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Contributing to the debate on NHS finance
September 2006

Case studies in turnaround

Case studies: St George's Healthcare NHS Trust, Bradford Teaching Hospitals NHS Foundation Trust, Portsmouth Hospitals NHS Trust, Brighton and Sussex University Hospitals NHS Trust

Foreword

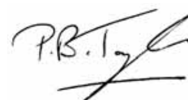
The term 'turnaround' seems to have only entered the NHS vocabulary in the last 18 months. But its use has grown quickly – with large numbers of organisations in the English health service producing turnaround plans and appointing turnaround directors.

The NHS is no stranger to efficiency programmes. It has a long history of drawing up financial recovery plans aimed at delivering financial balance. However all too often in the past these plans have not delivered lasting financial stability and have merely been replaced by new, more demanding recovery plans.

Turnaround, with its origins in the private sector, is seen as a fresh approach, bringing a more robust, commercial edge to recovery in the NHS, with a sharp focus on meeting the bottom line. However it is not a strictly defined process and different organisations have taken different approaches to turnaround.

At its first Policy Forum event in 2006, HFMA members and invited guests from around the NHS discussed turnaround and how it compared to earlier approaches to financial recovery in the NHS. The Forum concluded that it would be useful to pull together a series of case studies on turnaround to improve understanding of this 'new' approach to restoring financial balance and moving beyond into financial surplus.

This collection of articles, based on interviews with finance directors in NHS trusts and foundation trusts, is the result of that meeting and aims to improve understanding of how different organisations have approached turnaround.



Phil Taylor
HFMA Chairman

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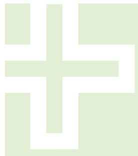

'Probably for the first time in the trust's history, we set up meaningful and focused monthly budget review meetings with budget holders'

Colin Gentile

Case Study 1: St George's Healthcare NHS Trust

Any NHS organisation currently going through the Department of Health's turnaround programme probably has St George's Healthcare NHS Trust to thank for the commercial approach being used. St George's has in effect piloted the whole process in the health service and with some two years since the process began, its experience may offer an insight into what the wider NHS can expect from turnaround.

St George's – a large teaching hospital in South West London with a turnover of some £340m – provides a classic example of how, if you use published accounts as a guide, an organisation can seemingly plunge from financial stability to financial crisis almost overnight. This must be how it seemed to anyone outside the organisation, which posted a small deficit in 2003/04 but then almost immediately started projecting a major overspend for the following year.

But the reality was that the organisation had been heading into difficulty for a number of years. A relatively small £650k deficit in 2003/04 was only achieved – as in many other organisations around the NHS – using a mixture of non-recurrent means, most notably significant one-off financial support from the SHA.

The scale of the underlying problem started to emerge in 2004/05. Director of finance Colin Gentile, appointed in June 2004 to help stabilise finances, remembers that during his recruitment the projected deficit was first said to be £4m and then later £11m. So his first job on arrival was to establish the real and full extent of the problem. This due diligence exercise – which involved a gap analysis of the previous year's underlying performance compared with current year budgets as well as a review of the balance sheet – established that the problem was far bigger than had been anticipated. 'We were looking at a deficit of some £30m plus a range of financial risks to be managed,' says Mr Gentile.

The trust had already set up a financial recovery board, with directors from the trust, the local PCT and the strategic health authority. And Mr Gentile presented the findings of the due diligence exercise to this board in July 2004. He admits that there was some scepticism around the table initially but with robust analysis behind the projections, the position was eventually accepted.

Mr Gentile says the trust's management took the position very seriously and began a programme of savings and post reductions. Positions were reduced on the basis of a pro-rata reduction applied to all budgets. He says it was important to send a message out that the financial position was not acceptable and would be tackled. External consultants were also hired to identify any short-term non-recurrent wins that could improve the situation for 2005/06.

The way the trust conducted its internal business also started to change. 'Probably for the first time in the trust's history, we set up meaningful and focused monthly budget review meetings with budget holders,' he says. 'I sat shoulder to shoulder with the director of operations and we reviewed the commitments that budget holders had signed up to at the beginning of the year. Such a focus on holding people to account hadn't happened before. It sent out a powerful message that budget holders were accountable to both of us for their financial performance and operational delivery. It was all about getting disciplines in place.'

The process started to chip away at the view that finance was the sole domain of the finance manager. General managers came into these performance meetings with their finance managers, but they were grilled and rated (on a red, amber, green basis) on their combined ability to understand their budget position.

Meanwhile the consultants brought in to identify the quick wins – PricewaterhouseCoopers – suggested that the trust should meet with their private sector corporate recovery team. Mr Gentile says it was clear that the corporate recovery process, with some adaptation, could provide a useful way forward at St George's. Funding the exercise was a problem – the process was at that point untested in the NHS and had to be paid for. However given the potential wider application, agreement was reached with the Department of Health finance director and the strategic health authority to split the funding three ways, with PwC also taking a large measure of risk in its pricing.

Starting turnaround

These discussions and subsequent working up of the concept took until February 2005, when the turnaround process finally and formally got under way. This meant that the formal turnaround programme contributed little to the 2004/05 position, although the greater discipline and budget review meetings

did have an impact. Compared with the £30m projected problem, the trust recorded a £21.7m deficit. And with some of the risks that had been identified on top of the £30m actually becoming a reality, the real improvement was in fact greater than the apparent £8.3m.

The turnaround process began with the consultants' remit being to assist the trust in producing a formal financial recovery plan. 'It was important that this was our own management's plan,' says Mr Gentile. 'PwC helped us to probe and gave us some ideas, but it had to be our plan.' The consultants also insisted that a dedicated team of trust managers would be needed to work with the corporate recovery people and this was duly created, comprising Mr Gentile as executive director working full time on turnaround and two senior managers, one from surgery and the other a service redesign manager. Mr Gentile says that the skill mix on the trust's team was important. 'Financial health is driven by operational health,' he says. 'To have financial recovery, you have to tackle the operational performance of an organisation.'

