A prescription for partnership

Engaging clinicians in financial management
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Clinical engagement in financial management has always been important. It is clinicians who are responsible for the way in which services are delivered and who commit resources. The importance of clinical engagement has been highlighted in recent Audit Commission reports, such as the *Review of the NHS Financial Management and Accounting Regime*, *Learning the Lessons from Financial Failure in the NHS*, and *Financial Management in the NHS 2004/05*, produced jointly with the National Audit Office (NAO).

In spring 2007 the Public Accounts Committee, in its seventeenth report, recommended that “the Department of Health should identify models of successful joint working between financial and clinical management and promote them across the NHS”. This report aims to help the Department of Health and the NHS in implementing that recommendation.

Our report, based on interviews at 16 sites, is aimed at clinicians, managers and finance professionals working within the NHS. It is also aimed at trust and primary care trust (PCT) boards which set the tone for their organisations. We also seek to influence strategic health authorities, professional bodies and government. We have also published two short briefing papers: one aimed at clinicians and one aimed at finance staff.

In the past, managing the money was often seen as the preserve of the finance department, but this approach will not stand up to the demands of the new NHS. Closer alignment of finance staff with the ‘front line’ will improve key aspects of financial management, such as financial planning and costing, by increasing awareness of cost drivers and the accuracy of financial forecasting.

This is even more important as NHS bodies strive to do better than achieve financial balance and are looking to service redesign in order to improve productivity and efficiency. There are real benefits to be gained if engagement can be achieved, in terms of efficiency savings that can be reinvested in improved services for patients. Good financial management and greater efficiency go hand in hand with better patient care.
It is not sufficient for financial skills to reside only within the finance department. An excellent organisation will ensure that financial management skills and competencies are spread 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 them with finance training where it is required.

This report reviews how engagement with clinicians, general managers and budgetholders leads to improvement in the quality of financial information, and how non-finance and finance staff can work together to improve efficiency and, by doing so, provide better patient care. By engagement we mean mutual understanding and cooperation between what are sometimes markedly different cultures and ways of working. Engagement is a two-way activity that involves the finance and clinical cultures coming together.

It is perhaps unsurprising that clinical engagement depends on effective communication and good working relationships. Or that it is more easily achieved when finance staff are proactive and knowledgeable, and that the structure of the finance department is less important than the style with which its staff operate. But there are characteristics that underpin effective clinical engagement. They can be summarised as:

- A clear organisational structure where management and clinical responsibility are aligned with financial accountability.
- Prompt provision of accurate financial information, tailored to the needs of clinicians and linked to clinical activity data. Delays, for example, as a result of making sure accruals are precisely right in departmental budget statements can have a detrimental effect on the usefulness and relevance of the information in the eyes of clinicians.
- Training for clinicians in financial management and for finance staff to raise their knowledge about the delivery of care.
- Service-line reporting and patient level costing in hospitals and practice based commissioning in PCTs. Service-line reporting techniques can be applied in other sectors as well as acute trusts. Programme budget information enables PCTs to take a similar approach by comparing expenditure in specific disease areas with the outcomes achieved.
- A management style that enables entrepreneurialism to flourish within clear rules of financial accountability.
The case studies in the report illustrate these points. They will not be unique. Other organisations will undoubtedly be able to demonstrate similar features, but they do show what can be achieved. Different approaches will be required at different NHS bodies and the individuals employed by them, to implement the kind of structures and processes that emerge from this report. We have, however, distilled the main factors that have proved to be successful in the organisations we visited into the checklist below. We recommend that chief executives, finance directors and medical directors consider together the checklist and how well their organisation performs against each of the factors.

### Checklist for chief executives, finance directors and medical directors

**Governance and accountability**

- Is there a shared vision for the organisation? Was this vision developed with input from all staff groups? Does it include the aims of delivery of high quality services as well as financial stability?

- How does the Board actively promote the importance of good financial management?

- Is there a devolved management structure? If so, has responsibility for financial performance been devolved so that it is aligned with accountability for the effective delivery of clinical care? Have corporate support services also been similarly aligned?

- Is there clarity about where responsibility for financial performance lies and the lines of accountability that exist below board level?

- Are accountability structures regularly reviewed to ensure they remain fit for purpose and facilitate effective financial control? Are they sufficiently flexible to ensure the engagement of clinicians and to encourage entrepreneurialism?

- What evidence do you have that clinical directors understand the importance of financial management and encourage best use of resources?
Communication and culture

- Have all staff that manage resources or have authority to commit significant resources received financial management training?

- Is there a structured training programme in place for finance staff to build familiarity with current clinical practice and with the culture and aspirations of clinicians?

- Do you have a training programme that encourages finance staff to be more than competent finance professionals and to develop influencing and interpersonal skills? Does your performance development system encourage this?

- Are directorate accountants visible outside the finance department? Are they proactive in dealing with financial issues and part of the team overseeing the management of the directorate?

- Do you have regular meetings with clinical directorates to discuss management issues, including financial management?

- What proportion of consultants do you have a working relationship with? This could be evidenced by the number you are on first name terms with.

The importance of good information

- Has your organisation implemented service-line reporting and patient level costing? If not, why not? Are you aware of the benefits that this information provides? What skills and systems will your organisation need to put in place in order to implement them? (Trusts only)

- If service-line reporting and patient level costing have been implemented how have the costs of support services and overheads been apportioned? Have you considered alternative models?

- How soon after the month end is financial performance reported? What steps are there in place to improve this? Has any analysis been undertaken to look at the trade-off between accuracy of financial information and its earlier production?
Are finance staff proactive in challenging clinicians and managers to take corrective action where overspends have occurred? Do finance staff promote the use of financial information to improve decision-making and in identifying opportunities to deliver efficiency savings?

Does your organisation plan to break-even or to achieve a surplus? Are you aware that the financial regimes for both PCTs and NHS trusts allow resources not consumed in one year to be utilised the following year?

Could you identify a number of areas where consultant entrepreneurialism has helped the organisation? Should this be encouraged in other areas?

Have you linked income and expenditure budgets at a directorate level? Are there clear and agreed rules on how these should be managed in relation to the trust’s overall position and how changes in income will be managed?

**Commissioning and purchasing**

Has your organisation attempted to involve clinicians in the procurement of goods and services? Has this been successful?

Are provider clinicians involved in commissioning discussions with PCTs? Has this been successful?

How has the PCT’s programme budgeting information been used? Has it been linked to health outcomes? Has it been used to help decide levels of investment in different services or to address spending issues? (PCTs only)

**General**

How would you rate your level of clinical engagement on financial issues in the light of the case studies in this report?
Introduction

The NHS environment is changing and approaches to financial management need to change accordingly. We all recognise that good financial management is essential for the delivery of high-quality efficient public services. Experience tells us that those NHS bodies that are able to manage their finances effectively do so because they have support and commitment from all parts of their organisation, including clinicians and general managers, and have effective governance arrangements in place.

Purpose of this report

1 Clinical engagement in financial management has always been important. It is clinicians who are responsible for the way services are delivered and who commit resources. The changes in the NHS have created new opportunities for clinical engagement and increased the importance of the role of the clinician in the financial arrangements of NHS organisations.

2 In the acute hospital sector, the logic of tariff funding is being followed through by many NHS foundation trusts and NHS trusts into a system of service-line reporting that treats the internal building-blocks of the organisation as trading units in their own right. This organisational model, often called a clinical directorate model, commonly gives a senior clinician influence over, and sometimes direct accountability for, an income and expenditure budget of many millions of pounds. Meanwhile, within PCTs, the movement towards practice based commissioning is increasingly giving GPs, and sometimes their practice staff, effective control over millions of pounds of NHS commissioning expenditure.

3 Together 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. Our report considers the opportunities available for the engagement of clinicians in financial matters and also how to mitigate potential areas of concern.
Our report *Learning the Lessons from Financial Failure in the NHS* highlighted a lack of engagement of clinicians in the core business processes of NHS organisations as an important contributory factor in financial failures (Ref. 1). The importance of cooperation between clinicians and finance professionals was re-emphasised in the spring of 2007 by the House of Commons Select Committee on Public Accounts. Among the six conclusions and recommendations of the Committee’s report is:

‘There is a lack of financial management expertise in the NHS, and a need to strengthen communication between those responsible for the finances and for the delivery of local health services. Measures to bring about financial balance need to stem from a partnership between financial managers and clinicians to enhance both the efficiency and effectiveness of healthcare. The Department should identify models of successful joint working between financial and clinical management, and promote them across the NHS.’ (Ref. 2)

This report aims to help the Department and the NHS in implementing that recommendation.

This report is timely for another reason; 2007/08 saw the end of high annual financial growth of approximately 7.5 per cent a year in real terms. The NHS now needs to accustom itself to much lower growth levels of around 4 per cent a year in real terms, taking its budget from £90 billion in 2007/08 to £110 billion by 2010/11. Those responsible for NHS budgets in 2008/09 and after are likely to find the emphasis on productivity and efficiency continuing as before, but without the cushion provided by significantly increased resources. Clinicians and finance professionals, and managers and boards within the NHS need to prepare for this imminent change in circumstances.

This report is aimed at clinicians, managers and finance professionals currently working within the NHS and attempting to combine high quality clinical care with sound financial management. It is also aimed at NHS trust and PCT boards which set the tone for their organisations. We also seek to influence strategic health authorities, professional bodies and government. We are also publishing two short briefing papers; one aimed at clinicians and one aimed at finance staff.
Clinical engagement in financial matters

7 There are two aspects to clinical engagement in financial matters. Firstly, clinicians’ acceptance and understanding of the emerging NHS business model and financial systems; an acknowledgement of why it has been introduced; and active participation in its processes. Secondly, the engagement of managers and finance professionals with the clinical culture and its values. In any field of enterprise, managers who ‘walk the patch’ and genuinely understand how goods and services are delivered are respected. Healthcare is no different.

8 By engagement we mean mutual understanding and cooperation between two markedly different cultures and ways of working. And by the term clinicians we mean not just doctors, but all the various health professions that contribute to the provision of NHS healthcare.

9 Recent Audit Commission publications have highlighted the importance of having a fit for purpose finance function and skills spread throughout the organisation. World Class Financial Management (Ref. 3) states that:

‘Financial management is a key management discipline. It is not just what accountants do, but something that every manager within an organisation is responsible for. In that respect, an excellent finance function is a necessary, but not sufficient, condition of good financial management within an organisation, although it obviously has a key role to play as a catalyst for improving financial management.’

10 Our report with the NAO Financial management in the NHS 2004/05 (Ref. 4) recognised the importance of taking a ‘whole-organisation’ approach to the achievement of financial balance and that delivering financial balance must be seen as a collective responsibility, rather than the remit of the finance director alone. The report states:

‘…this more holistic approach to financial balance requires buy-in from a wide range of individuals across the organisation. Not just the finance leads, but also senior clinicians and managers should be alive to new developments in their field which may impact on a body’s finances.’
So it is not enough for financial skills to reside only within the finance department. An excellent organisation will ensure that financial management skills are spread 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 them with finance training where it is required.

Methodology

This report is based on visits to 16 NHS organisations, which include NHS trusts, NHS foundation trusts and PCTs (Appendix 1). Within these organisations we have interviewed a wide spectrum of individuals, including: chief executives; finance directors and their staff; medical directors; clinical directors and other clinical managers; chairs of PCT professional and executive committees; doctors; nurses; therapists; pharmacists; operational managers and their support staff. We have also visited or interviewed other relevant organisations, ranging from professional bodies to senior Department of Health officials.

In producing this report we have drawn on previous Audit Commission reports, including those undertaken jointly with the NAO. We have also been advised by the Commission’s NHS Financial Management Advisory Group. We are grateful to all those who have contributed to, or commented on, this report. We particularly appreciate the time and effort given by individual NHS organisations that have shared case study material and given permission for its publication.

The structure of this report

We have organised the report around the principal themes that have emerged from our research. These are:

- governance and leadership, and the significance of organisational structure and the clinical directorate model;
- differences of language and culture, and their meaning for relationships between clinicians and non-clinicians;
- the crucial importance to clinicians of good information; and
- the role of clinicians in commissioning, purchasing and procurement.
Governance and accountability

Financial management operates within structures of governance and devolution decided at board level. The extent to which financial authority is devolved will often in practice depend on the immediate business environment as well as the capability of managers within the organisation. In the field of healthcare, clinicians, especially doctors, have a crucial role. It is they who commit resources. Governance structures need to allow them freedom to act and to ensure there is accountability for their actions. The finance function needs to be structured in a way that supports this. This chapter reviews the way in which some NHS organisations have approached this challenge.

Governance, devolution and clinicians

15 In all NHS organisations, as in commercial entities, authority and accountability rests with a board of directors. The standard tools of corporate governance, that is, standing orders, standing financial instructions and schemes of delegation, are approved by the board of directors, and are commonly based on guidance and models that are standardised across the NHS.

16 At a formal level it is therefore the board that decides on the degree of financial delegation. This is true for all NHS bodies. Decisions on delegation are also strongly influenced by, among other issues:

- **The size and scale of the organisation.** Especially in the acute hospital sector, NHS bodies control budgets that are very large by commercial standards. A turnover of £200 million a year or more is not unusual and workforces running into thousands of whole time equivalents. Corporate bodies on this scale tend to work through devolved structures accountable to a central core or hub.

- **The geography of an organisation.** Organisations that are physically spread across a number of sites are more likely to be managed effectively through devolved structures, though there are occasions when delegation may need to be reined in.
• Financial stability, both of the organisation itself and in its immediate operating environment. If unclear lines of accountability and a lack of culture of robust budget management are common factors in financial instability or failure, then the imposition of tight governance and centralised control is often the way in which a board, especially if it is a new board, restores financial control and confidence (Ref. 1).

• Financial systems. Working through devolved structures requires finance and performance management systems that allow the board and the central core of the organisation to monitor what is happening at care delivery level, and to intervene promptly when necessary.

17 Determining the extent of financial delegation applies to income as well as expenditure. It is particularly significant for commissioning organisations, since commissioning decisions often involve very significant amounts of public money and set a pattern of expenditure that can last for many years.

18 The financial delegation model chosen by the board also influences the way that finance staff are organised within an NHS body, and the style of corporate accountability. Typically the greater the degree of devolution, the greater the likelihood that management accountants, will be organised around the devolved trading units or profit centres rather than in a central department. This in turn affects the way of working of the core finance department, which may be freed to support strategic planning and direction but which will also need to manage processes of consolidation and corporate control.

19 These themes are common to large public and private sector entities. NHS bodies, however, are unusual in the degree of influence that senior clinicians, and especially senior doctors, have traditionally exerted and expect to continue to wield. In recent times the influence of doctors over commissioning has been materially increased by the introduction of practice based commissioning. This initiative is the subject of a separate Audit Commission study published in November 2007, Putting Commissioning into Practice: Implementing Practice Based Commissioning through Good Financial Management (Ref. 5).

The term management accountant is typically used to describe the type of finance professional that focuses on areas such as budgeting, planning, forecasting, costing and pricing. Job titles of management accountants will vary according to seniority but typical NHS examples include directorate accountant, finance manager and financial analyst.
20 The scale of clinical influence, whether at national level through professional and representative bodies or at local level, remains a practical constraint on the ability of NHS boards to pursue independent strategies or adopt robust management styles. A degree of consensus between management and clinicians is a prerequisite of success, in financial management as in other fields. But organisations that wish to thrive in the changing environment of the NHS in England need to do more than work within the boundaries of what is acceptable to clinicians. They need to harness the energy and positive commitment of clinicians, individuals who typically are devoting their entire career to meeting the healthcare needs of a community.

