HFMA Programme Budgeting Project - June 2005

A Practitioner's Guide to Programme Budgeting

Authors

Helen Kenyon, Assistant Director of Finance, North East Lincolnshire Primary Care Trust

Damian Kitchen, Performance Reporting Accountant, Northern Lincolnshire & Goole Hospitals NHS Trust

Steve Quint, Senior Finance Manager, South Yorkshire Strategic Health Authority

Sponsored by

PSCAL

hfma

Public Sector Costing Associates Limited

PSCAL provides:

- Specialist consultancy, support and training on NHS Costing
- High quality custom software to support Costing and Commissioning.

  The range currently includes:

  - PSCAL Reference Costs Analysis Tool (RCAT)
  - PSCAL SLA Monitoring System (SLAM) for Providers and Commissioners that complies with PbR methodology. The Provider version enables Trusts to complete the Programme Budgeting return.
  - PSCAL Budget Master
  - PSCAL Cost Master – a costing system specifically designed for NHS Trusts and PCTs

PSCAL

Registered Office:
Brook House
Haresfield
Glos. GL10 3DY

Telephone/Fax: 01452 725899
Email: enquiries@pscal.com
Website:www.pscal.com

01

Contents

02 Acknowledgements

03 Brief overview of programme budgeting

04 Purpose of this document

05 A guide to programme budgeting at hospital trusts

15 A guide to programme budgeting at primary care trusts

23 A guide to programme budgeting at strategic health authorities

31 Case study

35 Glossary of terms

02

Acknowledgements

This guide has been developed by the Yorkshire branch of the HFMA. The authors are Helen Kenyon, Assistant Director of Finance, North East Lincolnshire Primary Care Trust, Damian Kitchen, Performance Reporting Accountant, Northern Lincolnshire and Goole Hospitals NHS Trust and Steve Quint, Senior Finance Manager, South Yorkshire Strategic Health Authority. The HFMA's Financial Management and Research Committee is grateful to them for all their excellent work and believes that this guidance will be of real practical benefit to all those who are responsible for meeting the requirements of Programme Budgeting.

03

Brief overview of programme budgeting

The aim of Programme Budgeting is to provide a source of information which can be used by all NHS bodies to give a greater understanding of "where the money is going" and "what we are getting for the money we invest in the NHS".

In order to answer these two questions Programme Budgeting maps all expenditure by Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) to 23 programmes of care based on medical conditions. The mapping of expenditure to medical conditions has two prime uses:

- It provides commissioners with financial information which can be used to aid strategic decision making
- It provides information to aid performance management.

It is the responsibility of PCTs and SHAs to submit Programme Budgeting returns to the Department of Health (DoH). Although the DoH does not require returns from hospital trusts, they must provide a breakdown of the income they receive from commissioners (PCTs and SHAs) across the 23 Programme Budgeting categories to their commissioners for incorporation into their return.

The DoH has recognised that the implementation of Programme Budgeting will require refinement over a long period and therefore that the figures produced in the early years will be based on best estimates rather than a precise measurement of expenditure. Ongoing work is therefore required to ensure a year-on-year improvement in the information used to complete the return.

04

Purpose of this document

The purpose of this document is not to replace the DoH guidance on Programme Budgeting, but rather to provide some additional support, hints and tips to anyone who will be completing the return for the first time.

The DoH guidance on Programme Budgeting is comprehensive and easy to understand. It is therefore worth spending some time familiarising yourself with the guidance before you start.

Within this Practitioner's Guide to Programme Budgeting there are separate sections to support individuals completing this return from a hospital trust, PCT or SHA perspective. There are also points that may need further consideration in the future as Programme Budgeting develops. A case study has also been included which highlights a potential use of the information.

05

A Guide to programme budgeting at hospital trusts

Introduction

The Programme Budgeting process from the perspective of NHS Trusts is to produce two returns for each identified PCT. Of the organisations involved in the whole Programme Budgeting process the Trust's contribution is more mechanical in that the majority of its actions are clearly defined and involve working with spreadsheets.

Completion of the Programme Budgeting Returns for Hospital Trusts

The DoH's Programme Budgeting guidance prescribes the responsibilities of both PCTs and Trusts with regards to the completion and submission of the returns. It is the PCT's responsibility, in the first instance, to request returns from the identified Trusts. But it is also the Trust's responsibility to prepare returns for those PCTs which it anticipates will ask for a Programme Budgeting return.

One of the two returns which is PCT specific, sets out details of admitted patient care expenditure for the 'requesting' PCT. The second is a generic return and details the Trust's overall non-admitted patient care expenditure in terms of a percentage split which is calculated by running a software report found on the 2005 Reference Cost Web-site.
The format of these returns is given in the Programme Budgeting guidance.

