken, for example the number of patients treated and the level of income received.

Figure 2: An example of an expenditure budget statement for a ward

Budget statement for General Ward - Month 2 2008/09

	Month			Year to Date			Full Year		
	Actual £000	Budget £000	Variance £000	Actual £000	Budget £000	Variance £000	Y/E Forecast £000	Budget £000	Variance £000
Direct Expenditure									
Directorate staff costs	99	102	-3	202	205	-3	1,255	1255	0
Other staff recharges	34	29	5	79	60	19	339	339	0
Agency staff	25	30	-5	59	61	-2	378	378	0
	158	161	-3	340	326	14	1,972	1,972	0
Other expenditure									
Consumables	22	25	-3	45	50	-5	313	313	0
Equipment	12	15	-3	28	30	-2	183	183	0
Training & Prof Devlpt	3	4	-1	6	8	-2	47	47	0
Travel and subsistence	2	4	-2	5	8	-3	47	47	0
	39	48	-9	84	96	-13	590	590	0
Indirect Expenditure									
Support staff costs	6	6	0	12	13	-1	72	72	0
Pharmacy recharges	56	55	1	125	128	-3	677	677	0
Radiology recharges	37	38	-1	79	84	-5	471	471	0
Pathology recharges	26	28	-2	61	59	2	342	342	0
Laundry	12	12	0	25	29	-4	147	147	0
Catering	10	10	0	26	24	1	123	123	0
Cleaning	14	15	-1	36	37	-1	184	184	0
	161	164	-3	362	375	-13	2,016	2,016	0
Net spend	358	373	-15	786	797	-11	4,578	4,578	0

NHS organisations will take different approaches to how they report performance against income budgets

Source: Audit Commission

57 In Figure 2, whilst the general ward has underspent by £15,000 overall, it has overspent by £5,000 on ‘other staff recharges’ in month two. The budget holder might be prompted to consider the reasons why the ward has overspent against this one item and has consistently underspent against a range of other items. In this way, it can be demonstrated that budgets are much more than an arithmetical exercise – they are a fundamental element of planning and management. Looking at monthly budget figures rather than annual financial performance figures will give earlier warning of any change in trend and should prompt corrective action.

58 NHS organisations will take different approaches to how they report performance against income budgets. Some will report income and expenditure separately and others will combine income and expenditure to show a profit or a loss. This reporting of income and expenditure together is more likely to take place at business unit, service-line or directorate level as it is difficult to allocate income to a specific ward. Service-line reporting is considered in the next chapter.

59 Most NHS trusts and FTs will have a budget holder manual which explains what financial information will be produced and the timetable, as well as an explanation of the key terms.

Q Can I carry a surplus over from one year to the next?

Each individual NHS organisation will have their own rules on how individual budgets are managed over the year-end. There is a spectrum of options available to finance directors when deciding how this issue will be handled, from making no adjustments in the subsequent year's budget, to carrying forward the full impact of any under or overspending. The position may vary year on year depending on the overall financial position of the organisation and the scale of the specific surplus. The rules will usually be set out in the trust's budget holder manual or if not the finance department will be able to clarify the position at your trust.

Q In my trust we've all had to make savings to fund large overspends in other directorates' budgets. Why is this?

NHS organisations need to balance their books. If one area of the organisation overspends then, unless additional income is received, costs will have to be recovered in other areas. The board will make a decision about the best way to achieve financial balance and it may well result in those budget holders that have managed their budgets properly being disadvantaged. However, this doesn't mean that budget holders should not manage their budgets properly.

5 Making the best use of the money available

Introduction	34
Achieving value for money	34
Efficiency savings	37
Finance for decision making	40
Service-line reporting and patient level costing	42
The finances of changing service delivery	44

Introduction

60 This section of the guide looks at how different types of financial information can assist organisations' decision making. It looks at:

- achieving value for money;
- why public bodies are required to make efficiency savings;
- some of the key financial information to assist decision making, including explaining costing and benchmarking;
- some recent developments within healthcare finance; and
- the finances of changing service delivery.