21 This applies equally:

- In commissioning organisations, where the creation of PCTs under the 1999 Health Act did so much to bring GPs into the mainstream of NHS commissioning and hence into steering the strategic direction of healthcare delivery. Practice based commissioning now reinforces this process, offering the potential to increase the influence of other practitioners at practice level.

- In provider organisations, where structures built around clinical directorates are directly involving senior clinicians in budget management.

- In strategic health authorities and other national bodies, where the influence that effective clinical leadership can have should not be underestimated.

22 In the NHS, decisions on the scale of devolution and the extent of clinical influence rests with boards. This is appropriate: there are circumstances in which tight central control is essential. But our research shows the positive financial impact that clinical leaders can have in NHS organisations. In many cases this has stemmed from a board decision that greater involvement from clinicians is necessary or desirable to achieve a corporate vision or goal. This in turn requires the leadership of board members, and crucially the chief executive, as well as the courage to delegate. The achievements of the Bolton Hospitals NHS Trust (Case study 1), show how a vision of a different way of working can be translated into real improvements in both quality of care and operational efficiency.
Case study 1
The introduction of a new structure of devolution at Bolton Hospitals NHS Trust and its impact on clinical quality and financial performance

Background
Bolton Hospital NHS Trust is a large acute hospital trust in the North West of England. Its total annual income is around £160 million and it employs around 3,100 whole time equivalent staff. Following a number of years with underlying financial deficits, averaging approximately £3.9 million per annum between 2002/03 and 2004/05, the Trust has achieved a major financial turnaround.

Fit for the Future
Bolton Hospital NHS Trust’s Fit for the Future change programme was implemented in 2005 following wide consultation within the Trust. It was the chosen vehicle for achieving the Trust’s three strategic aims and included a new organisational structure and investment in organisational development. The three strategic aims were underpinned by the need to secure value for money and are set out below:

- greater clinical involvement and engagement resulting in the best possible clinical care in a safe environment;
- stronger team and partnership working between managers and clinicians with common ownership of problems and solutions;
- clear management accountability and focus allowing the trust to overachieve against delivery and service targets;
- clear management and clinical accountability for budgets ensuring all financial targets are met;
the creation of an organisational culture that empowers staff giving everyone the potential to excel at their roles and gain personal and professional satisfaction from what they do; and

the creation of an environment where continuous learning and improvement and professional development is the norm for each single individual.

Bolton’s new organisational structure created four clinical divisions: medicine and emergency care; surgery and anaesthetics; women’s and children’s services; and diagnostics and therapies. Each of these divisions is led by a divisional manager with direct managerial, financial and service accountability for the division’s performance. The four divisional managers report to the Trust’s director of nursing and performance. Working closely with each divisional manager is an associate medical director and a divisional nurse or allied health professional.

Key deliverables of the divisional manager role at Bolton are to:

- lead and develop the directorate to improve demonstrably patient experience and drive service improvement;
- ensure that the divisional team achieves all key performance targets;
- achieve maximum efficiency and effectiveness in the design of patient pathways and delivery of access targets;
- ensure that all financial goals and targets are met; and
- develop a culture that empowers all staff and is recognised as an environment where individuals can excel and gain pride and satisfaction from their work.

Associate medical directors report to the trust medical director but play a pivotal role within divisional management teams. Each is supported by a number of clinical leads. The structure was consciously designed to ‘allow the development of roles focused on achieving clinical excellence and best practice rather than simply organisational management accountability.’

A feature of the Bolton structure is a structure of leadership forums, consisting of:

- a monthly leadership team meeting, chaired by the chief executive and including divisional managers and associate medical directors and other senior clinical staff alongside the executive team; and
- a bi-monthly clinical forum meeting to which all clinical leads and nurse leads are invited.
Impact: trauma care
The Bolton Improving Care System is the trust’s interpretation of a Lean approach to healthcare delivery. One significant early improvement in patient care has been in trauma care, achieved via the introduction of a trauma stabilisation unit.

Bolton had a known problem with the mortality of patients with fractured neck of femur, particularly in older patients with chronic diseases. The Trust allocated a six-bedded area to care for patients, and introduced it during a week’s ‘rapid improvement event’; part of the lean approach and clinically led, in this case by a physiotherapist.

The introduction of the trauma stabilisation unit had the following direct impact:
• the 30-day postoperative mortality reduced by 37 per cent (externally validated);
• the length of stay reduced by 33 per cent from August 2005 to August 2006;
• there was a 38 per cent reduction in the average time taken to stabilise patients and get them to theatre (2.3 days reduced to 1.7 days); and
• post-operative recovery was less eventful, with daily geriatrician input.

Impact: trust financial position
Although it achieved financial breakeven until 2004/05, when it reported a deficit of £2.7 million, from 2002/03 to 2004/05 the Trust had an underlying financial deficit averaging approximately £3.9 million per year. Going into 2005/06 the underlying recurrent deficit of the Trust was quantified at £7.5 million (5 per cent of turnover): this was the level of savings required to address the deficit from previous years, the 2005/06 efficiency requirement and to put expenditure budgets onto a realistic basis.

A lower in-year target of £5.2 million was facilitated by brokerage.

The full £7.5 million was achieved recurrently, putting the Trust back into recurrent balance. In 2006/07 the Trust set a further ambitious target. While it undershot this, it delivered sufficiently to repay its brokerage and report a small surplus.

The Trust attributes this major financial turnaround to the above structural, cultural and process changes alongside improved internal and external relationships.

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In the NHS, Lean Thinking 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 Thinking can be applied to the NHS.
Bolton Hospitals NHS Trust: Recent surplus/deficit and savings performance

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* Due to exceptional items

** £2.3 million full year effect of 2005/06 savings plus £6 million in 2006/07

Thus, after a lapse into deficit the trust has, during 2005/06 and 2006/07, achieved a significant financial turnaround. The level of recurrent savings is particularly impressive.

**Commentary**

According to the Trust’s finance director, the Fit for the Future change programme has achieved its aim of getting professional general managers working in partnership with clinicians. A clear vision, ‘quality underpinned by viability’, has proved to be inspirational.

Lesley Doherty, director of nursing and performance development, believes the Lean Thinking methodology has shown concentrated quality improvements as nurses change their ways of working. Experience in trauma management has shown how hard quality measures can be combined with efficiency gain in the form of material length of stay reductions.

While it is hard to demonstrate a direct causal relationship between Fit for the Future and the Trust’s rapid financial improvement, there is evidence of the new management structure’s effectiveness and the scale of financial improvement at Bolton has been impressive.

**Source:** Audit Commission/Bolton NHS Trust Foundation Trust bid
Quality and efficiency

During our research, we found that the majority of the acute trusts we visited explained their decision to adopt a devolved structure as being motivated by a shared corporate vision of the future organisation. Even where the starting position was one of financial pressure, the future vision would extend beyond mere financial stability to improved patient treatment and care. Many now attribute their level of clinical engagement to a decision to make quality of care a priority, rather than a simple preoccupation with money. ‘We set out to be good as well as viable’, explained one finance director.

High quality clinical care and financial robustness are not mutually exclusive. Service improvement can bring about significant improvements in clinical outcomes and timeliness of care and save money at the same time. The redesign of the stroke service in South Devon is a good example of this (Case study 2).

Case study 2: Redesign of the South Devon Stroke Service

Background
The stroke care service for South Devon covers two PCTs, one care trust, one acute hospital and one social services organisation. Before the recent improvement initiatives the acute hospital had a 16-bed acute stroke unit that was only able to admit 46 per cent of patients with stroke.

Improving stroke care in south Devon
Prior to recent redesign initiatives there were lengthy waits for transient ischaemic attack (TIA) services and no ability to offer thrombolysis for ischaemic stroke.

Service redesign
A radical service redesign has implemented the following changes:

- development of a revised care pathway for the management of stroke, covering all aspects of care from primary prevention through to longer term follow up;
- redesignation of the unit in the district hospital as an acute stroke unit;
- development of a 15-bed stroke rehabilitation ward in a community hospital. This step down unit is led by a consultant physiotherapist and provides intensive rehabilitation to people who are medically stable; and
- teams of specialist staff in the community to enable continued rehabilitation.
The consultant therapist also leads joint working across health, social care and voluntary organisations across the whole continuum of care.

These changes have enabled the medical staff in the district hospital to focus on establishing a thrombolysis service, launched in February 2006, and improving services for TIA patients, including processes for urgent referral for TIA. The service can now offer appointments on the next working day.

**The significance of clinical leadership**

These service improvements were planned and implemented at a clinician to clinician working group for stroke. This included representatives from primary and secondary care, all professional groups and social care organisations, users and carers, and voluntary organisations.

Because the project was steered by a group of clinicians from across this broad spread of organisations, and included service users, any potential for dissent from individual organisations was contained and managed. There was some difficulty when hospital clinicians realised the new model of service would reduce ‘their’ activity, and some hospital doctors initially only wanted to send ‘local’ patients to the community hospital rehabilitation service; but this was countered by the mutual trust that had already been developed.

The consultant physiotherapist also set up a stroke patient and public involvement group. This group used an RCP/Picker service user questionnaire with a sample of over 300 people who had used the service. As a result the service has produced a guide to secondary prevention for users, and a comprehensive information booklet, and has set up a peer support programme under which ex-patients visit the ward to offer support and encouragement to current inpatients.

**Impact: clinical improvement**

There have been major improvements in access to treatment and care:

- over 90 per cent of patients are now admitted to the stroke units, compared to 46 per cent prior to the changes;
- patients referred with TIA can be seen on the next working day;
- appropriate patients with ischaemic stroke can access a thrombolysis service, 24 hours a day, 7 days a week; and
- following discharge patients can access specialist therapy follow-up, regardless of whether they return home or to a residential or nursing home.
For longer term care the therapy teams have developed processes for self-referral, improving access to care if further sessions of therapy are required. User feedback indicates that 43 per cent of respondents rate their care while in hospital in South Devon as ‘excellent’. This compares favourably with a national benchmark of 33 per cent. The South Devon service was rated in the top 6 per cent of all services in England in the 2006 Royal College of Physicians Sentinel Audit for stroke depression.

**Impact: efficiency gain**

During 2005/06 the length of stay on the district hospital stroke ward decreased by 12 days from 19 to 7 days. In 2005 the average acute length of stay for a stroke patient in England was 25.5 days.

The total average length of stay for stroke across the whole South Devon health community (acute and community hospital together) reduced from 25.8 days in 2004 to 23.4 days in 2005. The average total length of stay in 2005 was 29.8 days. Under the 2007/08 payment by results tariff the payment for each additional in-patient day of stroke care, beyond a 57 day non-elective trim point, is £127, suggesting the 2.4 day length of stay reduction achieved by South Devon is probably saving at least £300 per patient spell.

These improvements in efficiency are impressive and have released resources. The trust has not, however, put in place the systems that would have been needed for a robust comparison of the costs of the previous and new service models, partly because the changes predated the introduction of payment by results.

**Commentary**

The South Devon stroke project has incorporated all agencies, professions, users and patient groups involved in stroke care. It has taken an integrated approach to look at all aspects of management from primary prevention to longer term support and care. It has achieved impressive gains in both quality of care and the efficient use of resources.

Clinician-to-clinician dialogue has been crucial in implementing the service and overcoming potential obstacles. The payment by results regime provides for, but does not insist upon, the unbundling of the stroke care pathway; that is, breaking down an aggregate tariff into its constituent parts. For instance, the 2007/08 tariff for non-transient stroke for patients aged over 69 is £4,400, irrespective of the balance between hospital and community care. In some parts of the country acute trusts, fearful of lost income, have been reluctant to unbundle; but in South Devon effective clinical engagement has removed this possible barrier.
According to the consultant therapist leading the new community-based service, a number of key hospital clinicians were particularly helpful in quelling any early anxiety. It may also be significant that the district hospital, now South Devon Healthcare Foundation Trust, formerly ran the entire stroke service and hence was familiar with the initial access problem for certain groups of patients.

Source: Audit Commission

The underlying message that quality and efficiency are mutually compatible echoes our previous study *Learning the Lessons from Financial Failure in the NHS*, which observed that strengthening governance in troubled organisations can improve quality as well as financial performance. This is consistent with recent work in this field by the NHS Institute for Innovation and Improvement, which looks particularly at the potential for releasing resources by shortening hospital length of stay to levels that reflect accepted best practice (Ref. 6). We noted, in a number of instances, the crucial role of clinical leadership in making these improvements happen, from the initiation of improvements to steering change processes to persuading reluctant clinical colleagues.

In several instances we heard that, without the devolution of powers, including budgetary responsibility, from managers to clinicians, these changes simply would not have happened. One good example is the quest for efficiency gain in outpatient services within part of the University College London Hospitals NHS Foundation Trust (Case study 3).

**Case study 3**
The crucial role of clinical leadership during times of change at University College London Hospitals NHS Foundation Trust

**Background**
The Trust comprises a London teaching hospital as well as five other London hospitals. Its total turnover is approximately £550 million and it employs approximately 6,000 staff. Relatively recently it has occupied a large new hospital building in central London as part of a complex sequence of estate changes.

**Implementing change in clinical practice**
In order to improve its operational efficiency, the Trust decided to reduce outpatient sessions from 660 to 440 per week in one key specialty as part of its move to the new University College Hospital in London. The management challenge was to secure clinical agreement for change in this traditionally sensitive area.
Managers explored various options with clinicians, including hot-rooming to use rooms vacated by leave, measures to ensure reductions in non-attendance rates, reductions in follow-up rates, and an extension of the working day.

Several of these options required significant change in working practice. For the first option, for instance, there was an additional need for high quality scheduling software. Because of the required speed of implementation, clinicians formed a view that an extended working day consisting of three outpatient sessions (instead of the traditional two) would offer the most pragmatic solution. This would also give patients the flexibility to opt for evening appointments.

**Securing clinical engagement**

The key to success was clinical leadership. Specifically this involved exploring the options with the major participants in care delivery, ensuring an appropriate clinical perspective on the changes was always available. Besides outpatients, engagement of all supporting departments was essential so that relevant support services would be available during the evenings.

This approach proved helpful in a subsequent project to extend the working day in the imaging department.

**Securing staff flexibility**

The Trust had believed evening outpatient clinics would be attractive to patients. In practice, patients were keener to continue to receive care during ‘office hours’ and later appointments were not popular. Because of the shared clinical ownership of the original decision, the directorate has been able to renegotiate staffing schedules and reduce the length of the third daily clinic. It is now achieving 95 per cent occupancy in these sessions.

In addition, during the year after implementation further discussion with clinicians allowed further changes in clinical practice to be implemented, reducing the number of rooms required.

**Impact**

No assessment of the efficiency saving has been made as it was not the driver for the change. In themselves the changes described in this acute hospital case study might appear relatively minor. Yet effective clinical leadership, and practical ownership by clinicians of a trust business objective, has allowed a potentially difficult change in shift patterns to be implemented by consensus and then refined in a way that eliminates unforeseen surplus capacity and improves efficiency.

**Source:** Audit Commission
Organisational structures

When considering devolved organisational structures that empower clinicians and which therefore both encourage and require greater clinical engagement in financial management, we believe there are three mutually dependent dimensions:

- the hierarchy of posts that comprise the managerial structure of the organisation showing reporting lines and accountability;
- the scheme of financial devolution that is the bedrock of financial governance (the standing orders, standing financial instructions, schemes of delegation); and
- the organisation of corporate support functions: finance, human resource management, information and knowledge management, estates management and some other shared organisational services.

To be genuinely effective, organisations need to align these three dimensions.