PwC consultants also reviewed the due diligence work to ensure there was an agreed starting point. Having confirmed this, they then set about reviewing all the areas of spending bringing in both NHS and other sector benchmarks wherever appropriate to get a feel for the areas that the trust might want to explore. Benchmarking data was produced on clinical services and nursing costs as well as back office functions such as finance, human resources and IT.

This was followed by the external consultants challenging existing levels of spend. 'They simply asked some probing questions,' says Mr Gentile. 'For instance, they would look at nursing as a big area of spending and ask why the spend was at this level and why it couldn't be reduced by x%. And then they'd ask us to go away and have a look at how we might do this.'

Trust general managers set up workstreams to look at every area of spending and every stream of income. Multidisciplinary teams were then set up to look at these workstreams and come up with 'outline opportunities'. 'This was the first time we'd had large numbers of staff from the organisation focusing on areas and looking at them from the point of view of getting benefits out,' says Mr Gentile. 'For the first time this process focused the organisation rigorously on every single area and put finance up there as being as important as clinical services.'

He says that there were few if any surprises. 'There was no magic bullet and there was no £30m elephant sat in the corner that you could just lead out and say it has been there all the time. It was every single area. And what was really interesting was that staff said these were all areas that they had been telling managers they were not happy with for ages.' Among areas identified for improvement were the trust's paper-based, labour-intensive procurement system and the outpatients system, which had grown into a collection of cottage industries. 'People were telling us that we could save money and improve the service,' he adds.

Clinical engagement

Mr Gentile says that a precondition to turnaround is clinical engagement. As soon as he had undertaken the due diligence exercise, the whole executive team set about building a consensus around both the extent of the problem and the solution. 'We went out to every speciality, before we had any idea of how we were going to tackle the recovery, to say "we've got a problem" but more importantly to start busting the myths,' he says. These myths – which are not confined to St George's – include:

- We'll get bailed out
- It doesn't affect me
- The finance director will make it go away
- It is the finance director's problem.

The visits helped the trust to develop a collective acceptance that the financial and operational environment had changed and that management needed the help of clinicians and other staff to resolve the problems.

The then trust chief executive Peter Homa established a trust executive group with lead clinicians, lead nurses and representatives from the professions allied to medicine along with the executive directors. This group became the decision-making body, making operational decisions or making recommendations to the board. 'The key thing was that rather than being seen as the executive directors running the organisation, making decisions that impact on service departments, it showed it was the clinical leadership setting the direction,' says Mr Gentile. 'The intention was to involve a whole clinical community, with clinicians from beyond the trust executive group being involved – through discussions – whenever problems arose or solutions were needed.

Once the financial recovery plan had been drawn up, this was again taken out into the trust with the

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nursing director and clinical directors often presenting the plan to management team meetings of their directorates or care teams. Again Mr Gentile says this approach was important sending a clear message that this was the whole organisation's plan, not something being imposed by the finance director.

Implementing the plan

The recovery plan originally included some 67 different workstreams, although over time the trust has learnt to amalgamate a number of these so that its current version of the plan now includes closer to 50 separate workstreams. For instance there was a specific nursing plan with four separate workstreams within it, including reviews of:

- Skills required and skill mix
- Use of agency and bank nurses
- How the nursing workforce is matched to change in demand during the day
- Senior nurses with a high non-direct element in their work.

In total these four workstreams were believed to offer the opportunity to save some £2.5m recurrently.

Other areas examined included: productivity of consultants; doctors in training and how to manage them so they are compliant with working hour guidelines; medical secretaries; outpatients (which were traditionally dispersed around the trust); and day surgery. 'What is important is that we are looking at clinical processes as well as non-clinical ones,' says Mr Gentile. He accepts that few of the ideas are ground breaking and that they are already there either in practice in other organisations or in the minds of their own staff.

But he does believe that the external consultants have played a major role in putting the ideas into practice. 'PwC brought a number of things to the table,' he says. 'In particular whenever we came back with ideas from people, they would challenge the level of ambition in the proposals or the failure to take a broader perspective about what could be achieved by moving to best in class. And they brought in experts from outside. For instance a director of operations in manufacturing came in to look at our processes and identified high levels of transaction costs within the procurement process. Another retail expert spent two nights sitting on the wards and reported that improvements could be made by flexing staff levels to meet the change in workload during the night. Shops don't have the same level of staffing on a Tuesday afternoon as they do on a Saturday afternoon and the NHS similarly has quiet and busy periods. He provided some quantifications of what we could be aiming for. That is what PwC added, confirming what we suspected but also pushing us to aim higher.'

After the plan was presented back to the organisation and its partners, there was a short delay while a number of issues were resolved. For instance one of the messages from PwC was that a proper recovery often requires spend-to-save initiatives, and in particular requires funding of a dedicated, full-time turnaround team. Yet this required getting the SHA to agree an increase in the planned budget deficit. This agreement was finally reached at the end of August, with the trust agreeing a budget deficit of £12.5m, including £500,000 to fund the turnaround.