Q Is taxpayers' money being wasted because doctors are not taking the finances seriously?

There is no doubt that money could be spent better if decisions about how resources are allocated and spent are made by those individuals responsible for delivering care to patients. NHS organisations should make it easier for clinicians to get involved in the financial affairs of their organisations. A significant number of clinicians will have private practices and manage their own financial matters well; this enthusiasm needs to be replicated in the NHS.

Achieving value for money

61 Value for money is about obtaining the maximum benefit from the resources available. It's about achieving the right local balance between economy, efficiency and effectiveness (the 3Es). Value for money is generally considered to have been achieved when there is an optimum balance between all three elements – when costs are relatively low, productivity is high and successful outcomes have been achieved.

Q Is value for money more or less the same judgement I make when I buy a car?

Decisions about value for money are a daily reality in all our lives. We are constantly choosing which items or services to buy, and judging the right balance for us between quality and cost. Health services are no different.

Making the best use of the money available

62 Doctors and managers in NHS bodies should always be considering how to get better value for money from existing spending and how to ensure value for money when there is an increase in the resources being used. A particularly good opportunity to do this is when financial plans are being put together. NHS bodies need to understand the relationship between inputs and outputs for the services they provide, not only in terms of themselves but also for others so that they are able to benchmark their performance and be in a position to set themselves realistic targets for improvement.



A good opportunity for doctors to ensure value for money is when financial plans are being put together.

63 The Royal Brompton and Harefield NHS Foundation Trust improved value for money when it redesigned services for patients with level 2 dependencies (Case study 2). It illustrates how delivering better services for patients and achieving better value for money can be achieved at the same time.

Case study 2

Service redesign of level 2 facilities at the Royal Brompton and Harefield NHS Foundation Trust

The Royal Brompton and Harefield NHS Foundation Trust provides specialist cardiothoracic services on two hospital sites for patients with acute and chronic cardiopulmonary conditions and has a national referral base. The Trust received income of £235 million in 2007/08. In preparation for designation as an FT, the hospitals undertook a project to redesign their level 2 facilities, initially on one site, bringing together five units dispersed across surgical and medical wards into a single 20-bed facility able to cope with patients of level 2 dependency with cardiological and thoracic medical conditions and in the pre and post operative phases.

The initial aim was to improve patient care and render the FT compliant with National Institute for Health and Clinical Excellence, Royal College of Physicians and other guidelines relating to acutely ill patients and to provide a focus for the Hospital at Night team.

The changes were led by junior consultant staff with particular expertise in cardiothoracic surgery, anaesthesia, critical care, cardiology and thoracic medicine. Finance staff provided

costing information so that a development plan could be selected which met clinical requirements within the capital and revenue budgets available. The multidisciplinary team believed that in addition to the above aims it could allocate resource such that:

- patient flow could be facilitated through recovery and level 3 areas;
- educational and training opportunities could be optimised;
- the introduction of the revised tariff for critical care would ensure that patients could be appropriately classified and disease categories recorded accurately; and
- significant savings would be made in terms of reducing occupancy of level 3 beds by level 2 dependency patients.

By bringing together disparate level 2 facilities in the way described, the FT not only improved patient safety and care, facilitating compliance with national guidelines, but also projects savings of £110,000. These savings will be made through better staffing rotas and, with other measures, a reduction in inpatient length of stay (overall full-year benefit in the order of £1 million). There will be improved care pathway quality, better patient experience and reduced risk of infection.

Source: Audit Commission

Efficiency savings

64 All public sector organisations should be focused on ensuring that they improve efficiency year on year, so that they are making the best use of taxpayers' money. The current economic pressures mean that the focus on efficiency is likely to increase. Efficiency savings can either be cash-releasing or non-cash releasing. Cash-releasing efficiency savings result in the cost of the service provided being reduced. Non-cash releasing efficiency savings occur when more activity is provided but the cost of delivering the service remains the same. An example of this could be a reduction in average lengths of stay, which resulted in more patients being treated. Improvements in quality and efficiencies are expected to be secured through better procurement, commissioning, organisation and management, with any additional savings being reinvested in new or better local services.