Clinical directorates

The clinical directorate model, as it has evolved in England, typically involves sub-dividing the organisation into a relatively small number of operational units that can be seen to function as semi-autonomous business units, working within powers devolved from the board. This type of structure has been typical in NHS bodies since the early 1990s and the scope of clinical directorates inevitably varies markedly from one organisation to another. Our research found:

- a number of acute trusts using some four to six clinical directorates, of which typically surgery would be one, medicine would be another and diagnostics a third;
- broadly similar structures emerging amongst mental health organisations; and
- some larger trusts differentiating between district general hospital type activities and specialised functions, or between a main hospital site and outlying or peripheral sites.

We found limited steps towards a similar structure being taken within some PCTs. Examples within primary care settings appear to be uncommon, though this may reflect the extent to which PCT management structures remain fluid following their recent reorganisation. Birmingham East and North PCT is an example of a commissioning body using clinicians innovatively and successfully (Case study 4).
Case study 4
Birmingham East and North PCT has developed a management structure designed to bring clinical knowledge and influence to bear on critical areas of commissioning.

Background
Birmingham East and North PCT has a budget of some £570 million for services for its population, and controls a further £390 million for commissioning care across the West Midlands. It employs around 1,700 staff. The PCT has developed a management structure designed to bring clinical knowledge and influence to bear on critical areas of commissioning. The PCT now has what in effect is a clinical executive, with medical managers combining commissioning, based upon six localities, and corporate roles. This structure has supported initiatives around clinical redesign and referral management. This structure has now been in place for a year.

The management structure
The clinical director structure was designed to support the delivery of the PCT’s four key strategic goals. These are:

• to be so responsive to the population we serve that no one waits for the health care they need;
• that the health and well being of our population will have improved so much that people will enjoy 10 more years of quality life, wherever they live;
• our communities will be the most involved, informed and empowered in the country; and
• that people regard us as the first choice organisation to work with and for.’

Recognising that to deliver this ambitious agenda the PCT would require real, tangible clinical engagement to bring about results and change; the team designed the clinical director structure. This structure would also:

• support the delivery of practice based commissioning through the six localities; and
• represent part of the PCT professional and executive committee.

Locality directors and managers form a part of locality boards, with clinical directors providing leadership. This enables communication with the wider PCT and with GP colleagues. This structure has formed the governance springboard for the PCT’s initiatives on clinical redesign and referral management.
**Clinical redesign and referral management**

Two priorities for the PCT have been:

- the redesign and improvement of certain clinical services and pathways; and
- the introduction of referral management protocols and procedures to manage demand and specifically to control admissions to secondary care;

with a view to controlling costs and ensuring that clinical care is delivered in the most appropriate location.

The PCT’s commissioning finance managers supported the process with information on procedures or interventions that appeared unduly high in volume. Their data was reviewed by the executive clinicians and discussed within the Professional Executive Committee (PEC), resulting in a commitment from PEC members to focus upon seven specialties within which improvements to the patient pathway could be made. Once the specialties were identified, the PEC agreed the way forward for delivering change. This required the ‘pairing’ of leads within commissioning to work as a trio with primary care physicians and secondary care consultants.

Allowing primary and secondary care clinicians to work together through the specific parts of the pathway that could be redesigned has reinforced links with secondary care organisations. Meanwhile, each management lead has worked within the trio to facilitate changes to pathway of care. According to the PCT, the agreement of both clinical parties to each redesign, with a focus on improving patient care as well as saving money, has been fundamental.

**Impact**

The impact of this work has been:

- the development of unambiguous patient pathways that identify how patient care will be managed. There is now, for example, clear agreement that outpatient follow-up will be used for clinically driven reasons rather than as routine practice; and
- a reduction in the use of procedures that have limited or unproven clinical value.

This process has opened up positive communication channels between primary and secondary care and has developed into providing further support to GPs in other ways. As a result, the trios are thinking creatively about how to use the existing technology to improve the primary/secondary care interface.
From a commissioning point of view, this programme supports key areas for future consideration:

- it establishes principles that set out clearly what the PCT will not commission or not routinely commission in future;
- it ensures that, in the longer term, prior approval schemes are built around pathways; and
- it develops open communication between PCT, primary care physicians and secondary care consultants.

This approach helped the PCT to achieve £26 million savings in 2006/07 and a score of excellent for quality of services in the Healthcare Commission’s annual health check for 2006/07.

**Commentary**

The Birmingham approach demonstrates the power of clinical leadership in commissioning. It particularly demonstrates how effective clinician-to-clinician relationships can be in creating modern efficient care pathways and avoiding inappropriate use of hospital care.

**Source:** Audit Commission

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30 In general the number of clinical directorates within trusts appears to be reducing. This may be linked to management team dynamics: a smaller number of directorates, and therefore of clinical directors, reduces the span of control required of a chief executive and makes effective interpersonal relationships at senior level more likely.

31 The turnover of a typical clinical directorate, at around £35 to £45 million, would suggest a scale of activity allowing the directorate to be viewed as a substantial business entity in its own right. In some of the organisations we visited clinical directorates had turnovers in excess of £100 million. Nevertheless, each is bound to the broader ‘parent’ NHS organisation, from which it derives its powers, by a complex web of interrelationships including access to shared clinical facilities, operating policies and staff rotation. The precise reporting lines of clinical directorates differ from one organisation to another. In some instances, the clinical director is directly accountable for financial management and the achievement of income and expenditure budgets. In these cases the clinical director’s line of accountability may run to the chief executive of the trust, to the medical director, or to the trust’s chief operating officer. More commonly the clinical director reports
managerially to the directorate’s operational or general manager, and clinically to the medical director. An example of a typical directorate organisation chart is set out in Figure 1.

**Figure 1**

*Typical directorate structure within the NHS*

![Diagram of a typical directorate structure](image)

*Source: Audit Commission*

32 The precise role and responsibilities of the clinical director varied significantly among the various organisations we visited. The most visible variation is perhaps in the proportion of the individual’s job plan that is devoted to the clinical director role. The scope of the job also varies markedly according to the area of responsibility, the turnover and staff responsibilities of the directorate and its relative complexity.

33 Though their formal structures sometimes differed considerably, what united the successful organisations we visited was a lack of ambiguity about reporting lines. In each case a clear reporting structure defined the precise locus of financial management responsibility and accountability within the directorate.

**Finance structures**

34 Finance posts offering professional advice and support to clinical directorates are plainly of vital importance. In our research we were keen to establish the most successful reporting lines and ways of working for such posts.
From the viewpoint of the finance director, the dilemma of whether to devolve or to centralise the management accounting function is nothing new. In the NHS, devolution of finance posts to clinical directorates mirrors developments in other sectors, notably local government, where the pattern in recent years has tended to be for finance posts, especially in management accounting, to be devolved to service directorates. The accountant becomes part of the directorate management team, while retaining professional accountability to the organisation’s finance director.

This type of dual reporting structure sometimes places pressures upon individual finance professionals, who can be faced with a split loyalty: primary allegiance to the employing directorate, or to the organisation as a whole? Payment by results and service-line reporting can make this potential conflict more explicit, for instance when exposing a cross-subsidy between specialties within a hospital. When interviewing productivity-minded clinical directors, we found a particular suspicion of, and desire to expose, internal cross-subsidisation, whether between specialties or between more or less productive individual clinicians. These tensions test an accountant’s professional values.

Some finance directors in NHS organisations argue strongly against devolution, and have retained line management responsibility for all finance professionals. They cite problems with cross-cover; training; the maintenance of standard methodologies within an organisation; vulnerability arising from poor information flows; and inconsistencies in accounting treatment. One finance director, in an NHS trust where posts have not been formally devolved but who nevertheless spend most of their time within directorates, insists on a weekly one-hour meeting with all finance managers to keep up to date with what they are doing and to enable mutual information sharing amongst the finance managers.

For non-devolved finance professionals to be effective, it is essential that clinicians and other members of the directorate management team see them as full team members. What appears to work well, irrespective of formal reporting lines, is a group of people including clinicians, managers and finance professionals, working together in the fashion of a board. As one acute trust finance director put it: ‘then the accountants can’t ignore the clinical consequences of their actions, and the clinicians can’t ignore the financial consequences of theirs.’
Accountability

We found that clinicians respect, and are generally happy to work within, accountability structures and processes that are clear and are seen to be applied consistently. The methodology for holding budgetholders to account needs to be transparent, understandable and visibly enforced. The Salisbury NHS Foundation Trust case study (Case study 5) describes a clear and practical approach to ensuring sound accountability within a devolved structure.

Case study 5
Clinical directorates at Salisbury NHS Foundation Trust are held to account for the financial management of devolved budgets

Background
The Trust provides general acute and a range of specialised hospital services. It has an annual turnover of £140 million and employs some 3,800 staff.

Devolution and accountability
Salisbury NHS Foundation Trust works through a devolved clinical directorate structure, yet takes a pride in its corporate governance and control structure.

‘Outsiders joining the Trust cannot believe how corporate the organisation is’, states the director of operations and deputy chief executive. A recently recruited clinical manager echoed the judgment: ‘I have never worked in a trust that’s so… I don’t know whether it’s well managed or tightly managed.’

Each clinical directorate has an annual turnover of between £15 million and £20 million: smaller than in some comparable organisations. The clinical management team typically consists of: a clinical director; a directorate manager; a senior nurse; a finance manager; and a personnel manager. Formally, the finance manager reports, both managerially and professionally, to the deputy director of finance for the Trust; but for most practical purposes is viewed as part of the management team.

This team is accountable for the directorate budget. Some felt that the foundation trust application process had brought a greater appreciation of the meaning of accountability amongst clinicians within the trust, with a consequent improvement in chains of communication. The clinical directors at Salisbury meet as a group and support one another.
3:3 meetings
At the core of the Trust’s accountability processes are highly structured sequences of ‘3:3 meetings’. Each month three members of each directorate management team (clinical director, directorate manager, directorate senior nurse and the human resources and finance managers) meet their counterparts from the trust executive (director of operations, medical director and director of nursing). Minutes are taken and circulated. The clinical director and the directorate manager are always expected to attend, along with, on a cyclical basis, their nursing, finance or personnel lead. The agenda for these meetings is formal and structured. Activity, performance management, finance and clinical governance are standing items. However, a pragmatic approach is taken, ensuring that current priorities are always addressed.

‘If there are any financial problems, you’ll have to account to the executive team’, said one senior nurse, pointing out that the finance manager also has a powerful influence.

Organisational size and stability
There is a strongly held view at Salisbury that the relatively small size of the Trust is a real benefit. This was expressed both in terms of benefits for internal communications (‘the chief executive can connect with the workforce’) and in its implications for visibility (‘people can’t hide so easily’). ‘The chief executive knows most of us by our first names’, says one directorate manager.

Benefits are also claimed for organisational stability and a relatively low level of staff turnover. ‘The secret of Salisbury’s success is people who’ve been here for years’, reported one clinical manager; and the view was reinforced from within the finance department. ‘Three of our finance managers have 70 years experience at Salisbury between them…people live with their mistakes and learn by them.’

Source: Audit Commission

One trust finance director explained: ‘We have an internal system of ‘three strikes and you’re out’. That is, three months in deficit and we put a turnaround team in, either internal or external.’ The trust in question spells out to its clinicians what is expected by way of activity, calculated according to a standard 42-week directly productive clinical year. That is, allowing ten weeks for holiday, training and other absences, and then sets specific targets.
St Mary’s NHS Trust in London, offers interesting examples of how simple and clearly understood financial incentives and penalties can motivate desired behaviours (Case Study 6).

**Case study 6**

**St Mary’s NHS Trust’s approach to financial incentives and penalties for clinical directorates**

**Background**

St Mary’s NHS Trust was a large teaching hospital operating from a number of sites in Central and West London. It had an annual turnover of some £290 million. The Trust employed 3,700 staff. In 2006/07 the Trust reported a surplus of some £8.6 million, an improvement of around £5.5 million on 2005/06.

**Incentives for financial performance**

At St Mary’s Hospital in London the Business Planning Group adjusted the budgets for over- and under-performance on activity targets. An adjustment was first made for market forces factor, which at 44 per cent was very significant for the Trust. Then, for over-performance, 88 per cent of the remaining additional income was allocated back to the appropriate clinical directorate, with the remaining 12 per cent going to diagnostics. For under-performance the same principles applied in reverse.

‘It’s like RAB’ said the director of finance at St Mary’s. ‘If people underspent, they carried money forward. If they overspent, there was a penalty, though not a huge one.’

Financial adjustments were also used at St Mary’s as an incentive for improved coding. In 2005/06 uncoded activity attracted a £1,000 fine, representing the average marginal cost of that activity. The Trust reported that in 2006/07 99.9 per cent of activity had been coded.

**Source:** Audit Commission

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I St Mary’s NHS Trust has now been merged with other NHS organisations to form Imperial College Healthcare NHS Trust.

II RAB is an acronym for resource accounting and budgeting, the system of accounting used by central government and up until recently NHS Trusts.
Communication and culture

Clinicians and finance professionals do not simply use different jargon; their view of healthcare, finance and each other is often profoundly different. This chapter examines some of those differences, and considers how skills and training might reduce some of the areas of misunderstanding.

Communication

Doctors and accountants use different professional languages and have different underlying cultural beliefs, values and expectations. The challenge is to bridge this gap. If engaging clinicians in the NHS business culture was simply about unravelling the jargon of NHS finance and explaining how NHS systems work, life would be simple. Many senior clinicians, in both primary and secondary care, also manage substantial private businesses. Of necessity, they become familiar with the language and workings of accounting and commerce in addition to those of medicine. These individuals, mainly but by no means exclusively doctors, often show considerable enthusiasm for financial management.

How clinicians view NHS management

Among the clinicians we interviewed, we encountered a view, apparently commonly held, that NHS managers were committed and were trying hard, but were poorly trained and not always of a high intellectual calibre. In some cases they were regarded as disempowered individuals working within a system that did not value them or offer them true responsibility. One medical director spoke of non-commissioned officers in military hierarchies who deal with consultants. The medical director in question reported that consultants find the experience of dealing with NHS managers insulting.

According to one general manager from a nursing background, ‘most clinicians don’t believe managers care about quality. But when you’re in financial free-fall, it’s impossible to get an organisation to care about quality.’ We came across the perception that, if clinicians are motivated by a desire to provide high-quality healthcare, non-clinicians aim above all to balance the books.
45 We also found that the office of chief executive holds considerable status and authority. The concept of a board, however, appears to be less highly regarded: one medical director considered it to be ‘nebulous’ and emphasised the importance of a chief executive being visible. In all but the biggest trusts it remains entirely practicable for the chief executive to be on familiar terms with each medical consultant: one medical director we interviewed felt that a degree of personal rapport was quite possible with 120 to 150 individual consultants.

How clinicians view NHS finance

46 We asked numerous clinicians in senior posts about their relationship with finance. Their responses included:

• ‘it’s about credibility: someone we trust has looked at the data and given it a stamp of approval’;
• ‘be honest. It’s all about communication and teamwork’;
• ‘get out of the office. That’s the key to credibility’;
• ‘the important thing is to get involved with clinicians. Walk around, meet the nursing staff and the consultant team. Don’t try and understand it through the figures’;
• ‘doctors get frustrated when finance doesn’t understand our need to see patients in a timely way. They need to get out and see our pressures, such as the four hour [maximum accident and emergency department] wait’;
• ‘sometimes you feel like you’re saying the same old things and people don’t really understand what it’s like’; and
• ‘we need high level thinking, not “you can’t do that”’.