On PwC's recommendation, Mr Gentile was appointed as turnaround director, with an experienced finance director appointed to backfill his substantive position on an operational basis. (This differs from the model that is being rolled out across the wider NHS, where the Department has been insisting that commercial turnaround professionals should be appointed as turnaround directors.) The team was finally set up in

St George's turnaround timeline

November 2003:
New chief executive appointed

March 2004:
Trust finishes 2003/04 with a small deficit, supported by significant non-recurrent measures

April-June 2004:
Projected deficit estimates vary from £4m to £11m

June 2004:
New finance director appointed

July 2004:
Board told that due diligence indicates real underlying problem is £30m+

September 2004:
PricewaterhouseCoopers appointed to identify quick wins

September to November 2004:
Discussions begin with PwC's corporate recovery team

November 2004 to February 2005:
Discussions with Department of Health and SHA

February 2005:
Formal turnaround gets underway

May 2005:
Turnaround plan presented

September 2005 including a general manager, a dedicated accountant and a clinical director providing two sessions a week to the team. A central programme office has also been established, with support from BT, to project manage all the workstreams.

Each workstream has a project initiation document written by the workstream leader in a standard format with milestones indicating the key things that are going to happen and when they will happen. This plan also lists the key risks and dependencies, what resource they will need and, importantly, the financial benefit that they will release. The trust then rigorously monitors each workstream against its plan.

With a motto of 'every day counts', the turnaround team meets daily at 8.30 to review its action log, which sets out what needs to be achieved that day and that week. The projects themselves fill in monthly reports using a red, amber, green (RAG) system to highlight which project components are on track, with milestones being hit, and where things are slipping. A free text box enables them to flag up what support they need or provide other context.

There is a fortnightly group meeting with all the project leads, but Mr Gentile says that the advantage of being full time on turnaround is that he and his turnaround general manager can spend a lot of time out in the trust getting less formal feedback on progress so that problems can be picked up at a very early stage.

Mr Gentile suggests that the current turnaround process will be time-limited. He does not see a full-time turnaround team becoming part of the normal management structure once historic deficits have been eliminated. But he believes the disciplines are here to stay. 'We will definitely have the programme office approach to delivering business as usual,' he says. 'We will look to embed the performance management and the project handling disciplines into the daily routines so that the culture is one constantly looking for performance improvement.'

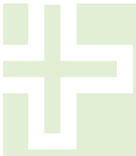
At the time of writing (summer 2006), Mr Gentile says the trust is still a year away from 'turning the corner' although he says the trust is without doubt moving in the right direction. In 2005/06, the trust delivered its original £10.2m cost reduction programme. This was partly thanks to a reduction in headcount of nearly 260 staff, accounting for savings of £3m in year and giving a £5.8m recurrent saving in 2006/07. Procurement savings also released more than £1m over the course of just six months. The trust's actual final position was a deficit of £11.5m, which compares with a target of £12.5m. This represents an in-year financial improvement of some £20.5m on the underlying deficit of £32m it had faced at the beginning of the year.

This financial improvement has come during a period of improved performance across the board, with the trust seeing 6% more GP referrals, 9% more elective admissions and 5% more emergency admissions than the previous year. The trust is also achieving the four-hour accident and emergency target as well as targets on cancer treatment times and in-patient, day-case and outpatient access.

But there is no complacency. Despite an improving reference cost position, the tariff with its inbuilt efficiency savings, means that all trusts face increasing financial challenges year-on-year. Against a demanding £30.6m savings target for 2006/07, the trust has identified sustainable savings of some £19m. And Mr Gentile says that getting further substantial recurrent savings out of the organisation is likely to require redesign of services within the trust and across the wider health community.

Key messages from Colin Gentile

1. Do due diligence to clarify the extent of the problem and make sure you've got it right. Then once you're sure it is right, don't allow anyone to tell you it isn't.
2. Get a business culture into the organisation even before you've got an answer. Get finance at the forefront and get it communicated. Get business processes introduced. So for instance require business case pro formas to be used. No form, no money and require applicants to show the benefit to the bottom line.
3. The executive team needs to be bought in – both the clinical and non-clinical executives. The whole team must recognise this is a collective problem not just for the finance department.
4. Understand that operational performance is the driver for financial performance.
5. Get your external stakeholders to understand the nature of the problem and the intended solution.
6. Try to negotiate a trajectory on savings to allow sustainable recovery rather than just taking costs out.
7. Finance needs to be out in the organisation being part of the solution giving top class financial advice.
8. Develop and invest in financial systems. Traditional financial systems and reporting are not nimble enough to inform management.



> 'The board and the lead managers throughout the organisation are absolutely signed up. This is what makes it successful.'
>
> **Bryan Millar**

Case Study 2: Bradford Teaching Hospitals NHS Foundation Trust

Towards the end of 2004, Bradford Teaching Hospitals NHS Foundation Trust could not get out of the news – for all the wrong reasons. A projected deficit of more than £11m, compared with a planned surplus of £2.3m had set alarm bells ringing both in the boardroom and at the independent regulator Monitor. Barely half a year into the new era of foundation trusts, the problems were seen as a major embarrassment for supporters of the new foundation movement.

But a further 18 months on and the trust's circumstances have seen a remarkable transformation. In fact the trust finished the financial year 2004/05 with a deficit of some £8m – an improvement on the mid-year projections. Even better news is that the final figures for 2005/06 showed that the foundation trust had reduced this to an income and expenditure deficit of just £2.9m in 2005/06. And even this deficit was planned as part of invest to save initiatives – particularly providing the non-recurrent funds for a voluntary redundancy and early retirement scheme – that will help deliver sustainable financial balance (and better) in future years.

Far from being the focus for continued media and regulatory criticism, Bradford's performance has led to it being singled out as an example of successful turnaround by both Monitor and the government. And while the foundation trust's original problems were played out in the full glare of the national, local and trade press, it has managed to go about its recovery in relative peace and quiet.