Improvements in quality and efficiencies can be secured through better organisation and management.

65 How good organisations are at identifying items for their cost improvement programmes and then realising the savings, is a significant part of financial management. Over ambitious plans, unforeseen cost pressures or inadequate management action can contribute to the cost improvement programme not being achieved. Some bodies routinely identify non-recurring costs areas and consequently fail to address their longer-term cost pressures.

66 Methods of identifying efficiency savings vary in NHS organisations. Some have a rolling programme of efficiency reviews, ensuring that all major services have a review within a certain number of years. Others target those areas that are viewed as being less efficient (often through the use of benchmarking information). Others share the efficiency savings target evenly across all budgets and rely on budget holders to be able to identify savings in individual budgets. However, a whole system approach is more likely to deliver sustainable efficiency.

67 Royal Bolton Hospital NHS Foundation Trust has introduced a structured approach to identifying efficiency savings (Case study 3).

Making the best use of the money available

Case study 3

Royal Bolton Hospital NHS Foundation Trust's approach to securing efficiency savings

Royal Bolton Hospital NHS Foundation Trust is a busy acute trust providing hospital services from its site in Farnworth, Bolton. The FT started to use lean methodologies in 2005 and created its own version, Bolton Improving Care System, in 2007.

The Blood Sciences Department of Laboratory Medicine started its Lean¹ journey in late 2005. Over the last three years, significant improvements have been made, in particular focusing around the processing of blood samples. A new way of working within specimen reception and the laboratories was developed combining Haematology and Biochemistry, with staff changing the way they work and taking on new roles.

Laboratory staff worked with both clinicians and finance staff to redesign processes and working practices in order to improve the quality of service provided and at the same time increase efficiency. The redesign process identified activities that did not add value from the customer's perspective and the patient's blood sample's journey was central to the refocused process. The workforce was developed and re-profiled with staff carrying out more added value roles. An environment has been created where staff are encouraged to learn from other organisations, to challenge current practices and to suggest where improvements can be made. Performance metrics are collected

and daily meetings held with staff in all areas. Quality and performance information is displayed within the laboratory so that all staff can see what the latest position is.

The financial information received helped to inform the decision-making process and to focus attention on the financial benefits possible.

Improving the performance of the laboratories has enabled clinicians to receive test results much earlier and therefore the patient receives a quicker diagnosis. As a result of the changes made, the turnaround time for Haematinics and Immunoassay requests was cut from over 24 hours to less than two hours. The average turnaround time for Full Blood Count reduced from 108 minutes to 69 minutes and the previous turnaround time for Hepatitis B antibodies was reduced from seven days to one day. A routine blood sample's journey was reduced from 309 process steps to 57. This has significantly reduced the possibility of defects within the process.

As well as the improvements in the service delivered, the capacity created has resulted in additional activity being undertaken within existing staffing levels. For example the FT acquired a new £250,000 contract for Thalassaemia screening which will be delivered within existing staffing levels. Space utilisation has also improved with the amount of floor space required reducing by 50 per cent.

Source: Audit Commission

¹ In the NHS, Lean is an approach that seeks to improve flow in the patient journey and eliminate waste. The NHS Institute for Innovation and Improvement and the NHS Confederation have both issued publications on how Lean can be applied to the NHS.

Finance for decision making

68 NHS bodies should employ techniques such as costing and benchmarking in order to provide decision makers with the information they need to make informed decisions. This is an essential element of delivering value-for-money services. The introduction of PbR has increased the importance of costing in the NHS. The Department of Health currently use costing information supplied by NHS organisations to develop the national tariff. Also NHS organisations need to have a thorough understanding of their costs to understand their business properly.

What is costing used for?