47 Many of the clinicians we interviewed expressed a great deal of respect for NHS finance professionals, perhaps more so than for NHS management in general. They respect an accountancy qualification and the qualities associated with the accountancy profession, especially technical expertise. Some feel that whereas general management is ‘fuzzy’ and full of uncertainties and ambiguities, financial management is harder-edged, rules-based and perhaps also more evidence-based and scientific.
48 However, we also encountered frustration with a perceived lack of rigour within NHS financial management systems. Clinicians expressed a degree of scepticism about the ability of individuals or organisations, within an ostensibly rules-based system, to introduce financial fixes, or not, without a clear framework of accountability. Financial deficits and their solutions are viewed by some clinicians as subject to too much arbitrary interference from outside the organisation and this apparent unfairness is a cause of some irritation. This view is not unique to clinicians. The Department of Health has made progress in this area, not least by introducing a stronger, fairer and more transparent rules-based NHS financial regime. The greater transparency introduced by these rules has meant that many underlying financial problems could be exposed. The Department has abolished the practice of moving money around the NHS, and no longer permits brokerage and planned support. Greater financial rigour has also been introduced, so that organisations have to address financial problems head-on and take steps to ensure that they live within their means.

49 We encountered a stereotype of the NHS accountant that did not appear to match contemporary reality. Finance staff, we were told, should get out of their offices more and get to know how clinical care is actually delivered. ‘Finance people count money and try and stop you spending it’, said one medical director, stating that finance had ‘historically been obstructive.’ Yet on closer questioning we were regularly told that this did not apply to the specific finance staff to whom that clinician normally relates.

50 Some senior doctors also complain of a perceived lack of intellectual parity between themselves and their finance colleagues. ‘One problem here is just a straight IQ gap’, reported the medical director of one foundation trust. ‘The top doctors are three leagues ahead of NHS finance. We heard suggestions, expressed as a matter of objective fact, that this intellectual gap leads to practical problems. ‘If you get someone as your management accountant that hasn’t got much ability, your life becomes a lot harder’, said one clinical director of a foundation trust. It needs to be stressed that these views were not expressed maliciously or derogatorily, although clearly such attitudes can make relationships and team working more difficult.
How NHS finance professionals view clinicians

Among the NHS finance professionals we met, we found nothing but respect for the clinical excellence of doctors, nurses and other health professionals. We also found numerous examples of finance directors praising the corporate contribution, knowledge, influencing skills and teamwork of their clinical colleagues.

At a more junior level, however, amongst finance staff we sometimes encountered a reflex reaction to financial skills and motives amongst clinicians. There was a perceived latent tension between, on the one hand, the financial management and budgetary control intentions of finance staff, and, on the other, a willingness among clinicians to spend whatever resources are necessary to ensure good quality patient care. In some cases one might have believed that cost improvement savings and financial recovery plans were being achieved by accountants rather than by clinicians or managers.

Developing skills and knowledge

Although many clinicians have warmed readily to greater involvement in the management and financial direction of their organisations, some are apprehensive about this change of direction and what it may mean for clinical priorities. Others recognise that a lack of structured training in management and finance issues may leave them exposed if they take on new responsibilities.

The British Association of Medical Managers (BAMM) has for some years been advancing the need for doctors, as they progress in their careers, to develop their management skills. BAMM focuses on helping doctors develop the knowledge and skills they need in management and leadership roles. Their Fit to Lead programme is a personal and professional development programme that aims to develop confident and skilled clinical leaders, and to recognise leadership experience and expertise within the medical profession.

The Department of Health’s national Financial Skills Development (FSD) strategy also recognises the need to spread financial management skills to non-finance staff. FSD Leads at individual SHA level are working jointly with workforce leadership leads in providing finance training for non-finance managers and are a resource available for use at local level.
A trust medical director reported that local training facilities had introduced leadership and management into their postgraduate medical training, and that many new consultants now have leadership training on their CVs. He insists that ‘doctors need to develop’ and their needs at different career stages need to be enabled by their employers. According to one accident and emergency consultant, ‘junior doctors should be far more aware of what’s going on with money.’ Finance should, it was suggested, be part of the curriculum at medical and nursing school, and part of the trust’s induction programme for all new staff members.

Specific needs are:

• training in human resource management skills and knowledge, recognising the extensive line management responsibilities that many senior clinicians acquire;
• training in financial skills and knowledge: the generic principles of costing, budgeting and other aspects of financial management, the specifics of the NHS finance regime, and measuring the efficiency and effectiveness of clinical care; and
• management and leadership skills development.

Harrogate and District NHS Foundation Trust has developed a structured approach to their training of budgetholders, most of whom do not have a financial background (Case study 7).

Case study 7
Harrogate and District NHS Foundation Trust has developed structured training material, that aims to improve the financial skills, knowledge and awareness of budgetholders.

Background
Harrogate and District NHS Foundation Trust (HDFT) is a relatively small acute hospital foundation trust in the North of England, based around a general hospital. Its turnover is £87 million and it employs around 2110 staff. The Trust achieved foundation trust status on 1 January 2005 and has a history of achieving its financial targets. HDFT was one of only two trusts to be awarded ‘excellent’ ratings for both quality of care and use of resources in the 2005/06 Healthcare Commission annual health check.
Financial skills and knowledge training

Finance staff at HDFT are based within clinical directorates. This is seen as essential for finance staff to understand clinical processes, a prerequisite for productivity gain.

To support its internal financial management and budgetary control framework, which is based on extensive devolution, the Trust has developed a range of innovative financial training material aimed at budgetholders. The main element of the training programme is a three day Effective Financial Management course that aims to improve understanding of financial management, give budgetholders an understanding of how to manage a budget effectively, and ensure that all resources are being utilised to achieve value for money. The training programme is run twice a year and is aimed at all individuals who manage a budget or have responsibility for the use of resources as well as any member of staff that wishes to learn more about how NHS financial management works. HDFT also offer a shorter foundation course as a more-high level introduction to financial management.

The topics covered in the Effective Financial Management course include:

- financial management and why it is important
- the characteristics of a good budgetholder
- Payment by results
  - what it is and what it means for budgetholders
  - the national tariff
  - reference costs
  - trading accounts
- accounting concepts, the ledger and coding
  - explanation of revenue and capital expenditure
  - accruals and prepayments
  - coding structure
- budgetary control
  - income
  - expenditure (pay and non-pay)
  - budget setting
  - cost pressures
• variance analysis
• reporting
• planning and service development
  – business cases
  – costing
  – efficiency, savings programmes and income generation
• internal control and audit
• wider health economy considerations

Attendees are also given case studies to work on between courses, based on real situations to test how well the concepts have been understood.

The purpose of budgetholders
Part of the training material is a document that sets out the HDFT’s expectations of the role of budgetholder. This is set out below:

A good budgetholder:
• understands the Directorate’s objectives;
• understands and is able to defend staff levels if necessary;
• satisfies themselves that everything is needed and well maintained;
• avoids unnecessary stock-piling;
• assesses and reviews the demand for consumables;
• influences medical staff where necessary;
• monitors the quality of the services being provided;
• makes sure the right people know;
• is positive about the need for change;
• is proactive in managing their budgets;
• understands what drives costs in their patch;
• uses budget statements to confirm what they already know, not to learn where they are;
• has well established accountability structures and communicates this to any delegated budgetholders;
• understands their authority and responsibility;
• is creative in managing their budget; uses virements, ‘spend to save’, looks for solutions across a wider patch, etc;
• maintains ongoing close working relationship and communication with their finance contact;
• is cost conscious and aware of what their budgets can afford; and
• understands service income, evaluates the impact of change and maximises organisational learning.

Impact
At HDFT all budgetholders understand their financial responsibilities and are aware of the impact their actions have on the overall financial position of the organisation. The finance staff have had a key role to play in this. One positive outcome is that, as budgetholders have improved their skills, they are also increasing the demands on the finance department to produce high quality and more timely information. Improvements have been made to the time taken to produce the monthly monitoring information and further improvements are being planned (Paragraph 76).

Source: Audit Commission & Harrogate and District Foundation Trust

Finance staff are also having to develop new skills and acquire new knowledge to work in the new environment. Although accountants and trained finance professionals have the skills and knowledge needed for financial management, there would appear to be a need for them to have structured training about the delivery of healthcare. There would also seem to be a case for regular updating of knowledge of NHS finance information systems, such as new software to support costing, an area not typically covered by accountants’ continuing professional development programmes.
For finance staff engaging with an environment of accelerating financial devolution, we see two pressing needs:

- **Structured training to give relevant knowledge of clinical practice.** At present, the principal way hospital finance staff gain their knowledge of clinical practice is by ‘walking the patch’, and such an approach is by nature sporadic and heavily influenced by local factors and personalities. Commissioners find even this route to knowledge acquisition restricted, leading to difficulties in maintaining their knowledge base. There is a need for more structured knowledge dissemination about the way clinical care is provided.

- **Developing the listening, influencing and general interpersonal skills that management in devolved environments requires.** Being technically competent in finance is not the only skill required.

'We need to be much more like the business partners of the directors’, said one acute hospital finance director, ‘and need to understand activity like we understand costs. We’ll need some training to cope with that.’

These development needs are equally relevant to general management. NHS managers also need relevant knowledge of clinical practice, and although the national training scheme for NHS managers offers an excellent introduction, there is no equivalent for managers entering the NHS from other sectors, perhaps in mid-career, or for managers changing direction within the NHS. This would seem to be particularly important in the field of commissioning, where a manager joining a commissioning organisation has a pressing need to keep skills and knowledge up to date and relevant.

Managers also need structured training in the working practices of NHS finance. Although finance departments have gone some way towards de-mystifying NHS finance in recent years, more needs to be done; and it may be that this requires specialised training skills rather than direct input from in-house finance staff. Any manager working at senior level in the NHS needs a working knowledge of the finance regime.
Finance style

Successful directorate accountants are already responding to the demands of devolved structures and the growing expectations of clinicians within them. They stress the culture of professionalism and learning within which they work, and the importance of relationships with clinicians. Above all, they emphasise their keen interest and direct involvement with the way treatment and care is actually delivered today. ‘We have a good understanding of our procedure costs’, states another, ‘but that only comes from spending time in theatre or with consultants.’

Very often the clinical response is less about NHS finance in general than about a named individual: the finance director, a directorate accountant, someone with whom a sound working relationship and a degree of trust has been developed.

Finance staff stability is an important issue. We found that medical consultants in particular value continuity in their relationships with finance staff, and express frustration at patterns of relatively high staff turnover in finance and at good individuals moving on. One attributed this frustration to different expectations of staff stability: traditionally consultants view their appointment as long term, and quite possibly for the remainder of their careers, whereas many finance professionals, even at finance director level, tend to change jobs rather more often.

Unsurprisingly, the qualities that clinicians respect in finance professionals are technical knowledge and expertise, visibility, understanding of the clinical environment, and continuity of working relationships. Overall we found that formal reporting lines seem to be less important than the style and professionalism with which finance managers carry out their work.
The importance of good information

Much has been written within the finance world on what constitutes good information for decision-making. This chapter covers some recent developments within healthcare finance, including patient level costing and service-line reporting. Its prime focus is on the information and presentation that clinicians and other budgetholders find most useful.

Clinicians’ expectations of information

Like all science-based professions, sound clinical practice relies upon good information. Doctors, nurses and therapists are used to making clinical decisions on the basis of accurate measurement of patients’ physical status. Some track trends over time; some work in real time. Clinicians also become adept at combining data from a number of sources, spotting inconsistencies, making allowances for the relative reliability of data, and acting on their conclusions.

But what constitutes ‘good’ information in the context of financial management and corporate governance? Finance professionals are familiar with the concept of a trade off between timeliness and accuracy: the notion that an extra week spent refining a budget statement may improve its accuracy, but may also diminish its practical value to management. Even in the most formal aspect of financial reporting – the year-end accounts – the value of closing the accounts and preparing the accompanying annual report within weeks rather than months has long been accepted.

Our interviews with NHS clinicians found a positive response to financial and activity information that is both:

• detailed enough to relate to actual clinical practice; and
• timely enough to cover very recent workload, so that patients and the detail of clinical interventions are still fresh in the mind.

‘Sending a budget sheet [the summary level budgetary control report commonly provided by finance departments] is probably not helpful’, stressed one clinical director. ‘Regular, reliable information on the top ten drugs we use has helped us to get involved properly. It needs to be picked off in bite-sized chunks’.
Where real-time management systems exist, clinicians are actively using their potential to support the efficient running of their organisations. The experience of the Somerset Partnership NHS and Social Care Trust is instructive, demonstrating how clinicians can drive efficiency if good quality, real time information, on patient status or the use of resources, is made available (Case study 8).

Case study 8
Somerset Partnership NHS and Social Care Trust use information systems to secure clinical support for major service change

Background
The Trust provides mental health and learning disabilities care across the county of Somerset and employs 1015 members of staff. Its annual turnover is in excess of £54 million. In 2006/07 the trust’s outturn was a surplus of £3,000.

Mental health care in Somerset
The Somerset Partnership NHS and Social Care Trust identified a shortage in the availability of good quality placements that are able to meet the needs of people with complex mental health problems. In itself this mirrored the situation in many other parts of England: provision had become variable in quality and uneven in geographical distribution.

Partly as a consequence, the Trust was also breaching its budget for placing mental health clients outside Somerset by some £3 million a year. The cost and quality of out of area placements was recognised as a problem. The cost over the last three years was:

- 2004/05 £5.9 million
- 2005/06 £5.3 million
- 2006/07 £4.4 million

Once patients left Somerset their clinical management became considerably more complex, and the trust had little financial leverage over remote care providers despite some individual care packages costing well over £200,000 per year. There was a particular pattern of a number of younger women being placed out of area. Some patients, notably those with Asperger’s Syndrome, were costing well in excess of £250,000 per year for placements that were for practical purposes indefinite.
Moreover, the financial impact was growing. ‘We were paying for a lot of “specialing” (the use of additional nursing support) at a going rate of £74 per hour for agency nursing’, reported one service manager. ‘And in some cases we had no clear picture of what [patients] were there for.’

**A new model of care**

Somerset’s plans to address the placements issue centred on the development of alternative local facilities, allowing many existing patients to return to the county and new placements to be avoided. They involved the creation of a specialised unit (ten beds) for patients with challenging behaviour, supplemented by a further unit (three beds) offering more intensive care and higher staffing levels. These in turn are linked to a network of supported housing across the county. The service is built around dedicated support time and recovery workers, who do not accept indefinite referrals. There are also extensive links with the voluntary sector.

The managerial challenge for Somerset was: getting clinicians to accept the new model of care; and a financial imperative that had become significant for the Trust’s continued financial viability.

One early move was to introduce a placements panel, with strong finance input and a clear process for looking at all applications. The panel consists of a senior nurse, a variety of clinicians including occupational therapists and social workers to review proposed placements. This replaced a system where individual clinicians submitted their proposals personally to the medical director. All placements, if agreed, have to be signed off by the lead director.

**Clinical directorates**

Meanwhile, the Trust was introducing a clinical directorate structure built around five clinical directorates and devolved budget management. Each service within the Trust has clinical leads that work in partnership with service managers.

The development of a genuine business trading culture has in practice been limited by the absence of a payment by results tariff in mental health care and consequent inability to divide income from commissioners between clinical directorates. But clinicians have responded positively to the opportunity to exercise leadership and take responsibility for budgets.
Clinical engagement and patient information

In the case of placements, the change process in Somerset was championed by an enthusiastic consultant psychiatrist, a factor that aided clinical engagement. He was supported by a robust process and dedicated staff who were very keen to improve the patient experience. Clinical leadership helped persuade colleagues that the change process was driven by care values rather than simple financial necessity. Management meanwhile recognised it had an important role in supporting the clinical lead through clear, transparent decision-making.

According to the Trust’s lead director and service manager, putting the client at the forefront is probably the key to gaining the active support of clinicians. And in Somerset this was encouraged by good detailed information about individual patients under the trust’s care, in the form of the RIO computer system. This in effect provides a fully electronic patient record, available in real time to clinicians and incorporating all clinical notes. Key benefits of the RIO system are:

- accessibility of the patient record; liaison psychiatrists, for instance, have access at all NHS premises within Somerset;
- reduced administrative time, with all documentation attached to a single record; and
- an integrated approach to care planning.