Bryan Millar, Bradford's director of finance – appointed in the autumn of 2005 – is quick to point out that, despite all the recent plaudits, Bradford still faces major challenges. It may have achieved its planned savings in 2005/06 and be on course for full recovery, but he says that the real learning point is that turnaround is not a one-off exercise designed to bring expenditure back within budget. Instead he says that it has to become part of routine management. At Bradford he says that performance improvement is now just part of the day job, not just for him but for everyone throughout the organisation.

'We identified a programme of savings worth some £9.5m, with savings delivered in 2005/06, the current year and the balance in 2007/08,' says Mr Millar. 'In 2006/07 we need £6m of performance improvement measures to deliver our plan. But if you look ahead, you realise that this is simply how life is going to be from now on.'

He points to the current tariff uplift of 1.5% - which doesn't even cover known pay awards. Then he says you need to factor in the loss of any business to the independent sector. 'And if you add in any areas of service development, it is clear you need financial headroom to be able to manage,' he says. For Bradford, on a turnover of around £240m, Mr Millar believes that the organisation needs to be generating about £8m - £10m of performance improvement each year. This demands a rolling programme of improvements and savings so that savings continue to be delivered in each and every year. Compared to the more traditional problem of responding to financial pressures and difficulties, the new approach is far more proactive.

The importance of ownership

Mr Millar says that the approach to delivering continuous performance improvement would not work if it was simply imposed on the trust. 'The principle – that we need a rolling programme of improvement – is bought into by the clinical management group, our key decision making and strategy forum below board level,' he says. 'The board and the lead managers throughout the organisation are absolutely signed up. This is what makes it successful.'

Bradford initially developed its own recovery plan and presented it to Monitor in May 2005. Although this set out some initial cost improvement plans and savings, it also proposed to engage management consultants to identify key areas for performance improvement. KPMG was subsequently appointed to facilitate the process.

The consultants created a 'project room' over the summer of 2005 and set about engaging with all the different areas of activity across the trust, including clinical and back office functions. One of their key roles was in expanding the use of benchmarking information in the trust, providing length of stay and unit cost comparisons from the NHS, the wider public services and the commercial sector to help identify areas where the trust could target improvement.

Following discussions with staff in all disciplines, in total some 30 to 40 separate projects were identified with proposals for improvement set out in project initiation documents. These were divided into two categories – those that would deliver savings in the

short to medium term and those that would need more time and work. A group of some eight projects formed the bulk of the £9.5m savings plan and this was presented to Monitor in November, at which point KPMG's involvement with Bradford came to an end.

Mr Millar is clear that the consultants helped. In particular he believes that they provided robust challenge to proposals – both challenging any defence of the status quo and the level of ambition in savings plans. 'I think inevitably you get challenge better when you bring somebody in with an objective external view,' he says. 'I think this is helpful in its own right, but it also doesn't compromise relationships internally.' It also provided additional short-term resource that simply wasn't available internally.

However Mr Millar is clear that the consultants' role ends with the drawing up of the plan and their list of proposals for savings. Implementation is and should be the responsibility of the organisation itself. While the consultants can provide advice and guidance, the organisation has to take its own decisions. In Bradford this was perhaps demonstrated by the decision to supplement the proposals with a voluntary redundancy and early retirement scheme, which generated recurrent savings of over £1m in 2006/07.

The clear message is that consultants are there to provide ideas, but the trust should not feel compelled to think that these provide the only solution.

Procurement has been one of the other main focuses for savings with e-auctions providing one way of ensuring that the trust obtains competitive prices. Mr Millar says that understanding what has to be achieved is important with the trust breaking the procurement savings down into how much had to be saved each week and even each day to achieve the target in the overall plan.

Investment incentives

Site rationalisation has been another key area with the trust looking to move out of antiquated Victorian buildings – with high running and capital costs – into more modern facilities. Again investment – this time in terms of capital – has been important to enable the savings to be realised. And in common with many trusts and foundation trusts around the country, Bradford has also scrutinised its spending on agency nurses and locum doctors. He says the key to realising savings in these areas is through a two-stage control process. First you need to have protocols in place governing when use of agency or locums is appropriate. But then – the area where the NHS often slips up – you need to ensure that these protocols are complied with.

While staff costs continue to be a key focus, the trust is in the early stages of looking at the appropriateness of encouraging directorate level skill-mix and agency utilisation reviews, possibly against a target level of savings.

Performance management of the savings plans involves meetings with each clinical director to review their plans and on a fortnightly basis a performance improvement programme meeting is held, where managers responsible for delivery of specific savings provide progress reports. This meeting is chaired by the foundation trust's chief executive and attended by all the trust's executive and clinical directors. The meeting provides an opportunity to review the overall progress towards delivering existing savings commitments, including the achievement of key milestones, and to assess the potential for future savings. The trust has also appointed a dedicated performance improvement director.

Mr Millar says he is 'constantly impressed' with the ideas that come forward from the frontline. While traditional recovery plans have often been seen as unwanted cuts imposed upon directorates, Mr Millar identifies a real enthusiasm to improve. 'Culturally, it has been a massive success in terms of people's willingness to embrace performance improvement and recognise the reality of the financial environment we are in.'

He accepts that Bradford's circumstances have helped. For a start it has had something of a new beginning, with new executives and non-executives appointed. But he also says there is a determination from staff who went through the problems of two years ago, not to go through anything like them again. This means that people will give time and consideration to any sensible proposals coming forward.

But that is not the only reason. Incentives have also played a part. 'We've sent out clear messages that we don't just want to make savings and work as hard as we can just to stand still, we want to develop what we are doing and improve the organisation,' says Mr Millar. 'So we are trying to acknowledge that we need to generate more savings than we actually need to stand still so we can link performance improvement to service investment.'