NHS organisations need costing information for a variety of reasons, for example to:

- help run their businesses effectively;
- help decision makers, managers and budget holders decide how services should develop in the future;
- manage service lines;
- understand how the costs of providing a particular activity compare with the income received for undertaking that activity;
- identify the costs of different activities at different levels (for example, for a particular speciality/department or for an individual patient);
- develop commissioning strategies;
- compare potential investment opportunities;
- build up realistic budgets and plans;
- monitor performance and benchmark services; and
- support negotiations for funding.

Source: Introductory Guide to NHS Finance (9th Edition), Healthcare Financial Management Association

69 For an NHS organisation to operate effectively, staff must understand the costs it incurs as well as how those costs change when there are changes in activity levels. Trusts must consider whether costs are variable (that is they increase in line with activity, for example expenditure on drugs) or whether they are semi-fixed costs (changing at specific intervals, for example expenditure on nursing staff if a new ward is opened) or if they are fixed costs (that is they remain the same regardless of the level of activity, for example rent and rates). NHS bodies should have a clear understanding of which factors influence their costs. To support accurate costing, they should also distinguish between direct and indirect costs and overhead costs.

Making the best use of the money available

Direct costs	Those costs that can be attributed to a particular service, for example drugs.
Indirect costs	Those costs that cannot be directly allocated to a particular service, but are shared over a number of them, for example the provision of cleaning services.
Overhead costs	The costs of support services that contribute to the effective running of a hospital. An example of this is the cost of the finance department.

70 Cost analysis should not be a one-off exercise. Costs should be analysed at regular intervals, as they are likely to change. NHS managers should understand the nature of the costs they are incurring, how they are expected to change over time and how they can be influenced and controlled.

71 A wide range of costing methods can be used in different circumstances and for different purposes. Costing information is particularly relevant when setting the price for a particular service or treatment where this is not covered by the national tariff. The Department of Health publishes the *NHS Costing Manual* which sets out the key principles and concepts to be used by NHS bodies when costing services. It has been developed to ensure consistency in costing methodologies used.

72 Costing can take place at various levels, for example from treating a particular patient to providing a new service. The national tariff is based on HRGs. HRGs place patient procedures and/or diagnoses into bands, which are clinically similar and consume similar levels of resources. The new HRG system (HRG4) is the basis of the 2009/10 tariff.

73 There is currently a requirement on NHS trusts and NHS FTs to submit annual reference costs (on an HRG basis). They itemise costs of treatments in every trust and are used for a number of purposes including benchmarking cost improvement, measuring relative efficiency, identifying best practice and costing health improvement programmes. At an individual trust level they are compared against the national tariff to highlight the relative efficiency of activities and to assess where the trust is likely to incur a profit or loss under PbR.

NHS bodies should benchmark their costs wherever possible to ensure that they are securing value for money

74 When considering the provision of new services or amending existing NHS services, the cost implications need to be considered. The Summary features 2gether NHS Foundation Trust which shows how costing was a key element in influencing which service model should be used (Case study 1).

75 NHS bodies should benchmark their costs wherever possible to ensure that they are securing value for money. Benchmarking is the process of measuring and comparing costs against other similar organisations to obtain information that will help the trust identify and implement areas for improvement. This can be facilitated by using the NHS's productivity metrics,¹ via benchmarking clubs or by using the National Schedule of Reference Costs produced by the Department of Health.

Service-line reporting and patient level costing

76 Service-line reporting provides a framework that enables NHS bodies to understand the combined view of resources, costs and income, and hence profit and loss, by service-line or specialty rather than at directorate or trust level. Managing at this level allows managers and clinicians to make more effective decisions about, for example, growing or reducing services on the basis of efficiency and profitability, where cross-subsidisation is occurring (that is where profitable activities are subsidising non-profitable activities) or where services might be better provided in the community. Service-line reporting enables managers and clinicians to identify the financial effects of their actions more clearly. Although some trusts have been using service-line reporting for years, PbR has encouraged more trusts to adopt a more comprehensive and thorough approach.