According to the Trust’s head of information, acceptance of the RIO system itself required clinical champions, but eventually clinical professionalism ensured that the former systems of paper records were terminated. ‘People used to think it was a “people service” and technology had no role to play. But now we have the information to hand. And when information is pulled from a clinical system, that’s so much more powerful than from an admin system.’

Access to good information has transformed the clinical culture within the Trust. Clinical managers now expect good data, and will request information regularly to confirm or deny assumptions about performance.

Impact: financial improvement

The financial problems of the Trust were ultimately resolved by major service redesign, of which the new approach to out of area placements was one significant element. It was service redesign, with a vision of much improved quality of care, that kept the clinicians on board. The Trust has broken-even over the last three years largely due to the savings made as a result of the service redesign.
Commentary

‘The Trust’s stability plan, a response to a trust-wide forecast overspend of between £1.1 and £1.2 million in 2006/07, was implemented by bringing forward changes that had already been agreed. But the practical achievement of expenditure reductions was down to clinical leadership.’

(Finance director)

‘Clinicians now understand you can’t just spend. The introduction of a clinical directorate culture has united consultants, finance and managers. Clinicians now cover for one another, and have established trigger points for bringing in locums.’

(Service manager)

On the issue of out of area placements, the Trust has been able to achieve considerable savings through service redesign. This has been made possible by effective clinical leadership combined with the strong operational management and practical clinical ownership of a financial problem that in the past might have been left solely to management to resolve. The Trust attributes this change of clinician attitude to a new culture that has been driven by a clinical directorate structure and an expectation of good information with which to manage. Ultimately the case study demonstrates the power that robust activity and financial information can have in changing a whole organisation’s outlook.

Source: Audit Commission

Financial systems

73 The clinical priority of having sufficiently detailed information in a timely manner has implications for NHS finance systems. Without good quality information, managers will probably find it more difficult to motivate clinical involvement in business management and reap the benefits that it offers.

74 But what of the wider implications for financial and governance systems and procedures? One is for the feeder systems on which all financial ledgers and reporting depend. For financial statements supplied to clinical managers to be both detailed and timely, organisations need slick monthly processing of all transactions that support the ledger. In practice this almost certainly means full integration of payroll with the ledger and creditor payments with the ledger, or robust and reliable interface routines, and a minimum of manual intervention. Most NHS bodies already achieve this standard. Some use shared
service organisations, either at a local or national level, to support this. Where there are systemic reasons why detailed reporting within clinical directorates or rapid report production cannot be achieved, organisations will need to identify the constraints and act to remove them. NHS bodies must ensure they are in control of both the quality and the timeliness of their financial reporting. In practice there may need to be a trade-off between accuracy and timeliness.

A second implication is that management accountants, whether centralised or devolved, must resist any temptation to build extensive periods of report refinement, for instance, through journal transfers, overly detailed accruals, budget adjustments or reprofiling of income and expenditure, into standard month end routines. In our site visits we found schedules for the production of monthly management accounts that ranged from the challenging to the unambitious. In the words of the assistant director of finance of one of the trusts we visited, ‘the best information’s no good at all if it’s late.’ A common view amongst NHS finance staff is that it is acceptable to produce budget performance ten working days following the month end. Our view is that any modern management accounting team should be able to produce financial statements earlier than this. In World Class Financial Management we found examples of financial monitoring and forecasting information being available to top management and the Board as soon as three days after a period end. Each day that can be trimmed from this timetable not only makes the information more valuable to budget managers, but also releases more finance department time for strategic interpretation and other activities. World Class Financial Management also makes the case for reviewing how organisations disseminate financial information:

‘World class organisations allow budgetholders to access monitoring and forecasting information on the system or the organisation’s intranet (rather than waiting for paper print outs). This allows quicker analysis and response to performance information and should include the ability to drill down below the headline figures to the underlying data.’

Harrogate and District NHS Foundation Trust (HDFT) currently close down the general ledger on the fifth working day and budgetholders receive information on the seventh working day. This is a significant improvement on the position two years ago when budgetholders received information on the twelfth working day. This improvement was achieved by automating many of the processes including rationalising the information feeds into the ledger and making fewer manual accruals. HDFT also eliminated very time-
intensive reports, introduced ways of writing reports that produced the information automatically, and implemented strict timetables. The FT also developed Excel macros to enable budget statements and payroll reports to be sent electronically to managers, reducing the administration time required. HDFT is looking further to improve its internal reporting in the next 12 to 18 months by making budgetholder information available online by the end of the third working day after the month end. To do this they are planning to apply lean thinking principles to all the key processes to identify time savings and explore technology based solutions that enable budgetholders to access information online.

**Transparency and quality assurance**

77 Structured approaches to ensuring that data is of high quality are an accepted part of good information management. In the NHS, considerable effort has been applied in recent years to improving data quality, for instance, clinical coding. Payment by results relies upon the accurate classification of clinical activity and has been instrumental in making this improvement happen. The Audit Commission’s payment by results data quality assurance framework focuses on the quality of data that underpins payment by results and will be undertaken at all acute trusts during 2007/08 and reported to their host PCTs. Good quality data is, of course, not only required to support payment by results, but also for clinical purposes.

78 But good quality data in itself may not be enough. We found a particular clinical emphasis on the transparency of data, and clinicians’ ability to trace lines on a report directly back to patient episodes. Any adjustment, however valid, can incite suspicion and at the very least may prove a distraction. This includes accounting adjustments that allocate costs not directly identified with a clinical cost centre, such as diagnostics and other indirect costs, as well as organisational overheads.

79 Finance professionals should be wary of over-refining accounting statements for clinical directorates, or of an over-ambitious approach to preparing ‘accurate’ all-inclusive income and expenditure reports for specialties. Along the way, clinician confidence can be damaged, unjustifiably no doubt in many circumstances, and attention can be distracted. We found some organisations arguing strongly for a contribution approach to clinical directorate budgets, instead of a comprehensive allocation of overheads.
Patient level costing

Currently there is a requirement for NHS bodies to submit annual reference costs. The Department of Health Costing Manual (Ref. 7) provides NHS bodies, including PCTs, with detailed guidance on the principles and practice of costing to be applied in the NHS including for the production of reference costs. The Manual states that:

‘Costs should be matched to the services that generate them and should reflect the full and true cost of the service being delivered. This will be best achieved by maximising the proportion of costs charged directly to services and adopting a standardised approach to the apportionment of overheads and indirect costs.’

The reference costs submitted are used nationally in a variety of ways, including benchmarking relative efficiency, via the reference cost index, and as the basis for the national tariff. At individual trust level, reference costs 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 payment by results. In order to allow robust comparison between NHS bodies, the Manual is very prescriptive on how costs should be derived. Figure 2 describes the different types of costs.

Figure 2

Direct costs – those that can be directly attributed to a particular cost centre or patient. An example of this could be drugs.

Indirect costs – those costs that cannot be directly allocated to a particular cost centre but shared over a number of them. An example of this could be laundry.

Overhead costs – the costs of support services that contribute to the effective running of a health care provider. An example of this could be the cost of the finance department.

NHS bodies are, however, being encouraged to develop their costing information beyond reference costs. As the Department of Health’s recent consultation paper on the future of payment by results observes, the key to accurate costing is good patient level information. This alone allows both managers and clinicians to attach patient level data to financial information, working from the ‘bottom up’ (Ref. 8).
Data organised around the individual patient’s care pathway can be analysed to show the total cost of treating that individual. Such systems are commonplace within private hospitals, and are typically used to produce the invoice that is passed for payment to patients or their insurers. They may, in time, also allow commissioners to compare the relative value offered by care packages for people with long-term illnesses, for instance, mental health placements, and acute hospital care.

Not all costs can be directly attributed to a patient. Indirect costs and overheads require apportionment and NHS organisations take different approaches to this. Some of the NHS organisations we visited use standard prices or charges rather than actual costs, for example a standard cost per diagnostic X-ray, or a standard price per bed day for each ward. This approach has the dual advantage of:

- speed and certainty of processing. Clinical directorate budgetholders know what to expect by way of recharge and can factor it into decisions on, for instance, undertaking additional activity; and
- ensuring that any variance between budgeted cost, on which standard charges are based, and actual cost remains with the support function, and can be scrutinised as necessary.

Other NHS organisations use actual costs. For example, the cost per bed day would fluctuate in a particular month according to nursing staff levels and skill mix. The benefits to this approach are that it ensures that all costs have been allocated, but can distract clinicians and managers into focusing on fluctuating unit costs rather than productivity.

In foundation trusts actively involved in patient level costing initiatives, we found a considerable degree of support and enthusiasm for it amongst clinicians, especially those in managerial positions. One of the hospitals already involved in patient level costing initiatives, Cambridge University Hospital NHS Foundation Trust, has undertaken a major review of its costing methodologies to ensure that they are robust enough to support the new approach and the level of scrutiny anticipated under it (Case study 9).
Case study 9
Cambridge University Hospitals NHS Foundation Trust’s action to improve its costing systems

Background
The Cambridge University Hospitals NHS Foundation Trust, based around Addenbrooke’s Hospital in Cambridge, is one of the largest in the country. It has a turnover of £420 million and employs around 6,800 staff.

The Cambridge Costing Project
Cambridge University Hospitals NHS Foundation Trust launched its ambitious costing project in August 2005. The project’s purpose has been to establish the methodology, structure and data the Trust needs to produce sound costings. Its critical success factors are:

• to realise all of the opportunities generated by improvements to the quality and accuracy of patient care;
• to understand and realise the financial benefit of these efficiencies both in terms of cost and income;
• to achieve an average length of stay performance within the upper quartile of best performing trusts for selected healthcare resource groups;
• to achieve a day surgery ratio within the upper quartile of best performing trusts;
• to increase the number of admissions on the day of surgery; and
• to reduce the number of excess bed days.

Outcomes
Key cost drivers identified by the project include: average length of stay; theatre time; diagnostic tests; and high cost drugs and devices. The project is focusing on increasing performance in these areas, identifying and quantifying potential savings, and identifying the impact on Trust income. This in turn requires improvements in the quality and availability of information.

The project has had a material effect on clinician engagement within the FT, because of its linkage to a broader initiative on efficient patient care that is reviewing the efficiency, quality and safety of patient care within the Trust. It is working at patient level, with an objective of producing a ‘hotel bill’ for individual patient episodes.
The patient therefore becomes the building block for costing. The Trust has seen patient level costing as an inevitable next step on from service-line reporting and the trading account approach to financial management.

Addenbrookes has now produced patient level income and expenditure reports for a number of specialties. This has involved:

- preparing an itemised expenditure analysis;
- splitting up all income, non-tariff as well as tariff; and
- and working with directorate management on identifying the cause of variations.

This analysis links directly with service-line reporting, giving assurance that patient level costs and income are reliable.

**Project leadership**

Accountability for the Cambridge costing project lies not with the finance department but with the information systems and analysis directorate, and the project board has been clinically led.

**Project impact**

‘Talking to clinicians has stood us in good stead’, says the manager of the costing project. ‘We work with them, use our contacts, and they trust us. We would never have achieved what we have achieved otherwise.’

Clinicians are hungry for more detail, she reports. Lead clinicians want to understand where there is variation within a directorate and the reasons for this variation.

Although the direct financial impact of the costing project has not thus far been measured, the foundation trust sees it, with the mutual trust it has generated, as an essential step prior to integrating revised and more accurate costing information with the budget-setting process. This is likely to be the project’s next step.

**Source:** Audit Commission

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87 As part of its current consultation, the Department of Health proposes to establish a clinical costing standards group to help produce guidance covering the costing standards and data sets (units of currency for each cost type, for instance, the number of minutes in theatre) needed to ensure consistency of methodology between different providers.
While patient level costing has been seen as mainly relevant to acute trusts, providers of non-acute services could benefit from taking a similar approach. Both the Somerset Partnership case study already described and the case study from the Oxfordshire Learning Disability NHS Trust (Case study 10) relate to this important area. Cooperation between clinicians and managers, and between commissioners and care providers is essential to control costs.

Case study 10
Oxfordshire Learning Disability NHS Trust’s joint commissioning arrangements for packages of care, built up from individual care plans

Background
Oxfordshire Learning Disability NHS Trust is a specialist trust providing a range of health care and social support services for people who have a learning disability and for their families and carers. It has a turnover of around £37 million.

The Trust has been a specialist provider of support to people with a learning disability for over 25 years and is currently 1 of only 2 specialist learning disability trusts in the country. It supports over 220 people in their own homes with tenancies and supported-living arrangements. The Trust also has 300 short-term break properties located across Oxfordshire offering both day time activities and overnight respite to some 169 people.

The link between tenant care and budgets
In Oxfordshire everybody supported by the Supported Lifestyles Directorate has a person-centred plan. This is an individualised approach to identifying how a person wants to lead their life and the support required to make this happen.

The information that is contained in an individual’s life plan is then used to produce an individual summary of needs. Summaries of need identify the person’s support in specific areas such as personal care, shopping, support with finances, support with health needs such as medication and so on. From this, the number of direct support hours required in order to deliver these activities is identified, and an individualised cost is calculated. The calculation takes into account the hours that are specific to that person and the hours that are shared with the other tenants. The result of this approach is that the Trust is able to provide individualised costs to commissioners.
**Summaries of need**  
The summary of need takes the information contained in tenants' lifestyle plans and converts it into a weekly plan of direct support hours for individuals and hence for the house as a whole. This is analysed by time of day (plain time, night-time enhanced, Saturday and Sunday work) and also whether the support is purely individual or is shared across a number of tenants. The model then converts the standard weekly hours into annualised hours and hence into the whole time equivalent (WTE) staff required to deliver the support. The WTE calculation includes an allowance to cover annual leave, sickness, training and supervision. The annualised hours are then used to produce an estimated cost of the service.

The summary of need is reviewed annually by the team leader or team manager in collaboration with a management accountant in the finance department. The process models the impact of any changes to tenant need and facilitates a discussion about whether or not this needs to be re-negotiated with commissioners.

**The summary of needs and the budget**  
At budget-setting time, managers review the summaries of need for their residential houses. The up to date summaries are then used to drive the budget for the next financial year. Budgets are set to ensure staffing is sufficient for the direct support hours agreed with commissioners. Budget managers can therefore see a direct link between the budget and the service they are tasked to provide. Changes to the budget are not made unless there is a change to the summary of need that is agreed by commissioners.

**Joint commissioning**  
The summary of need is the core document for negotiating changes to tenants’ needs. It clearly sets out the direct support hours provided over a week on particular activity types. Care managers and team leaders can review these hours together to question and assess whether the levels of support are mutually agreeable.

**Impact**  
The weekly activity schedule brings transparency to the process by which the Trust and its commissioners agree required levels of support and hence the cost of individual care packages. Within the Trust, operational managers and finance staff work together to establish appropriate support levels at a cost acceptable to commissioners. Finance staff keep up to date on operational changes at house and at individual tenant level.
The financial impact of the process has not been quantified, and indeed direct financial savings were not its objective. Rather, these clear joint commissioning arrangements have brought a certainty and mutual trust that enables resources to be used well.

Source: Audit Commission

Service-line reporting

89 If clinicians warm to patient level costing, clinical directors and managers appear to warm to the concept of service-line reports (also known as business unit reports, trading accounts or directorate income and expenditure accounts) for clinical directorates. Moreover, many finance directors see service-line reporting as crucial for clinical engagement. ‘True clinical engagement has only really begun since we moved to trading accounts’, reports one acute trust finance director. Before that they played at finance. There was no ownership of income among the clinical directors.