The following checklist lists those items that hospital trusts need before completing their Programme Budgeting returns:

Acute Trust Checklist - you will need the following:

- Blank copies of the Programme Budgeting returns, preferably in an Excel file so that the cells can be populated as and when the information becomes available
- A list of the PCTs that have requested returns and those that have not requested returns but which the Trust believes should be sent a return. The list should include the Programme Budgeting leads for the corresponding PCT and their e-mail addresses
- A download of the Trust's admitted patient care activity from the Grouper software in an Access file. The file should show each patient's corresponding PCT and the activity's Programme Budgeting code

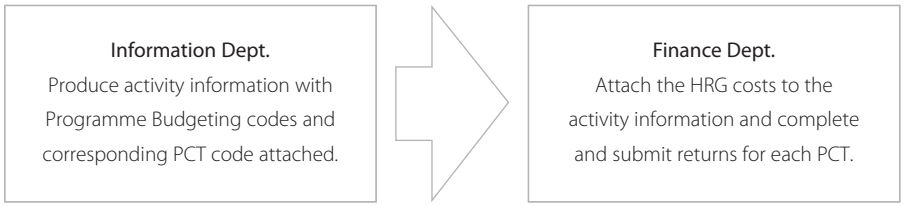
- A download of the Trust's non-admitted patient care activity from the DoH Reference Cost submission site in an Excel file
- Blank writeable CDs
- Access to a CD-writer
- Deadlines - be aware of the deadlines of all the organisations involved.

In one trust which has already been through the process, the completion of the non-admitted patient care Programme Budgeting return required the Trust to download the corresponding return information from the Reference Cost submission website. The DoH's guidance on how to do this was easy to follow and the whole process did not require advanced IT skills.

The completion of the admitted patient care Programme Budgeting return required some additional work:

- An activity download from the V3.5 Grouper software, showing the Programme Budgeting categories and the PCTs, had to be obtained
- The activity then had to be grouped by PCT
- The Trust's corresponding HRG cost had to be assigned to the activity
- The activity then had to be grouped by Programme Budgeting category
- The grouped information was used to complete the admitted patient care Programme Budgeting returns.

The flow of information and the processes required can be better understood with the following diagram:



A Guide to programme budgeting at hospital trusts

Admitted Patient Care Return

At each stage of the process for completing the admitted patient care return, the Trust experienced difficulties with interpreting descriptions. These are discussed in the sections that follow.

+ *'Activity download from the V3.5 Grouper software' and 'Identify the activity for each PCT'*

i) To attach a Programme Budgeting category code to the Reference Cost activity, within the V3.5 Grouper software, a flag needs to be set within the V3.5 Grouper software and a process run. For the 2003/04 submission the V3.5 Grouper software was new and the Trust's Information Department were still learning to navigate around the software when they were asked to set the Programme Budgeting flag. This caused some confusion, as neither the Finance Department nor Information Department knew what output this process would generate or whether the output produced contained the information required for the Programme Budgeting exercise.

It is worthwhile making sure that the Information Department knows what needs to be done, both in terms of setting the Programme Budgeting flag, what information is needed and what will be generated for the Programme Budgeting process.

The Programme Budgeting download should be derived from the same activity used for the Reference Cost submission. This ensures that there is consistency between the Reference Cost submission and the Programme Budgeting submission and that the two returns can be reconciled with each other. One download can be made with the relevant information needed for both returns.

ii) The Trust's original intention had been to have the Programme Budgeting information downloaded into an Excel spreadsheet and to calculate the cost of each Programme Budgeting category by using pivot tables and Excel 'look-up' formulae. Due to the size of the Programme Budgeting download it could not fit on to a single Excel worksheet. To get all of the data on to a single document the download had to be made to Access (see Examples - Figure 1).

The Access file for the download should not cause too many problems. To transfer the information from Access to Excel requires the use of 'filters' and the 'copy' and 'paste' functions of both Access and Excel.

On the Access download use the 'filter - by selection' function on the 'purchaser' code column and reveal the activity information for each PCT. The information in this column is PCTs' National Organisation Codes. Remember only copy the activity information for the PCTs that returns are being sent to otherwise time will be wasted unnecessarily copying information to the Excel worksheets. For each relevant PCT 'copy' the information from Access and 'paste' it to a worksheet in an Excel spreadsheet. Each PCT should have its own worksheet, which prevents any potential crossover between PCT Programme Budgeting information and ensures there is not too much data on the worksheet - ie the reason that the download had to be made to Access and not Excel (see Examples - Figure 2).

For those PCTs that are not being sent returns collate all their activity on to one single worksheet and continue to attach the HRG costs. This information will be needed for the Programme Budgeting reconciliation (see Examples - Figure 2).