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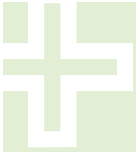

'We've sent out clear messages that we don't just want to make savings and work as hard as we can just to stand still'

Bryan Millar

One of the main ways this has been done has been with capital investment. In the first two years as a foundation trust, Bradford massively underspent its depreciation – meaning less than £3m was available in each year for capital spend – partly to build up some cash balances. 'But this year we have decided to have a show of faith and we've made all our depreciation and a little more available for capital investment,' he says. 'We are involving clinical directors in shaping the capital programme for the year. It has shown a willingness on behalf of management to help directorates develop their services.'

Mr Millar also insists that relationships with the wider health economy are important. Turnaround cannot be effected in isolation from commissioning bodies or other providers. Dealing with the future financial challenges through increased activity and increased growth is fine, but if there are different assumptions in the plans of hospital providers and PCT commissioners, then somebody is bound to be heading for a problem. Bradford knows all about this. Significant differences in the assumptions made by it and its local commissioners led to some of its problems back in 2004, with Bradford boosting staff numbers to deal with anticipated growth that local PCTs simply did not recognise.

It has learnt from this and Mr Millar says the trust now enjoys good relationships with its commissioners and has a shared activity plan. Although there will always be different views about, for instance, how successful a PCT demand management initiative will be, the variations are very much around the margins. He accepts that income growth will be important, but for the next few years at least, the focus is likely to remain on improving performance and cutting costs.

There can be no complacency. Mr Millar says that Bradford has made excellent progress but the challenge remains 'really, really hard'. 'We are in a great place in terms of people's willingness and buy-in to the organisation's approach,' he adds. ' But we are in a really difficult place in terms of the ongoing difficulty turning these ideas into actual savings, not just this year but the year after and into the future.'

Key messages from Bryan Millar

1. Don't get into difficulty in the first place. It may sound obvious but the same decisions need to be taken to prevent financial problems from developing as when you are actually in difficulty. You can put off the decisions but they will still need to be taken at some point. The message is to accept the reality of the situation and take early action. While the decisions may be difficult, they will be far easier than when in the full glare of formal turnaround.
2. Apply the same principles that you would with your own finances. There has been a tendency for the NHS to draw up budgets without a clear idea of how they will be funded – hoping that cost improvements will be identified or that additional income will be forthcoming. Accountants in their personal lives would not plan to spend more than their income and organisations also have to stick to the basic principle of living within their means.
3. Improve the cash position as far as possible to create a buffer and the potential for investment on spend to save initiatives.
4. Consider the market position looking ahead and plan to develop services that will 'beat the tariff'.
5. Don't think that just because it's been written down it will happen – and develop realistic contingencies in case it doesn't.
6. Focus on the key issues – don't be sidetracked by relative trivialities.
7. Look for win/win outcome with commissioners – don't waste time and effort on fruitless disputes. Mutual certainty is mutually attractive in a volatile environment.
8. Link to overall objectives of trust – ensure that staff understand how and why savings will be made rather than demanding a 'slash and burn' approach.

Case Study 3: Portsmouth Hospitals NHS Trust

On today's scale of deficits, which in some cases run into the tens of millions, Portsmouth Hospitals NHS Trust's £750,000 deficit in 2001/02 hardly registers. However it was the recognition that the reported deficit was just a fraction of the real underlying problem that kick started the organisation's financial recovery programme. Four years on the trust can boast three years of break-even, virtually free from non-recurrent fixes, with a modest £1.1m surplus in 2005/06. Yet the disciplines adopted during the recovery process are still very much in use.

Finance director Bill Shields, appointed in April 2003 as part of a management restructuring, says the organisation now accepts that financial recovery is not something you do once and then return to steady state. 'It has to be an iterative and continuous process,' he says. 'Trusts need to be looking now at how they can deliver savings so that they are viable in five, six and seven years' time.'

This has been driven home to the trust by the financial forecasts undertaken as part of the foundation trust diagnostic programme. As part of this process, like other trusts with private finance initiative deals, the trust has had to produce seven year financial forecasts, moving well beyond the shorter time horizons used in the wider NHS. The message is stark with a potential £60m problem developing by the end of the time period looked at. But Mr Shields says this is not a reflection of the unaffordability of PFI unitary charges. The £240m scheme will undoubtedly mean that significant costs will be fixed in a unitary charge. But Mr Shields says the £60m gap is more a simple consequence of cost pressures outstripping the inflation built into funding streams and demanding efficiency targets that are now directly built into the tariff uplift.

Mr Shields is convinced that Portsmouth is not alone. If other NHS trusts looked seven years into the future, they would find a similar trend. The point is that trusts cannot simply focus on recovering existing deficits or ensuring that financial balance is delivered for the current year. While Portsmouth may no longer have a current financial deficit to recover, it still needs the disciplines of financial recovery to head off future problems.

Portsmouth began its recovery process several years before the NHS adopted commercial style recovery approaches. And while it would not claim to be a pilot for the current turnaround approach being rolled out across England, Mr Shields says there are several common components.

He says the first job when he joined was to ensure the organisation knew it had a problem. For too many years the organisation had been told about financial problems, only for them to apparently disappear at the end of the year, covered by reserves or non-recurrent fixes. This meant that people didn't take warnings of financial problems as seriously as they should – the finance director would always be able to fix them. This attitude had to change and it had to change quickly especially as the focus on other performance targets at the time was in danger of exacerbating the problem. 'We'd been rated as zero stars for two years in a row and then we had financial issues on top,' says Mr Shields. 'The danger was that because the zero star rating was related to quality and performance issues, people were starting to get the mindset that they needed to spend their way out of trouble.'