90 The concept of service-line reporting is essentially about treating defined segments of an NHS organisation as if they were discrete trading entities. In addition to traditional expenditure budgets, there is also a charge for indirect costs, sometimes with a share of overheads Income related to the payment by results and other income it generates is also included. Monitor, the NHS foundation trust regulator, has developed detailed guidance on service-line reporting and has recommended that NHS bodies take steps to implement it in order to understand the relative profitability of the organisation’s services. Appendix 2 sets out how service-line reporting differs from the traditional organisation-level reporting.

91 One foundation trust that has gone to considerable efforts to introduce an effective service-line reporting and profit centre structure is University College London Hospitals NHS Foundation Trust (Case study 11).
Case study 11
University College London Hospitals NHS Foundation Trust’s implementation of profit centre analysis and service-line reporting

Background
The Trust comprises an internationally renowned London teaching hospital as well as five other important London hospitals. Its total turnover is approximately £550 million and it employs approximately 6,000 staff.

The Trust has been working with Monitor and McKinsey as part of a pilot scheme for the development of service-line reporting, and is introducing a profit centre framework from 2007/08. This is the latest stage in a programme for development of the Trust’s management processes, begun some five years ago, within which responsibility for the management of services has been transferred to clinicians working in conjunction with general managers.

Clinical board structure
University College London Hospitals has recently restructured its internal clinical board structure, reducing from three clinical boards to two. These boards are called Acute Hospital and Specialist Hospitals, reflecting the main functions of the Trust:

• to provide high quality acute healthcare to its local community;

• to provide specialist services, underpinned by world class research, both locally and nationally; and

• to educate future generations of clinicians.

One of the explicit purposes of this realignment is to allow greater management autonomy and scope for decision-making at divisional board level, as part of a transition to a profit centre approach to management.

Profit centres
The Trust is using three types of profit centre:

• internal purchasers, for example general surgery, which provide services to PCTs;

• internal providers, for example medical physics, which provide services to internal purchasers; and

• profit centres that are both purchasers and providers, for example pathology.
After establishing a gross surplus or deficit (gross margin) on trading activities for each profit centre, and ranking them for comparative performance, a contribution towards central headquarter overheads and an expected level of dividend, based on return on capital employed, is levied. The Trust envisages attributing all operating costs to profit centres through the direct charging, or allocation, of:

- direct costs, such as the cost of consultants, nurses and wards costs;
- indirect costs, including theatres, pathology and imaging; and
- overheads, including accommodation, facilities and headquarter costs.

The profit centre system replaces the Trust’s previous financial management processes that operated largely within historically funded baseline budgets. The Trust has designed a format for its profit centre reporting and is managing the transition, recognising that it is a significant internal change for both managers and clinicians.

**Clinical engagement**

The Trust has operated a clinical directorate model for a number of years, with more than 20 directorates reporting through three clinical boards. Medical directors on these boards have become financially aware and literate, and have become used to accountability. But payment by results has led clinicians to expect a direct linkage between trust income and the actual work they do, and has led to a need to understand more about the likely level and causes of cross-subsidisation. Peer pressure has become an important factor within the clinical boards, as specialties strive to demonstrate their financial viability.

Moreover, clinical directors within the Trust have a well-developed understanding of NHS financial realities. This is the result of previous involvement in developing services, service reconfiguration, and mergers and acquisitions of other hospitals in recent years, that have brought about a well developed understanding of the positive implications of service and activity growth. And within the clinical boards accountability is to the medical director, so doctors hold doctors to account. Greater transparency allows management attention to be concentrated on areas where there is potential for gain or improvement.

According to the Trust deputy chief executive, the new structures and the profit centre approach have only partly been driven by the need for improved financial performance. Monitor has encouraged a slimming-down of the clinical board structure, making it tighter and more focused. The opening of the new UCL hospital has also been significant.
Financial impact
It is too early to say what the financial impact will be. The system became live in April 2007 and the Trust is going through a transition phase. A series of workshops have been organised involving a range of senior clinicians in management, general managers, directors and others across the Trust to work through the issues, implications, the new ways of managing and becoming accountable and how the new performance management system will work. The Trust recognises that this is not an overnight change and the longer term plan is that the full rollout will take 2 or 3 years or so.

Source: Audit Commission

Another NHS organisation that has begun to implement service-line reporting is Newcastle upon Tyne Hospitals NHS Foundation Trust. The following case study describes how it approached its implementation (Case study 12).

Case study 12
Newcastle upon Tyne Hospitals NHS Foundation Trust’s approach to the implementation of service-line reporting

Background
Newcastle upon Tyne Hospitals Foundation Trust (NuTH FT) is a large teaching Trust, operating from three (soon to be two) main hospital sites in Newcastle upon Tyne. Its annual budgeted income is £616m (2007/08) and it employs over 9,000 staff.

The NuTH FT has recently taken on the challenge of implementing service-line reporting, with the principal aim of improving decision making at directorate level.

The finance department believed it would gain sufficient clinical engagement on service-line reporting, but was initially sceptical about the technical feasibility. In common with other organisations attempting to take up service-line reporting for the first time, NuTH FT encountered a range of problems, some of which seemed insurmountable to the finance staff who were familiar with them of old. The income accountant, told the Audit Commission team at the end of its work, ‘It was helpful to take a fresh look at the overall information system, without getting bogged down in the detail.’
Key issues and ways in which they were addressed are set out below.

**Lack of clarity over what constituted a service-line**
The Trust’s various organisational frameworks (financial, clinical, and administrative) were not entirely consistent, so defining service-lines for the purposes of financial reporting was not straightforward. The first-stage model includes 29 service-lines, covering the Trust’s 22 clinical directorates and selected other service-lines that management wanted separately analysed.

**Lack of reliable activity data to enable costs of support services, for example, theatres, labs, radiology, etc, to be allocated to service-lines.**
In the first stage, the project team concentrated on developing a workable solution in one area (radiology), constructing a standard cost based on historical data and assembling useable activity data from the specialty’s information system. A key objective of the second stage of the project is to tackle other identified data gaps, including the allocation of clinical staff resources between service-lines.

**Difficulty associating income with service-lines**
A large part of the Trust’s income comes through payment by results, and can easily be allocated to a service-line. However, a significant minority of the Trust’s income is for non-payment by results services, including teaching. Historical funding agreements and unclear contracts with commissioners meant that considerable work had to be undertaken to understand how this income relates to activity. The Trust is seeking a better shared understanding with its commissioners of the contents of its commissioning contracts to aid this process in the future.

**Progress made**
Since having a workable model available, the Trust has now produced full service-line reports for quarter one and embarked on a programme of information areas that can be improved in the medium-term and engaging all clinical directors and general managers. Participants in a finance workshop were briefed on the principles of service-line reporting, discussed the key messages emerging from the first-cut model, the limitations of the currently available data, and the proposed next steps.

**Source:** Audit Commission
As with patient level costing, NHS organisations can take different approaches to the treatment of indirect costs and overheads. Numerous clinical activities do not fit neatly into a clinical directorate model. Among them are diagnostics, radiography and most work undertaken by allied health professionals. It would be wrong to see these activities as overheads, and in many cases they can offer a significant contribution to overall efficiency. Wherever possible these costs should be recharged.

Some finance directors we visited made a case for comprehensive allocation of overheads on the grounds that it maintains scrutiny, and therefore acts as a prompt to efficiency, of the share of resources consumed by central organisational functions such as finance, human resources and information management. Others take the view that it is not appropriate to allocate costs to a directorate that it has no control over, for example the cost of the finance department, and favour the ‘contribution to overheads’ method. This approach has been taken by King’s College Hospital NHS Foundation Trust in their service-line reports (Case study 13). The Trust has developed an integrated approach to both patient level costing and service-line reporting that has already delivered considerable benefits.

Case study 13
The implementation of patient level costing and service-line reporting at King’s College Hospital NHS Foundation Trust

Background
King’s College Hospital NHS Foundation Trust is a large teaching hospital based in inner South London. It has an annual turnover of £450 million and employs around 5,100 staff.

Three years ago King’s College Hospital launched a programme to improve the patient experience and to reduce unit costs. In 2004/05 the Trust reported a deficit of £2.7 million, and it was clear that unless the Trust took action the financial position would continue to deteriorate. The scale of the underlying deficit was so significant that it would not be resolved by traditional NHS approaches such as vacancy freezes.

Kings’ aim was to ensure that the hospital would be the provider of choice amongst local residents, assuring the future viability of the Trust under the patient choice initiative. This was known as the ‘First Choice Kings’ programme. Clinicians were asked to develop strategies for each service area, setting out what aspects of the
services currently being delivered they expected to expand and which would remain static. A fundamental lack of understanding about cost drivers and about the relative profitability of each area soon became evident.

**Patient level costing**

The Trust initially established a project group to develop service-line reports, but the programme soon developed into patient level costing on the basis that it is more meaningful to clinicians. Clinicians found the information more useful at finished consultant episode level rather than organised by ‘spell’, moreover, at patient level clinicians can recognise the patient’s name and remember the treatment that they had.

Information is provided monthly, so the maximum time between treatment and receiving the information is 8 weeks: much better than receiving healthcare resource group information after the year-end. All consultants have access to the information via the Trust intranet. They mainly look at outliers and drill down for additional information.

**Service-line reporting**

Service-line reports are based on contribution to overheads rather than absolute profitability. The Trust sets a target contribution level for each directorate: direct and indirect costs are allocated, but not overheads. This approach was taken because the Trust felt it inappropriate to apportion items over which directorate management has no control. Performance targets are now specified in terms of percentage contribution.

The benefits include greater transparency. In the past suspicion that some services had a better deal was commonplace: now everyone can see there is a level playing field. The Trust considered whether to use standard or actual costs for apportionment: for instance, a standard charge per day on a ward or the actual cost. Actual costs are used, to ensure that all costs are recovered by the year end.

Directorates are permitted to keep 70 per cent of any over-recovery of overheads, and a monthly budget adjustment is made. This money can be used to buy equipment and other non-recurrent items, but the standard Trust business case protocol still applies. The finance director reserves the right to amend this practice in the event of overall Trust financial difficulties.
The Trust has recognised that it is far from simple to stop doing ‘unprofitable’ services, other than at the margins of activity. There are cross linkages between sub-specialties, so some ‘unprofitable’ services are needed to support other profit making areas. Overall, however, the Trust seeks to mitigate losses and maximise profits. This is another reason why it uses target contributions rather than profit or loss.

**Reporting**
The Kings software produces over 300 standard reports, and budgetholders can choose whatever is most appropriate. Information on data quality is also provided. Some clinicians have requested tailor-made reports. All reports are available on the Trust intranet alongside budget statements, payroll information and other financial information. It only takes five clicks to drill down from service-line reports to individual patient data.

**Finance staff**
The Trust employs 1.5 whole time equivalent finance staff to support its costing system. Financial analysts in the directorates have sufficient knowledge of the system to be able to drill down and interrogate it, and need a sound understanding of care pathways and cost drivers. According to the Trust finance director, the force of their personalities is crucial to the success of the system. With modern systems performing traditional bookkeeping and journals, financial analysts need to add value. The posts call for personality and credibility.

**Benefits realisation**
To support its change programme, the Trust established a team of 12 change leaders. The Trust had previously spent large sums of money employing consultants to undertake this work, which could be provided in-house more economically. The team consists of managers with varied backgrounds, though all have experience of process-driven services and use Lean thinking and ‘right first time’ principles.

A key driver for the team is reducing unit cost; a key performance indicator is length of stay, where the biggest single impact on reducing unit costs can be made. In some areas there has been a 20 per cent reduction in average length of stay.
Clinicians want to be involved so that they can expand their work and undertake more specialised cases. However, complexity usually means an increase in length of stay, necessitating efficiencies elsewhere and perhaps managing more patients in the community. Efficiency needs to be improved to ‘pay for’ service development; and the Trust now has proper information to enable informed discussions with its commissioners.

**Impact**

King’s College Hospital achieved foundation trust status in December 2006. Its financial position moved from a £2.7 million deficit in 2004/05 to a £0.1 million surplus in 2005/06 and a £4.4 million surplus in 2006/07. This incorporates a net £8.0 million spend on developing the improved systems.

Chief Executive Malcolm Lowe-Lauri said ‘We are delighted to have achieved foundation trust status. Our deferral by Monitor in 2004 for financial reasons reinforced the need to tackle our underlying financial position head on, and gave fresh impetus to our planned First Choice transformation programme. This has now been running for almost two years, and has really helped improve our finances and our efficiency. We are now reporting a strong financial position in a particularly challenging environment.’

Kings plans to develop its systems to include patient outcomes after three months, to assess clinical effectiveness. The Trust is also examining whether processes can be broken down into their different stages to help pinpoint cost variations.

**Source:** Audit Commission
Tailoring financial information to the needs of users is important. *World Class Financial Management* states that:

‘Internal and external users of information will rely on a range of financial and non-financial information and indicators to support them in making their decisions. When producing information for use by these decision makers, it is therefore important that this information is properly tailored to the needs of its audience. Those who prepare reports need to consider carefully who the report is for and what its purpose is, including what decisions the user will be making based on the information they provide.’

Providing the right level of detail to clinicians is key. The system developed by Kings College Hospital NHS Foundation Trust provides on-line summary data, through which more detailed information can be accessed. There is a menu of standard reports that budgetholders can select from to best meet their requirements.

**Entreprenourialism**

Many NHS finance professionals spend most of their careers working within a system that regards year-end financial break-even as success, and annual cost cutting as a necessity. They are salaried employees whose remuneration is, in most organisations, only indirectly linked to the financial performance of the entity. The career of a successful clinician can be radically different. In primary care the conventional model of general practice remains the independent practitioner: GPs by necessity become familiar with the business culture. The same is true of many other primary care health professionals, ranging from dentists and pharmacists to a wide variety of therapists. And in the hospital sector private practice remains a significant interest for many doctors.

‘Accountancy training and clinical training lead to different frames for viewing the world’, observed one medical director. ‘If those frames clash, expect [clinical] disengagement.’ A clinical director parodied the NHS finance outlook as ‘commissioners get money in, doctors spend it, but my goal is to get to break-even.’ Clinicians who run successful private practices, however, tend not to be inspired by break-even. They are attuned to cost control within a context that accommodates financial investment where appropriate, growth rather than cutbacks; but also a managerial toughness that is willing to withdraw quickly from unprofitable product lines. In short they are motivated by profit. It is precisely
this group of clinicians that is now assuming commanding roles in practice based commissioning and in the leadership of clinical directorates. And they find themselves frustrated: not with the discipline of NHS finance in itself, but with what they see as a lack of business awareness, financial ambition and entrepreneurialism within it. Service-line reporting has brought this into sharper focus.

99 According to one trust clinical director, ‘clinicians propose initiatives, like new clinics and innovative ways of providing services. They think aggressively about how they can market themselves and how we can put the trust out in the market-place.’ Asked why, she identified three motives: kudos, the potential for private practice, and ‘a genuine pride and desire for this place to be a successful organisation.’

100 But growth and success are not the prerogative of clinicians alone. The recent financial transformation that has taken place within the IVF service offered by the Liverpool Women’s NHS Foundation Trust is a good example of finance professionals taking a key role (Case study 14).

Case study 14
Liverpool Women’s NHS Foundation Trust: a cooperative approach between clinical and finance experts towards restoring a specialised healthcare service to surplus.

Background
The Liverpool Women’s NHS Foundation Trust has a turnover of circa £80 million and employs around 1500 staff. Its Hewitt Centre for Reproductive Medicine is one of the largest IVF centres in Europe. A review of the financial performance of the Hewitt Centre at the end of 2005/06 revealed that the centre was incurring losses on both its NHS and its private treatments. This was contrary to what was happening in other IVF centres. The review provided the stimulus for transforming the service into one that makes a profit while operating to the highest clinical standards.