Service-line reporting – a frontline perspective
By Stuart Shepherd

More than three years have passed since University College London Hospitals Foundation Trust ventured into service-line reporting, at its simplest a means of allocating income and costs across all of a healthcare organisation's divisions or service lines.

But for Professor David Fish, medical director at University College London Hospitals, reporting on profit and loss does not adequately describe all the issues that the wider process addresses.

He says, 'You could say that the service-line reporting of the money is just an enabler for all the other things that happen. If you use the wider term of service-line management

¹ These are on the NHS Institute for Innovation and Improvement website, www.institute.nhs.uk

Making the best use of the money available

then you start to focus on the real issue – improvements to the quality of care that come about through better clinical engagement.’

Inverting the pyramid

Professor Fish describes the move that a trust makes when it shifts to service-line financial reporting as inverting the pyramid. Traditionally, millions of pounds of annual income would come in and be allocated by the board on the basis of historical costs, lobbying and patronage. But with service-line reporting, on top of the pyramid is what drives the income under PbR – the patient and clinician interaction.

‘The clinician gains an understanding of the costs of a service and the resources they can allocate to it,’ he says, ‘while down at the bottom of the pyramid the trust board take on a role that is more aligned with monitoring and strategy rather than operational matters.’

Professor Fish believes that since 2006, University College London Hospitals has sought to develop the cultural rather than detailed aspects of this approach among its clinicians. Why? To create a mindset that seeks to improve service quality either by offering increased throughput, more responsiveness to clinical need, higher numbers of referrals or perhaps a greater critical mass.

Centre stage

‘There are professional accountants to take care of the financial flows’ says Professor Fish.

‘For clinical staff the focus is more on putting the moment of healthcare at centre stage.’

‘An example of this, but one that still takes the accounts into account, so to speak, would be in neurosciences’ he continues. ‘Clinicians felt the small intensive care unit and a limited number of isolation rooms were placing constraints on theatre throughput. Renovation would require major capital expense and the conventional means of getting this would be to go to the board with your begging bowl. But with service-line management, the team developed a business case which sought to borrow from the trust, as if it were a central bank, while laying out a repayment plan that emphasised improved efficiencies and clinical income.’

Where an expensive service, such as restorative dentistry, runs at a loss, service-line management affords a trust the transparency to reach decisions about how it might be supported by another service and what the consequences there might be.

Professor Fish says, ‘This enables clinicians and professional managers to engage in conversations that have meaning to both sides, to overcome issues rather than ignore them and understand how money flows around the system more as a logical rather than hierarchical process.’

Source: Health Service IT Special Report, sponsored by CACI and Bellis-Jones Hill, 25 February 2009

77 Alongside service-line reporting, there is also a growing impetus for trusts to introduce patient-level information and costing systems. They allow for a deeper understanding of service profitability and opportunities for improving efficiency within a trust. It involves a bottom-up approach to costing, using information about individual patients' resource consumption. The costs of individual patients are aggregated to generate costs for differing groupings, for example by HRG, by procedure or by consultant. This not only provides a much better understanding of what drives costs, but also allows for a greater level of transparency and accuracy.

Q Service-level reporting is turning us into a business rather than a hospital. The trust always balanced the books before we had this information, so why is it needed now?

Hospitals are indeed businesses and it may have been more by luck than judgement that financial balance was achieved. Some trusts and FTs are so large that if they were companies they would be quoted on the FTSE 250. This means that their finances need to be managed properly and that there is an understanding of which elements of the services provided are profitable and which are not. There may be very good reasons why a hospital will continue to provide services where the income does not cover costs, but it should be part of a rational, thought-through strategy.

The finances of changing service delivery

78 There are a variety of reasons why changes to service delivery might be made; for example, to improve the patient experience, the need to meet efficiency targets or to move services from secondary to primary care. The financial consequences of such changes should have been determined and set out in a business case.