Clear communication

So getting people to face up to the real financial imperative – to reduce spending and impose strict financial control – was a vital first step. This started with getting the board and the senior management to understand, but also getting the wider clinical workforce to buy into the scale of the problem. 'We did this by presenting the message as clearly and concisely as we could and then spent as much time telling as many people as possible about it,' he says. 'We were completely open.'

The trust also recognised that it needed some external support to underpin its recovery process and after a full tendering exercise appointed PricewaterhouseCoopers (PwC). In comparison with the current turnaround process in the NHS – where consultants are often drafted in to support trusts and PCTs in drawing up their turnaround plans – Portsmouth already had a recovery plan that had been approved by its board, identifying a number of broad areas where it was targeting savings. But Mr Shields accepts that the trust needed help in fleshing this out and driving implementation.

The consultants divided the savings plans into six workstreams

- Tactical quick wins
- Business drivers
- Operational efficiency
- Financial control
- Organisational design
- Service improvement.

> 'Trusts need to be looking now at how they can deliver savings so that they are viable in five, six and seven years' time.'
>
> **Bill Shields**

'Due diligence of how the savings will actually be realised is key.'

Bill Shields

Mr Shields says that the trust took a prescriptive approach with most of the £8m savings target identified in the first three headings. Project groups were set up with an executive sponsor and support from PwC and these were required to report back to a transformation project board (TPB) on a monthly basis.

The quick wins were seen as crucial, both in getting some early successes registered and in sending out a message that the trust meant business. Mr Shields says that while technical and non-recurrent measures may have disguised the full extent of problems in the past, they still have a role in buying time to allow the development of more long-term schemes.
As part of this quick win approach, the trust spent time looking at the capitalisation definitions, reviewing its rates and capital charges and tightening controls on vacancies and use of staff banks and agencies. 'These schemes are nowhere near enough to deliver financial recovery, but they make a contribution and they got us started,' he says.

In the business drivers and operational efficiency workstreams, PwC's business recovery team played a major role. Rather than try to tackle everything at the same time, the trust chose to focus on a number of key discrete areas including: pharmacy; pathology; facilities; administration and clerical staff; nursing; and waiting list management.

Retail therapy

Mr Shields says the trust took a deliberately non-NHS approach, looking to learn from private sector experience, including other sectors such as retail.

For instance in pharmacy, Portsmouth was the first NHS trust to run a reverse on-line auction for pharmaceutical supplies, saving the trust close to £700,000. And in terms of nurse staffing, the trust has sought to challenge traditional NHS rostering practice so that nurse holidays are spread throughout the year. The knock on impact could be a reduction in agency nursing spend and Mr Shields believes that the trust could save £1m-£2m from this initiative alone.

But it is not just big changes that the trust has focused on. For instance analysis of cleaning routines on the ward suggested that cleaning time could be reduced by changing the floor type – a small change that in combination with other changes can lead to a noticeable difference in spending.

Although the trust's main work with PwC has now come to an end, it continues to pull in consultancy support as and when needed for specific projects. For instance it is using a clinician-led team to look at the application of Lean thinking principles to some aspects of the trusts activities and this is being supported by consultants from Healthworks.

The trust launched a number of reviews and initiatives as part of the organisational design and service improvement workstreams using private and public sector benchmarks to look at the fitness for purpose of a number of its functions including finance.

Procurement was again a key area for scrutiny and the decision was taken to invest in the function. Mr Shields says this is an invest-to-save programme that under current plans will reap a 10 fold return on the £300,000 investment. The investment has seen key appointments made and staff trained up, for instance so they are capable of running the e-auctions. However he is careful about over reliance on spend-to-save initiatives in general. 'There is a tendency for them not to deliver everything they promise in the timescale,' he says. 'Due diligence of how the savings will actually be realised is key.'

For instance, he says that just promising a reduction in length of stay is not enough. Too often, the staff time savings from length of stay reductions simply get 'sucked back up' into other areas. 'What schemes need to demonstrate is not just that they will reduce length of stay, but how the staff and beds will be taken out.'

Mr Shields is clear that people need to understand that the key to savings in the NHS will be reductions in staffing. He says that this needs to be realised by managers, staff and the public. And expecting all these reductions to come from staff turnover and natural wastage is simply unrealistic. 'We need to take out about 1,000 staff (from an establishment of some 6,500) over the next four to five years,' he says. 'Staff turnover of about 9% simply won't deliver what we require. If we wait for staff reduction to happen through natural turnover, it will cripple the organisation.'

Mr Shields says the organisation has been performance managed to a 'significant degree'. In addition to the transformation project board, which reviews project progress on a monthly basis, the trust executive management team also monitors progress each week and finance and performance meetings keep a check on the savings programme. Each scheme is monitored. But Mr Shields says that the trust also

keeps an eye on the overall financial position of each division. He says there is a danger that people can concentrate too much on the recovery plan and lose sight of the business as usual. If the plan is not being delivered, remedial action is required and this is reported back through to the trust board as necessary. Further schemes can then be sanctioned if necessary.

Financial control has also been tightened. A zero-based budgeting exercise has led to more buy-in of budget managers. Instead of the traditional approach of budgets being rolled forward plus an increase for inflation, budgets have been calculated on the basis of what is realistically needed to do the job. This has not only pushed some divisions to reduce expenditure, but improved their understanding of their establishment levels. This has been accompanied by a tighter scheme of delegation, much more rigorous monitoring of all developments by the trust planning group and much tighter recruitment controls overseen by a 'workforce target panel'.

The success so far is impressive. The trust (rated at 2 stars in the final star ratings exercise) made workforce reductions in 2005/06 that will save £4m in a full year. It is on course for a 30% reduction in bank and agency staff this year and advertising expenditure controls have saved a further £500,000.