Transformation
The Trust pursued four parallel approaches to ensuring a financial surplus:

Bottom-up costing, led by finance specialists and involving a wide range of staff, that has resulted in a comprehensive cost model jointly owned by the Hewitt Centre and finance. This model was then used to support service redesign and the development of a new business model.
Trading account preparation, enabling the true financial performance of the Hewitt centre to be clarified. This involved matching clinical activities to costs, reviewing overhead apportionments and improving previously poor data quality.

Service redesign, split into a number of processes. A series of process mapping exercises took place over a 4 week period, and incorporated structured feedback from all staff, including finance staff, on how the service could be improved. Over 40 separate proposals resulted in immediate non-pay savings of £10,000 as well as savings in staff time. A prioritised implementation plan was then put in place.

A new business model, allowing the expansion of the service, was devised. This model implemented in October 2007 underpins a partnership arrangement with North West Fertility Limited a company established by consultants, allowing the expansion of services to non-NHS patients and driving efficiency within the service for both NHS and self funding patients.

Impact
The director of finance and the clinical director agree that the bottom-up costing work has led to a much better understanding of staff usage, including the nurse-led nature of many treatments, and hence of the potential for using consultant time better. It has also provided a robust basis for negotiations with NHS commissioners and for setting appropriate prices. Meanwhile the switch to trading accounts, as well as giving the Hewitt Centre a clear focus on delivering its ‘bottom line’, has convinced the trust of the value of such accounts. The Hewitt Centre now provides a template for roll-out to other trust departments and directorates, and has made finance staff familiar with the accounting processes that trading accounts require.

Productivity within the Hewitt Centre has improved by around 30 per cent, and further areas for attention have already been identified. Staff appear to own the changes that have taken place. A trading deficit for the service in 2005/06 of £0.2 million has been transformed to a surplus of £1.2 million at the end of 2006/07. In addition the access to the service for patients has been improved with a dramatic increase in the number of cycles delivered from 942 in the whole of 2005/06 to 1,206 under the new service model in 2006/07.

The improved trading performance of the service has enabled the Trust Board to approve in principle a capital scheme of circa £4 million for the upgrade of facilities and expansion of capacity that will be undertaken in partnership with North West Fertility Limited.
Commentary
The Liverpool experience demonstrates how the answers to financial problems can lie in productivity and income growth as much as in cost reduction. It is also a good example of finance staff and clinicians working together to achieve the same aim. The foundation trust financial regime makes such solutions attractive to providers, but income-led solutions, based on improved productivity, can be of concern to NHS commissioners.

Source: Audit Commission

Entrepreneurialism and financial control

101 The challenge, for NHS boards and for finance professionals, is to establish ways of working that allow entrepreneurialism to flourish, yet contain the overall level of risk associated with it. An entrepreneurial approach to the management of a clinical directorate need not be inconsistent with sound financial control and the operation of standing financial instructions and levels of delegation. It does however require robustness and clarity in three key areas.

102 One is linkage between income and expenditure budgets. The entrepreneurial culture that some clinicians envisage allows in-year overspending of an expenditure budget, provided it is spent on extra activity and more than offset by extra income that will follow. This requires budgetary control at a bottom line level, and a transparent regime for the allocation of the extra income that any extra activity will earn.

103 The second is linkage between clinical directorates and the total organisational position. In principle this is achieved by the setting of a balanced budget, within which the budgets of individual clinical directorates are framed. However, if any part of the organisation finds itself in significant financial difficulty during the year, the board needs to be able to recognise this and, if necessary, constrain the freedom of action of other parts of the organisation. Entrepreneurial freedom, therefore, depends partly on the performance of others, as in the relationship between a subsidiary and a holding company in the commercial world.
The third is a clear relationship between activity levels and income. The principles of payment by results make the actual level of income that flow from commissioner to provider as a consequence of extra, or less, clinical activity predictable; but local agreements may specify it in more detail. If any additional income does flow, some of it will often be attributable to support functions within the organisation. So robustness in this area involves clarity about the overall quantum of any additional, or reduced, income, and the way it will be distributed internally.

If these three criteria are met, and the whole is contained within reporting and accountability processes that safeguard board control, we see no reason why trusts and foundation trusts should not adopt the more entrepreneurial financial control culture that some clinical directors are advocating. We see no real scope, however, for introducing a similar culture within commissioning, where entrepreneurialism must relate to making maximum use of the funds available rather than in securing additional income. The freedoms and rewards of the practice based commissioning regime encourage such an approach.
Commissioning and purchasing

The commissioning relationship between PCTs and healthcare providers is increasingly dominated by practice based commissioning. This chapter examines some of the examples of clinical leadership we found in this key area. It also reviews other opportunities for using clinical skills and knowledge in commissioning and procurement.

Practice based commissioning and PCTs

Practice based commissioning in the NHS is aimed at getting primary care clinicians, particularly GPs, more actively involved in commissioning and financial management. Practice based commissioning now offers a powerful financial incentive for GP practices to alter care pathways and change referral patterns in the interests of both efficiency and effectiveness. The development of practice based commissioning is reviewed in more detail in our report *Putting Commissioning into Practice: Implementing Practice Based Commissioning through Good Financial Management* (Ref. 6) published in November 2007. Savings made under practice based commissioning are available for reinvestment. There are also financial incentives for practices to take part in the scheme. We have already seen its impact in South Devon and the following case study from North East Lincolnshire (*Case study 15*) shows how one organisation has used this initiative to make real savings.

Case study 15

North East Lincolnshire Care Trust’s approach to risk management within practice based commissioning

**Background**

North East Lincolnshire Care Trust commissions healthcare for a population of 170,000. It covers 33 GP practices, of which 30 are participating in practice based commissioning. In 2006/07 its total financial allocation was some £207 million, of which £126 million was delegated to GP practices under practice based commissioning.
Objective
The commissioners’ aim was to reduce emergency hospital admissions, reduce referrals to hospital and thereby reduce expenditure on hospital care. This would in turn allow alternative services to be developed in primary care settings in line with national strategies.

Managing financial risk
Budgets for practices were set from historical activity, recosted to the payment by results tariff price for 2006/07. This historical spend was then compared with a weighted capitation share, using the national formula, to give a distance from target for each practice.

National guidance allowed a 10 per cent variance from target, but adopting this threshold would have perpetuated some marked differentials between practices and the Care Trust chose to move more quickly. The finance department assessed the risk entailed in giving practices below the weighted capitation threshold a greater share of resources and considered that 5 per cent would be a reasonable compromise between:

- the risk of moving practices to weighted capitation target quickly; and
- the concerns of below-capitation practices denied their ‘fair’ share of funding.

Approximately 66 per cent of the Care Trust’s commissioning budget, and 80 per cent of its total resource, including prescribing, is devolved to practices. A contingency pool has been set up by the Care Trust and practices, made up of a 1 per cent top slice from total practice indicative budgets for high cost, low volume activity.

As financial reporting needed to change to match practice based commissioning responsibilities, new approaches have been developed within the Care Trust. Finance and activity reports for each practice are now posted monthly on the Care Trust intranet, with variations from budget monitored through budget meetings.

A key principle has been that, in managing significant budgets at a detailed level, the corporate financial position cannot be compromised. For instance, savings released under practice based commissioning are diverted to under-resourced practices in a controlled way over a period of time.
This has led to the finance department preparing new policies in support of practice based commissioning that cover distance from target, service improvement, efficiency savings and the use of contingency funds. These have been incorporated into a practice based commissioning handbook that describes process and responsibilities.

**Impact**

Actual net savings in the transition year were £140,000. Expected savings in 2006/07 through reduction in hospital activity were £500,000, of which £300,000 was invested into primary care services. Practices are entitled to savings on a recurrent basis where they are able to demonstrate change in practice. In 2006/07 the Care Trust shared 60 per cent of savings generated through practice based commissioning; this will increase to 70 per cent in 2007/08.

**Source:** Audit Commission

107 Most practice based commissioning initiatives have been medically led, but GP time is an expensive resource for the NHS. Numerous other clinicians, ranging from practice nurses to specialist nurses to therapists, work at, or are organised around, GP practices. We encourage practices to adopt the same pragmatic and cost efficient approach to skill mix in commissioning as they expect providers to adopt in care delivery.

108 Numerous GPs have become involved with commissioning and PCT management because of a passion to change the way that care is delivered. Exmouth in Devon is just one example of how clinicians, through direct involvement in commissioning, can change care pathways in a way that releases significant NHS resources *(Case study 16).*

**Case study 16**

**GP involvement in commissioning at Devon PCT**

**Background**

Devon PCT commissions healthcare for almost 750,000 people across the whole of Devon. It was formed in 2006 through the merger of six PCTs. Within Devon there has been considerable interest in innovative primary care arrangements aimed at improving efficiency and reducing cost. One such initiative has been implemented at the Claremont Medical Practice in Exmouth (list size of 11,000), where a particular priority has been the care of patients with long-term conditions. The practice’s aims were to:
• prevent inappropriate admission to hospital;
• promote timely discharge from hospital; and
• ensure patient care is delivered in the least intensive setting;
thereby releasing resources for reinvestment and improving the quality of patient care.

Although national models of improving the care of people with long term illness have mainly centred on the role of community matron, in Exmouth there was a view that a team-based approach offered higher prospects of success.

**Creation of a practice based team**
The practice created an integrated team of 14 nurses, with a broad skill mix, to provide all practice and community-based nursing care. The team works across traditional boundaries between practice nurse and district nurse roles. Its philosophy is to provide ‘care, in the right place, at the right time, by the right person.’

Nearly all the nurses were employed by the PCT, placing the whole team on an equal basis for terms and conditions of employment and access to continuing professional development. Practice based commissioning has helped to make this possible. The nursing team also constituted a platform from which a practice based joint health and social care team could be piloted, and its practical success made it possible for a social worker and a pharmacist to join the practice team.

**Team interventions**
The practice found that established national criteria, for instance on recurring admissions, proved ineffective at local level for identifying clients at risk. The team developed an instinctive caseload model that uses whole team awareness to identify clients at risk of hospital admission. On a white board, centrally displayed in a confidential area, clients are categorized according to level of risk using traffic light, red, amber and green indicators. This classification is also flagged on the practice’s central client records so all staff are aware of high-risk clients. Using a whole team approach, the team proactively case manages the most vulnerable and highly complex patients, manages specific diseases, addresses public health issues and supports clients to manage their own health. This includes use of the expert client programme.
The joint assessment process now creates a monitoring tool that the team uses to track client progress. Care is delivered by the most appropriate professional, using the long-term conditions case management approach for clients most at risk of deterioration. There is a clear communication flow and active sharing of information between all members of the team. This allows structured and responsive ‘casual reviews’ according to client’s needs. The team engages other agencies/services, such as the reablement team, intermediate care, external care agencies, ambulance services etc, as appropriate.

The team uses creative solutions to support clients’ medicine management, including structured concordance reviews face to face in clients’ own homes if required. If a patient is admitted to hospital, early liaison with the patient journey facilitator within the hospital encourages prompt discharge to the appropriate care setting. This process is supported by daily review of emergency admission data.

**Making the team a success**

The change strategy adopted by the practice included the identification of quick gains through relatively simple interventions. The NHS Modernisation Agency’s 10 High Impact Changes helped prioritise the team’s work and gave leverage for implementation.

One practical example of efficiency gain has been built around improved internal communications. The time during which GPs undertake home visits, between 12.30pm and 2.30pm, was quickly identified as a pressured time when the risk of hospital admission is high. The team introduced a procedure whereby GPs, during this period, use one phone to contact a named member of the team to discuss potential admission. As nursing team members often knew the history and background of the patient, it has often proved possible to reroute patients to alternative support if required, such as intermediate care, support at home, rapid response or residential intermediate care beds.
**Impact**
Although it is always difficult conclusively to prove cause and effect, emergency admissions have been reduced from an average of 13 per week to an average of 9 per week. As the average cost of admission is approximately £3,000, this amounts to a saving of approximately £600,000 per annum. This has been sustained over a period of 18 months. In addition:

- there has been an improvement in the patient experience. The project has been patient-focused throughout, and the nursing team approach offers the choice of support at home;
- the practice reports that clinical outcomes have improved as a consequence of applying the principles of case management for long-term conditions; and
- improved understanding and recognition of professional roles has brought about improved working relationships between agencies.

**Commentary**
The success of the Exmouth approach is inextricably linked with practice based commissioning and the direct financial incentive it provides for admission avoidance. In the management of long-term conditions, unplanned hospital admission can represent a breakdown of care and, besides placing a burden on hospital resources, may represent poor quality of care for the individual. No one wishes to spend time in hospital unnecessarily. In Exmouth the thinking behind practice based commissioning, that of giving clinicians real financial autonomy, has been extended by internal delegation to a team of nurses and other non-medical conditions, with impressive results.

**Source:** Audit Commission

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**A role in commissioning for provider clinicians?**

Although clinicians have a growing influence on commissioning within PCTs, our research shows us that the same is not yet true of NHS providers. Many more hospital clinicians are now getting involved in management, and therefore in ensuring the delivery of clinical care in accordance with service level agreements, but our research in trusts and foundation trusts found very little effective clinical engagement with the commissioning process. So service level agreements are commonly negotiated centrally and handed on to clinical managers to deliver.
This appears to be, at least in part, because of perceptions of the commissioning process as protracted and tedious. But it may also be because, before the recent reorganisation of PCTs, the balance of power in commissioning organisations frequently lay with providers. There has therefore been little justification for the involvement of costly and scarce clinician time in an arena that can be handled well by non-clinicians. This may change. The reorganisation of PCTs, the introduction of practice based commissioning and pressure on PCTs to use the independent sector, all point towards a future balance of power that is more evenly distributed. And as NHS access and financial targets grow ever more demanding, boards may find it important to involve clinicians in their negotiation if they are to expect clinical ownership.

Where hospital clinicians work actively with commissioners at a strategic level, there are signs that the outcomes can benefit the health system as a whole. Practical cooperation in potentially contentious areas can be productive, generating workable solutions and avoiding conflict. Indeed initiatives such as those outlined above in redesigning care pathways and reducing the number of admissions to hospital (demand management) works best when undertaken in partnership with the local acute trust which will have to make financial adjustments if the initiatives are to be successful.

The Harrogate experience in respect of high cost drugs is a useful example of how clinicians, working together, can agree a shared understanding of good value with well-understood working rules (Case study 17).

**Case study 17**
The role of the clinical director at Harrogate and District NHS Foundation Trust in the procurement of medicines and negotiating local agreements for high cost medicines

**Background**
Harrogate and District NHS Foundation Trust is a relatively small acute hospital foundation trust in the north of England, based around a general hospital. Its turnover is £87 million and it employs around 2,100 staff.

Spending on medicine at the Trust had grown by an average of 17 per cent per year since 2001/02. As part of a wide-ranging strategy for expenditure containment in the North Yorkshire NHS, local commissioners asked the Trust for support in managing the use of high cost medicines.
The payment by results financial regime sets a national funding tariff for approximately 600 treatments, and the costs of the majority of drug treatments are included within the tariff. Trusts therefore receive income to cover drug costs as part of this income stream. However, there are significant exclusions from the payment by results tariff, such as chemotherapy, renal dialysis and several high cost drugs, including anti-TNF agents, HIV anti-retrovirals and immunoglobulins. The Trust receives no income for these excluded high cost drugs and the only way of funding them is by prior agreement with PCT commissioners.