79 A business case is a document developed as part of the procurement process to support decision making for new investments or to change or develop a new service. A business case sets out the case for undertaking a project, whether capital (a new building) or revenue (new clinical staff to deliver a new service), weighing up the objectives and benefits against the estimated costs and risks. Business cases should:

- set out measurable objectives;
- appraise all the options available (including the 'do nothing' approach, an indication of the preferred option and an explanation setting out why it is favoured);
- demonstrate affordability and value for money;
- provide a timetable reflecting the life of the project; and
- define the roles and responsibilities of those involved in the project.

Making the best use of the money available

80 A business case should make a compelling case to the audience that is going to judge its merits and should be subject to a robust appraisal process which evaluates its relative costs and benefits, both financial and non-financial. Most business cases will be considered and approved by either the organisation's board or in some cases a sub-committee of the board. Some business cases require approval to be sought externally. For example, significant capital investment projects are evaluated and approved by the Department of Health, whereas business cases relating to the reconfiguration of local services may require the approval of the local PCT.

81 Some changes to services may be designed in such a way as to incur no additional financial cost. However, others will require an investment which may be financed through efficiency savings or by new sources of funding. Planned service changes may require a one-off investment in the first year and be self sustaining thereafter (often referred to as pump priming). Others may require double running costs. This is where, for a limited period, services continue to be provided as they are, while the new provision is simultaneously developed to eventually replace it.

82 The Plymouth Hospitals NHS Trust is at the start of the process of changing the way it delivers services and recognises that whilst working in a different way will improve patient care and save money it is a long process (Case study 4). The starting block is, however, identifying the benefits that can be achieved.

A business case is a document developed as part of the procurement process to support decision making for new investments or to change or develop a new service

Case study 4

Clinical pathway redesign at Plymouth Hospitals NHS Trust

Plymouth Hospitals NHS Trust provides a wide range of acute and general hospital services to people of all ages. The Trust received £346 million income in 2007/08.

The Trust's finance director sees the current economic crisis as a real opportunity for promoting significant behavioural change over the next couple of years. Working to the mantra that improving quality costs less, the Trust set up a clinical systems engineering and a clinician-led service improvement team that reviewed the typical clinical pathways of non-elective patients through the hospital.

The team divided emergency clinical pathways into three broad groups covering short stay patients, patients needing intervention and patients with more complex needs. Using value stream mapping the team identified where value was added to patients' stays in hospital and where there were delays to treatment. With better design of clinical pathways and improved communication between the various organisations involved in discharging patients it was estimated that

it was possible to reduce average occupancy from 31 to 18 beds in one specialty.

Similarly, many gains were found in elective care, through aiming for best practice in admissions; discharge planning at the point of pre-operative assessment and smoothing discharge over seven days. The team found far greater gains, however, in looking at theatre session and clinic productivity.

Overall, the research showed that the Trust ought to be able to undertake its current workload on half the number of beds and two-thirds of the theatre capacity. Although some specialties have made some of these changes, the Trust has not yet achieved the level of savings believed to be possible.

Dr Steve Alder, the Trust's Head of Clinical Systems Engineering, said, 'Our analysis has identified areas where we can treat patients better and at the same time reduce costs, but we will not achieve these changes without a radical change in the behaviour of clinical staff and in particular, consultants. We are at the start of a long process, but one well worth pursuing.'

Source: Audit Commission

6 Further sources of information

Further sources of information	48
Useful websites	48

Further sources of information

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Useful websites

www.audit-commission.gov.uk

www.dh.gov.uk

www.hfma.org.uk

www.monitor-nhsft.gov.uk

Glossary

Accountable officer

The nominated officer at each NHS body, normally the chief executive, who carries personal responsibility for financial management.

Budget

A budget is a summary of estimated or intended expenditure, or income, or both for a given time period, normally for a 12 month period.

Budget holder

Budget holders are accountable for the budgets delegated to them, including managing income and expenditure and the financial stewardship of the budget. A budget holder will be expected to monitor income and expenditure and liaise with the finance department if underspends or overspends are expected. A budget holder is responsible for authorising expenditure against the budget and ensuring that the proper financial procedures are followed when obtaining quotes and for monitoring supplier performance to ensure the best value for money is obtained.