But the message is clear, savings such as these need to be found on an annual basis if long-term viability is to be secured. And to do this, organisations need to embed the disciplines of financial recovery.

Key messages from Bill Shields:

1. Finance directorate must play a key role but not on its own.
2. Must be board, managerial and clinical buy-in.
3. There can be no exceptions – all parts of the organisation can contribute to cost reductions.
4. Need a combination of recurrent and non-recurrent schemes and quick win and long term redesign.
5. Work force reduction is key.
6. Benchmark against the best – don't get complacent.

> 'It is not like a monthly budget review but a weekly progress chase.'
>
> **David Dumigan**

Case Study 4: Brighton and Sussex University Hospitals NHS Trust

The NHS is no stranger to financial recovery. The drawing up of a financial recovery plan has been the age-old response to financial problems in any overspent NHS organisation. But all of a sudden it is different. Borrowing the language of the private sector, financial recovery has become 'turnaround' and ministers have made it clear that the NHS cannot continue to hide its financial problems behind a confusing system of non-recurrent fixes and brokerage. Restoring and sustaining financial balance has become the health service's number one priority.

Brighton and Sussex University Hospitals NHS Trust, is in the thick of the current turnaround initiative. The trust has posted deficits for the past three years and has a cumulative deficit in the balance sheet of £26m at 31 March 2006. And with a high (although reducing) reference cost position, it has recognised that the new tariff based on national average costs poses additional challenges. With the whole local health economy facing major financial challenges, the trust has effectively been living in recovery mode.

But finance director David Dumigan says that this time it does feel different and he is confident that the admittedly high upfront costs of turnaround will pay off and deliver a financially stable organisation. He estimates that the current turnaround exercise at Brighton could cost £1m, which is hard to swallow when the organisation is already in debt. But he believes the trust could have realised £25m of recurrent and sustainable savings within two years.

This sounds ambitious – equivalent to more than 8% of the trust's £300m turnover. And the NHS has had ambitious savings plans before but then failed to deliver – an issue highlighted by the Audit Commission and the National Audit Office in their recent report on financial management. So why should it be different this time?

Mr Dumigan says there are three reasons why turn-around will work. First there is the commercial rigour with which the turnaround process in being applied. But equally as important is the clinical engagement that has been fostered within the organisation. Finally, Mr Dumigan says that the existence of payment by results gives the turnaround process a much better chance than former recovery plans.

The turnaround process is built on a proven methodology that first identifies the problem and then identifies workstreams in which financial savings and service improvements can be targeted. Perhaps the key difference for NHS organisations from earlier savings initiatives is the way in which individual savings plans are translated into discrete projects with accountabilities clearly assigned. Regular milestones have to be achieved and are then intensively monitored, on a weekly basis, by a specially established project management office (PMO).

Group workstreams

In Brighton, five group workstreams were identified:

- resource planning
- infrastructure
- support services
- commissioning
- a catch-all 'other' workstream.

'Each of the detailed plans is on Microsoft Project which is revisited every Thursday by the workstream leader and their management accountant who sit in front of the chief financial restructuring officer [CFRO – Brighton's turnaround director],' says Mr Dumigan. 'They have to explain how they have delivered what they said they would deliver last week and what they will do next week. It is not like a monthly budget review but a weekly progress chase.'

Mr Dumigan admits that the process is really straightforward. 'But we've simply not done this before in the NHS,' he says. He accepts it can be an intimidating prospect, sitting in front of the highly paid and very experienced CFRO, particularly for the accompanying accountants, many of whom are only accounting technician level. But Mr Dumigan says the CFRO tries to adopt a balance between being tough and supportive. And he adds that while some staff have become anxious about the weekly meetings, many others are rising to the challenge.

The other main difference between turnaround and earlier recovery plans is the engagement of clinicians. This is often talked about – the need to 'on board' doctors – but it is always harder to put into practice. However it is emerging that real clinical engagement is now a clear characteristic of successful turnaround in the NHS. In Brighton this has been realised by restructuring the organisation into three clinical divisions (emergency, elective and specialist), each headed by a divisional clinical director with a seat on the board. With four clinicians now on the board, there is far greater clinical buy-in to any decisions taken and a far greater sense of responsibility for the

overall financial health of the trust.

Payment by results also provides the right context for turnaround to be a success. For a start it has forced organisations to collect more detailed information about their costs and services, making decisions far more informed. But it also provides the incentive structure to drive change. The incentives for the organisation of undercutting the tariff are being mirrored in Brighton with an internal incentive structure that passes the benefits down through the organisation to where cost or service improvements have been made.

Signs of improvement

So are things improving? Even just a few months in Mr Dumigan believes that the organisation is moving forward. 'We feel we are on the up,' he says. 'There is a positive feeling now about the organisation. We have had some weak performance issues, not just on finance. For instance on accident and emergency and MRSA levels we were poor. On A&E we were the 154th worst in the country, now we are steadily moving up the national league table and endeavouring to sustain the improved performance.' He says that not all of this improvement can be attributed to the recent turnaround process. Brighton had already recognised the need for action and had made a concerted effort to change A&E performance. But he says the organisation has embraced turnaround and the CFRO in particular had brought a real focus onto the financial aspects and a positive approach to tackling the challenges.

The turnaround plan aims to deliver £10m of cost savings this year, £18.6m in 2007/08 and then recurrent savings of £24.4m from then on. And these are not just figures plucked from the air to present a balanced forecast. The savings have all been identified, written down and are being aggressively monitored. Any plan that goes off course is immediately flagged up and investigated. However even this will not be enough to deliver underlying financial balance.