A policy for managing high cost medicines
Financial pressures within the North Yorkshire NHS had increasingly focused management and clinical attention on the issue of high cost medicines. Commissioners were anxious to identify and understand the likely financial impact of new medicines, and had set up a high cost drug commissioning board with this end in view. Meanwhile hospital doctors, especially in cancer care, rheumatology, neurology and dermatology, wished for clarity about what drug regimes commissioners would and would not fund.

The Trust defines a high cost medicine as:

- individual patient medicine costing £5,000 or more per annum; and
- where the treatment of a small number of patients results in a cumulative medicine cost of £5,000 or more per annum.

The commissioners and the Trust agreed, in October 2006, a policy framework within which future decisions on high cost drugs would be taken. Key points within the policy are:

- the use of a locality prescribing group to control and peer review the use of medicines on the grounds of safety, efficacy and cost effectiveness;
- a medicines management group to review the financial and funding requirements of expensive medicines in conjunction with the relevant PCT;
- external funding to be sought for expensive medicines prior to commencement; and
- no patient receiving benefit from a high cost medicine to have their medication stopped on cost grounds alone.
Criteria for decision-making
The medicines management group considers the funding of new drugs according to the following criteria:

- evidence of efficacy;
- evidence of safety;
- NICE appraisal;
- impact on patient safety;
- included or excluded from tariff;
- total cost per annum;
- cost/benefit over existing therapies;
- operational benefit/ impact on trust targets; and
- potential savings in other areas, such as reduced length of stay and impact on nursing time.

Impact
The Trust reports the new and more transparent system has gained the support of hospital clinicians, who had previously been critical:

- of lack of transparency, sometimes attributed to lack of PCT expertise in medicine management; and
- of apparent naivety on the part of public health doctors.

The potential for the process of communicating negative decisions to patients to also involve apportioning blame to other clinical professionals has been reduced, removing a serious potential cause of disharmony.

Source: Audit Commission
Programme budgeting

The programme budgeting initiative introduced by the Department of Health is providing valuable information that is helping public health clinicians review relative levels of investment in different diseases. It is a powerful tool for encouraging clinical involvement in resource allocation, and can also help with public and patient involvement and in engaging with local strategic partnerships.

Programme budgeting is a retrospective appraisal of resource allocation, in which a PCT’s expenditure is analysed across 23 disease groups with a view to influencing future expenditure patterns. In 2006, the Department of Health published PCT level expenditure data, linked to relevant outcomes data, using interactive map-based software. Norfolk PCT has reviewed its programme budgeting information and combined it with health outcomes to aid decision-making on future levels of investment (Case study 18).

Case study 18
Norfolk PCT’s approach to using programme budgeting information

Background
Norfolk PCT was formed in September 2006 from a merger of five former PCTs. It covers most of the county of Norfolk, including Norwich but excluding the Great Yarmouth area. The PCT commissions health care for a population in excess of 700,000 people and spends some £840 million per year.

Programme budgeting in Norfolk – the significance of mental health care
Within Norfolk PCT, the former Norwich PCT had considerable experience of using programme budgeting techniques prior to merger. Its Health of Norwich annual reports would identify, for each programme:

- the big issues and objectives;
- how much the PCT spends, and how that compares with elsewhere;
- the breakdown of expenditure between hospitals, community services, GP prescriptions and so on;
- health inequalities and trends; and
- how the PCT might do better.
This experience has been applied to the combined 2005/06 expenditure of the former
PCTs in order to steer commissioning strategy.

A conventional analysis of the PCTs’ £844 million expenditure with health providers in
2005/06:

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norfolk and Norwich University Hospital</td>
<td>232,319</td>
</tr>
<tr>
<td>General medical, pharmaceutical and ophthalmic</td>
<td>115,749</td>
</tr>
<tr>
<td>GP medicines prescribing</td>
<td>110,468</td>
</tr>
<tr>
<td>Norfolk PCT Community Services</td>
<td>69,503</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>60,326</td>
</tr>
<tr>
<td>Norfolk and Waveney Mental Health Partnership</td>
<td>49,214</td>
</tr>
<tr>
<td>Other acute and specialist</td>
<td>43,998</td>
</tr>
<tr>
<td>Learning difficulty (central pool)</td>
<td>27,292</td>
</tr>
<tr>
<td>Other mental health and specialist etc</td>
<td>24,723</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>843,773</strong></td>
</tr>
</tbody>
</table>

This analysis does not highlight the significance of any individual clinical care groups;
nor does it offer commissioners any practical route to strategic change. In
comparison, the programme budgeting analysis of the same cost data, identifying
Norfolk’s top eight expenditure programmes:

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>109,873</td>
</tr>
<tr>
<td>Circulatory diseases</td>
<td>89,520</td>
</tr>
<tr>
<td>Cancers</td>
<td>65,755</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>51,468</td>
</tr>
<tr>
<td>Trauma and injury</td>
<td>49,540</td>
</tr>
<tr>
<td>Musculoskeletal (non-trauma)</td>
<td>46,023</td>
</tr>
<tr>
<td>Respiratory</td>
<td>44,598</td>
</tr>
<tr>
<td>Learning disability etc</td>
<td>42,325</td>
</tr>
<tr>
<td><strong>Total (23 programmes)</strong></td>
<td><strong>843,773</strong></td>
</tr>
</tbody>
</table>
This analysis reveals spending on mental health care, at 13 per cent of total resources, to be out of alignment with spending in similar PCTs and significantly above the national average of 11 per cent.

Further analysis of expenditure on mental health care showed that bed usage was high and there was a particular issue with prescribing. For antidepressant prescribing Norwich PCT had the highest prescribing levels amongst a large group of comparator PCTs in the midlands and east of England.

Reducing antidepressant prescribing, therefore, became one of eight programme objectives for mental health, alongside, for instance, increasing non-medication therapy and reducing expensive out-of-area placements wherever equally good outcomes are available locally.

**Impact**

Within Norwich, the main pressure point within Norfolk PCT, the level of antidepressant prescribing has already fallen by almost a third.

Any change of this order in prescribing patterns requires the support of individual GPs. The former director of public health at Norwich PCT, reports that this was readily forthcoming once programme budgeting had provided evidence of Norfolk’s status as an outlier. Cost data, provided by a fellow clinician, proved to be the essential lever for change.

The financial impact of reducing antidepressant prescribing has been material. Achievement has been helped by:

- programme objectives being written in terms acceptable to clinical opinion, that is, not simply as financial savings targets; and
- planned changes being perceived as an improvement in the quality of patient care.

In the PCT’s opinion programme budgeting offers a common framework and a common language that builds bridges between finance and medicine, managers and clinicians, and the NHS and its public. It works best when allied with marginal analysis, a tool of health economics that evaluates the added cost and added benefit when resources are added to, or subtracted from, a programme.

**Source:** Audit Commission
Procurement

Procuring goods and services from external suppliers can alienate clinicians if the end result is perceived as limiting the quality of clinical practice. The experience of clinical leadership of the South West London Elective Orthopaedic Centre’s procurement of prostheses demonstrates that it is possible to both ensure continuing engagement and save material sums of money (Case study 19).

Case study 19
South West London Elective Orthopaedic Centre use of consultant surgeons to negotiate a new agreement for orthopaedic prostheses with commercial suppliers

Background

The South West London Elective Orthopaedic Centre (SWLEOC) is a purpose-built NHS elective orthopaedic hospital, providing predominately hip and knee replacements to a population of 1.5 million people in South West London. The centre uses 65 beds (two 25 bed post-operative wards and a 15 bed recovery suite) with four state-of-the-art operating theatres and high dependency and critical care facilities. It is located on the Epsom Hospital site in Surrey.

A partnership board that includes the chief executives of Epsom and St Helier NHS Trust, Kingston Hospital NHS Trust, Mayday Healthcare NHS Trust and St George’s Hospital NHS Trust, is responsible for the overall strategy and management of the Centre.

During 2006/07 SWLEOC completed over 3,000 hip and knee replacement operations, making it the UK’s largest hip and knee service. Its turnover in 2006/07 was £20 million. SWLEOC employs 170 staff, including 4 full-time consultant anaesthetists and a further 38 consultant surgeons and anaesthetists who attend SWLEOC during programmed activity time from the 4 partner trusts.
Prosthetics

Prosthetics costs amount to some £6 million per year. They therefore form a very significant element of SWLEOC’s total expenditure. SWLEOC has reached an agreement with all prosthetic suppliers to stock consignment prosthetics at the Centre, at prices set by SWLEOC, with no guarantees of volume. The prices are reviewed annually. If the suppliers cannot agree to SWLEOC prices for components they are not stocked. SWLEOC provides over 50 different variants of hip and about 14 different variants of knee, offering the surgeons a wide selection of products, allowing for clinical choice to be the decision for use over price.

This process was adopted to address a fundamental challenge. In the words of the Director of SWLEOC: ‘How do you get 21 visiting surgeons to agree on product use when the vision of the Centre was about clinical choice? I knew I couldn’t drive the traditional approach of restricted products for high volume discounts, so we had to seek another route. Also, I didn’t want to restrict the product range. If you want to be a centre of excellence you need to provide the full range of prosthetics so you can meet all clinical needs.’

SWLEOC followed a procurement model used by HSS, based in New York, the biggest hip and knee replacement provider in the world.

Impact

According to SWLEOC this agreement saved SWLEOC £1.5 million on its prosthetic budget in its first year of operation. A further £500,000 was saved in year two.

In addition to this the new stock management arrangement means that suppliers are always looking to reduce stock and instrumentation. SWLEOC supports this if they can maintain a ‘just in time’ service effectively. As a result suppliers provide expert support in stock management and instrument support.

Source: Audit Commission
Conclusions

The organisations we visited reported that, given the right frameworks and the right information, clinicians, and especially medical consultants, take easily and willingly to financial and business management. Far from being reluctant partners in a business-driven NHS, they can quickly assume a leadership role. This may in turn test the limits of the business culture within the NHS. For example the introduction of service-line reports has increased the potential for ‘cherry picking’ services at the expense of the less profitable ones. This has implications for the NHS as a whole.

Our research shows that a number of organisations have developed successful approaches to ensure the engagement of clinicians in financial management and they are not alone in this. We could have visited many more organisations to find similar approaches. It is clear that clinical engagement depends on effective communication and good working relationships. There are, however, some processes and techniques that can help improve clinical engagement in financial matters. Set out below are the key conclusions from our research.

**NHS Boards are responsible for ensuring there are effective financial management arrangements in place and making clinicians accountable for their use of resources can bring significant benefits**

- High quality clinical care and financial discipline are not mutually exclusive. We found examples of service reconfigurations that have brought about improvements in outcomes and timeliness of care and saved money at the same time.
- Clinicians respect clear financial procedures and visible leadership. Formal structures vary but there must be clarity about where financial management responsibility lies and the lines of accountability below board level.
- Clinical directors have a key role in promoting the importance of effective financial management arrangements and the best use of resources.
Finance staff structures seem to be less important than style and professionalism

- There are two typical finance staff structures: directorate accountants managed by clinical directors or directorate general managers; and directorate accountant posts retained within the finance department. It does not seem to matter which is chosen: the overriding factor is that clinicians value finance staff who are visible, proactive, knowledgeable and confident.

- Finance staff have a key role in organising financial management training across the organisation and for all the different staff groups.

- Continuity of finance staff is important as it helps with the development of long-lasting productive relationships.

Clinicians and finance professionals can view the world quite differently

- There are differences of culture as well as differences of language but, in the main, clinicians respect the professionalism of senior finance staff and finance staff respect the clinical excellence of doctors, nurses and other health professionals.

- Some clinicians expressed concern over whether they had received sufficient training in management and finance issues, and whether involvement in these areas would impact on their clinical work.

- The NHS finance role is often perceived as ‘gate-keeping’ and control, with finance staff and general managers being preoccupied with achieving financial balance rather than delivering high quality efficient services.

Good, timely, useful information is key to clinical engagement

- There is considerable clinician support for service-line reporting and patient-level costing. Financial reports need to be produced with sufficient speed and in enough detail to enable clinicians to relate financial information to their actual practice, hence the popularity of patient level costing.

- Clinicians find access to real-time information immensely powerful.

- Many clinicians suspect finance department apportionments or any adjustments that are not fully transparent, particularly in areas such as the treatment of support functions and overheads.
• In PCTs, programme budgeting information coupled with health outcomes information has provided public health professionals and commissioning staff with vital information on which to base decisions about the level of investment in different areas of care.

• It is critical that finance departments rise to the challenge of providing timely, sufficiently detailed information, to gain the support of clinical colleagues.

Where clinicians have led commissioning or purchasing negotiations the result can be very positive

• The introduction of practice based commissioning in the NHS has resulted in GPs becoming even more involved in commissioning and financial management. But very few hospital clinicians get involved in the commissioning process.

• We found some examples where clinician involvement in the negotiation of the procurement of goods and services had been extremely beneficial and had led to savings.

There is a crucial tension between entrepreneurialism, risk taking and financial prudence

• Many senior clinicians run successful businesses in their own right. Some express frustration at the lack of entrepreneurial business awareness amongst NHS finance professionals.

• There is evidence that an entrepreneurial approach to the management of a clinical directorate need not be inconsistent with sound financial control.

• Some NHS bodies have developed performance management systems that reward economy and the generation of additional income.
Appendix 1

Organisations involved in the study

Birmingham East and North PCT
Bolton Hospitals NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Devon PCT
Epsom and St Helier Hospitals NHS Trust
Harrogate and District NHS Foundation Trust
King’s College Hospital NHS Foundation Trust
Liverpool Women’s NHS Foundation Trust
Newcastle Upon Tyne Hospitals NHS Foundation Trust
Norfolk PCT
North East Lincolnshire Care Trust
Oxfordshire Learning Disability NHS Trust
St Mary’s NHS Trust
Salisbury NHS Foundation Trust
Somerset Partnership NHS and Social Care Trust
University College London Hospitals NHS Foundation Trust
## Appendix 2
### Benefits of service-line reporting

<table>
<thead>
<tr>
<th>Current example of NHS foundation trust segment reporting</th>
<th>What your I&amp;E statement could look like after implementing SLR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall NHS foundation trust</strong></td>
<td><strong>General surgery</strong></td>
</tr>
<tr>
<td><strong>NHS income</strong></td>
<td><strong>Cardiology etc.</strong></td>
</tr>
<tr>
<td>– Elective</td>
<td>– Clinical</td>
</tr>
<tr>
<td>– Non-elective</td>
<td>– R&amp;D</td>
</tr>
<tr>
<td>– Outpatient</td>
<td>– Teaching</td>
</tr>
<tr>
<td><strong>Other income</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>– Private</td>
<td>– Clinical</td>
</tr>
<tr>
<td>– R&amp;D</td>
<td>– R&amp;D</td>
</tr>
<tr>
<td>– Teaching</td>
<td>– Teaching</td>
</tr>
<tr>
<td><strong>Direct costs</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Indirect costs</strong></td>
<td>– Clinical</td>
</tr>
<tr>
<td><strong>Contribution margin</strong></td>
<td>– R&amp;D</td>
</tr>
<tr>
<td><strong>Overheads</strong></td>
<td>– Teaching</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

No transparency of profitability by service-line (SL)

R&D and teaching income split out by service line – clarifying cross-subsidisation between clinical activity, R&D and teaching

Contribution and EBITDA margin by service line

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**Source:** Monitor
References

5 Audit Commission, *Putting Commissioning into Practice: implementing Practice Based Commissioning through Good Financial Management*, November 2007
6 NHS Institute for Innovation and Improvement, *Delivering Quality and Value*, 2006.

Suggested further reading

Department of Health, *Care and Resource Utilisation*, 2006
Dr Foster Intelligence, *The Intelligent Board*, 2006
A report to support World Class Financial Management

*World Class Financial Management: A Discussion Paper*

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