Capital expenditure

Capital expenditure is expenditure on items which have a usable life of over one year, such as buildings and equipment.

Commissioner

NHS body, usually a PCT, that is purchasing healthcare services for its population.

Commissioning

This is the process whereby PCTs assess the health and social care needs of their local population, set relevant priorities and allocate resources accordingly and negotiate agreements with providers (NHS, private and voluntary) to deliver services to meet these needs.

Cost improvement programmes

A series of actions identified by an NHS body which are intended to reduce costs or improve efficiency. The programme should be established to meet both Department of Health minimum targets for efficiency improvement and internal requirements to secure income and expenditure balance.

Department of Health

The Department of Health is the government department responsible for improving the health and well-being of the people of England. It sets national standards and shapes the direction of the NHS and social care services, as well as promotes healthier living.

Financial management

At a basic level it is the management of money within an organisation. This includes activities such as financial planning, budget monitoring and control. It has been defined by the Chartered Institute of Public Finance and Accountancy as 'the system by which the financial aspects of a public body's business are directed and controlled to support the delivery of the organisation's goals'.

Incremental budgeting

The most common method of budget setting, it is where budgets are rolled forward from one year to the next and adjusted for known or expected developments and inflation.

NHS foundation trusts (FTs)

NHS FTs are a new type of NHS hospital. The first wave of NHS FTs was introduced in April 2004. NHS FTs are free from central government control and strategic health authority performance management.

Non-recurring funds

A one-off allocation of funds.

Overhead costs

The cost of support services that contribute to the effective running of a hospital. An example of this is the cost of the finance department.

Payment by Results (PbR)

This funding system was designed to ensure that NHS finances are deployed directly in line with patient treatment. It requires PCTs to pay NHS providers of acute services a nationally set tariff for clinical activity undertaken. This replaces the previous system of fixed-price block contracts.

Practice-based commissioning

Practice-based commissioning is a reform policy that aims to give more responsibility to GP practices in England. Under practice-based commissioning, GP practices are to be given their own notional budgets with which they can commission health services for their patients.

Primary care and PCTs

Primary care covers the health services provided by GPs, community dentists, opticians, pharmacists, community nurses and allied healthcare professionals. PCTs are the bodies responsible for assessing the need for local healthcare provision, planning and commissioning health services and improving health.

Provider

NHS body, usually a trust or PCT, but can also be another public sector body such as a local authority social services department, a voluntary sector organisation or a private sector supplier of services.

Revenue expenditure

Revenue expenditure is spending on day-to-day items such as salaries and running costs.

Scheme of delegation

This is a schedule setting out where responsibility lies for decision-making within the organisation. Some decisions will be reserved to the board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives.

Secondary care and NHS trusts

NHS trusts and FTs are the organisations responsible for running hospitals and providing secondary care. Patients must first be referred into secondary care by a primary care provider, such as a GP (except for A&E admissions).

Service-line reporting

Service-line reporting measures a trust's profitability by each of its service-lines, rather than just at an aggregated level for the whole trust. This allows clinicians and managers to understand the profitability of their service, what drives profitability, or what impact different decisions have on profitability. FTs are organised around a portfolio of services, each with their own distinct set of patients, medical conditions treated and clinical leaders. In business terms, the service-line is the natural business unit of the hospital.

Standing financial instructions

This document details the financial responsibilities, policies and procedures adopted by a trust. They are designed to ensure that the trust's financial transactions are carried out in accordance with the law and with government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

Strategic health authorities

Strategic health authorities are regional bodies that are responsible for strategic leadership, organisational and workforce development and ensuring local health bodies (PCTs and NHS trusts) operate effectively and deliver improved performance.

Value for money

Value for money is about obtaining the maximum benefit with the resources available. It's about achieving the right local balance between economy, efficiency and effectiveness (the 3Es).

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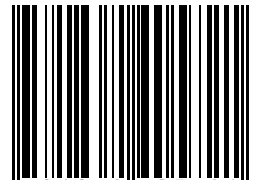
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