'With the £25m savings we are then financially viable provided we also deliver strategic service change, which needs to make a further £10m of savings,' he says. And these strategic changes cannot be taken by the trust in isolation as they will involve some services being redistributed around the existing eight acute trusts in the former Surrey and Sussex health economy. Although some people feel the sheer number of separate organisations is unsustainable, at the very least all organisations face changes to the portfolio of services they offer. A separate review of strategic service options across the health economy was due to be completed during the summer and this will then be followed up by public consultation in the autumn.

Given the trust only has an underlying deficit of £12m, the need for such heroic savings might surprise the general public. But Mr Dumigan says that the requirement to make 2.5% efficiency savings year-on-year means that the financial challenge is far greater than simply eliminating any previous income and expenditure imbalance. On the trust's turnover, the efficiency savings which are now built into the

Brighton's route to turnaround

The concept of turnaround in the NHS was given its first public outing in December 2005. On the back of half year projections suggesting the NHS was on target for a net overspend of £623m in 2005/06 (£948m gross), the Department of Health announced that turnaround teams armed with experience of turning around commercial organisations would be sent into the NHS bodies with the biggest problems.

A preliminary assessment (undertaken by KPMG) identified 18 organisations as needing urgent intervention to drive turnaround and Brighton and Sussex with a projected deficit at that time of £14m for the year – some 5% of its £300m turnover – was part of the first pack. (The actual deficit was £11.3m.)

In fact the trust was already ahead of the game. It had recognised the need for outside support several months earlier and had itself commissioned KPMG to carry out a diagnostic assessment and produce a turnaround plan. While the trust had decided not to use the consultants further at that point, it did recognise the need for additional resources dedicated to turnaround, appointed its own full time turnaround director and was intent on putting the plan into action. However this got overtaken by central events and KPMG's Department sponsored December review – which gave the trust the lowest possible marks for finance and management capability – suggested the trust had not made enough progress on its own. So the trust became part of the formal turnaround initiative.

This time the trust appointed PricewaterhouseCoopers as its turnaround advisers and subsequently appointed Donald Muir as its chief financial restructuring officer (turnaround director) on a consultancy basis.

'The requirement to make 2.5% efficiency savings year-on-year means that the financial challenge is far greater than simply eliminating any previous income and expenditure imbalance.'

David Dumigan

tariff will require the trust to take £6.3m out of its cost base as well as reduce costs as the trust has a reference cost index of 110 (2004/5). 'That is £30m in three years just to stand still,' he says (£18.9m for efficiency savings plus the £12m underlying deficit).

The challenge does not end there. The trust's savings plans do not include any repayment of accumulated deficit. If the resource accounting and budgeting rules that have applied to date were to continue to apply (with income reduced by the previous year's deficit, while still being required to recover the balance sheet deficit), the trust would have an accumulated deficit of over £100m by the end of 2007/08, despite having returned to in-year balance. In fact the strategic health authority is planning to protect the trust from the RAB income adjustment, but even so the trust will have an accumulated deficit of £20m by the end of this year. (During the summer of 2006, the Audit Commission recommended that the RAB regime should no longer be applied to trusts – a response was expected from the government in the autumn.)

Cash shortfall

While recovery of this balance sheet deficit is feasible over the long term, Mr Dumigan says the real challenge is making good the real loss of cash that the deficit represents. He admits that the trust is only just coping with this cash shortfall. But with just over half of its creditors currently being paid within the 30 days set by the Better Payment Practice Code, he says this is unsustainable. Realistically he says that the historic deficit has to be converted into long-term debt by some form of balance sheet re-structuring. To address the cash shortfall, assets will need to be disposed of (perhaps by sale and lease back) or an external injection of cash enabling it to start meeting its obligations to creditors.

Mr Dumigan is convinced that the more commercial approach to financial recovery that characterises the new turnaround initiative is making a difference. He believes the Brighton trust is on the path to recovery. But the challenge will continue long after the turnaround teams have gone back to their private sector headquarters. And the key to long term financially stable organisations will be a mix of strong financial control, difficult strategic decisions and changes to the NHS financial regime. The real indicator of success though will be if in three years time the trust is applying for foundation trust status. For if it is, the trust will have restored financial balance and be focusing on developing its activities rather than recovering its finances. That would answer any critics who think that turnaround has little to offer the public sector.

Key messages from David Dumigan

The over-riding message is 'communicate and act, then ensure that if someone doesn't act there are consequences'. But the following are also important

1. Prepare a strategic financial plan based upon the 'do nothing model' which will inevitably be a dire plan – delivery of a 2 .5% efficiency gain, implementation of demand management plans and consequent loss of income etc – to size the challenge.
2. Seek ownership of the dire plan and explain that 'unless we sort the money out we will all continue to struggle from hand to mouth and can't concentrate on the real business of delivering high quality patient centred care. Let's all get involved to sort the money out!'
3. Get ownership of the plan to return to financial balance based upon benchmarked data and remember that 'approximately right is better than precisely wrong'.
4. Ensure as far as possible that this is a whole health economy issue that will require solutions from all parties including PCTs and social services, not just the acute trust.
5. Don't be afraid to use external support to help prepare and deliver, even though it may be costly. Ask yourself: 'Do you have the expertise, internally, to sort this out?'. If the answer is 'no', there's no point making a ham fist of it by using the wrong people, even if they are inexpensive as this will cost more in the long run.
6. Don't be afraid to invest to save – a small investment can make a big saving. Ask for ideas from within the organisation on this basis.
7. Understand your costs and use the tools of payment by results as a motivator for change and create incentives to reduce the cost base.
8. Get the basics of financial control and the control environment right.
9. The best ideas could well be in the heads of those staff that do not have the word 'manager' in their title.
10. Without clinicians being really engaged in the whole management process and really feeling that they have the power to make changes, little can happen.