+ *'Attach the relevant Healthcare Resource Group (HRG) cost to the activity'*

This area required the most work effort:

Attaching the correct HRG cost to the activity information proved to be a lengthy process as the correct HRG cost for each specialty and patient type needed to be 'looked up' and attached to the activity. The potential for an error occurring was quite high so care had to be taken when attaching the correct costs. With a broader knowledge of Excel formulae, it may be possible to develop formulae that reduce the possibility of errors occurring.

In the Excel file use the 'sort by' function and sort the activity by specialty code, HRG code and then by the patient type. This sorts and groups the information into an easy to handle format. Use the 'lookup' function in the Programme Budgeting returns Excel spreadsheet to 'look' at Reference Cost submission files to attach the relevant cost per HRG to the activity in

the Programme Budgeting returns' file. List the HRG cost information as the last column of the data (see Examples - Figure 2).

+ *'Group the costs into the Programme Budgeting categories'*

The download taken from the V3.5 Grouper software should have attached to each activity item a Programme Budgeting category code (see Examples - Figure 1).

Having applied the HRG costs to the 'returns' file the cost per Programme Budgeting category can be found by running a pivot table. 'Pivot' the data to show the Programme Budgeting category and the 'sum' of the corresponding costs from the HRG cost column. The information in the pivot table can be used for the Programme Budgeting return (see Examples - Figure 2).

Setting a pivot table up on each worksheet, for each PCT, will make the 'opening', 'closing' and 'saving' of the 'returns' file time consuming - this is because of the amount of memory required for the Excel spreadsheet. If the number of PCTs requiring returns makes the functions of the Excel file too time consuming then set up a number of Excel files each with the details of five or six PCTs. This will mean that the Trust will have to be more vigilant working with the files or with updating or extracting data from all of the files.

+ *'Complete the Programme Budgeting Returns'*

Use the information from the Excel file to complete the returns for each PCT. To save on time, it is worth setting up a blank proforma Excel file, completing the details for each PCT but saving the PCT's return file as a separate file. Remember a return will not need to be completed for all of the Trust's commissioning PCTs.

+ *Programme Budgeting Reconciliation*

Produce a summary of all of the Programme Budgeting returns and reconcile the total figure with the Reference Cost submission. Any differences should be investigated. This may take

some time and manipulation of the information to make the data comparable (see Examples - Figure 2).

+ *Sending the Programme Budgeting Return*

Some Trusts were asked by their SHA to provide, in addition to their returns, 'back-up'/ audit trail information to those PCTs that were sent a return. The information suggested was the Reference Cost submission files. The Programme Budgeting returns were small enough but the submission files were too big to be e-mailed.

E-mail the Programme Budgeting returns to the relevant people within the corresponding PCTs. If need be send the 'back-up'/ audit trail information on a CD via the post. 'Burning' CDs is an easy option as long as a CD writer can be found and is available when needed.

Another suggestion is the 'zipping' of the files. However, this can be problematical in that some NHS network firewalls do not allow 'zip' files to be e-mailed or to enter the organisation from an external source. The way that the 'zip' file is identified is by examining the last three letters of the file name as follows:

Programme Budgeting.doc	*Word document*
Programme Budgeting Download.xls	*Excel document*
Programme Budgeting Back-up.zip	*Zip document/ file*

To prevent the zip file being rejected by the firewall rename the zip file, for example, to a 'zop' file. The file above would be renamed as *'Programme Budgeting Back-up.zop'*

This should allow the file to be e-mailed and not rejected. The file can still be opened by the PCT by un-zipping it, assuming they have the relevant software.

A Guide to programme budgeting at hospital trusts

Non-Admitted Patient Care

As previously stated, the Programme Budgeting percentage split for non-admitted patient care can be exported from the Reference Cost submission website, after the Reference Cost submission.

Non-Admitted Patient Care Using the Spreadsheet

For the 2003/04 Programme Budgeting submission an Excel spreadsheet was produced and published on the DoH's website. The option with the spreadsheet was that it could be used instead of the download from the Reference Cost submission website. Some Trusts seemed to experience difficulties in downloading the relevant information from the Reference Cost submission website and the spreadsheet offered an alternative. However, this spreadsheet is no longer available on the DoH website.

Future Development

With regards to NHS Trusts any future developments are likely to be in relation to the mechanical process of producing the information. For example, Reference Cost software programmers are producing 'Add on' functions to their Reference Cost software to enable Trusts to use the software to calculate the Programme Budgeting return information and produce the returns in the required format. The 'add on' is not cheap but does reduce the level of work required to produce the Programme Budgeting returns.

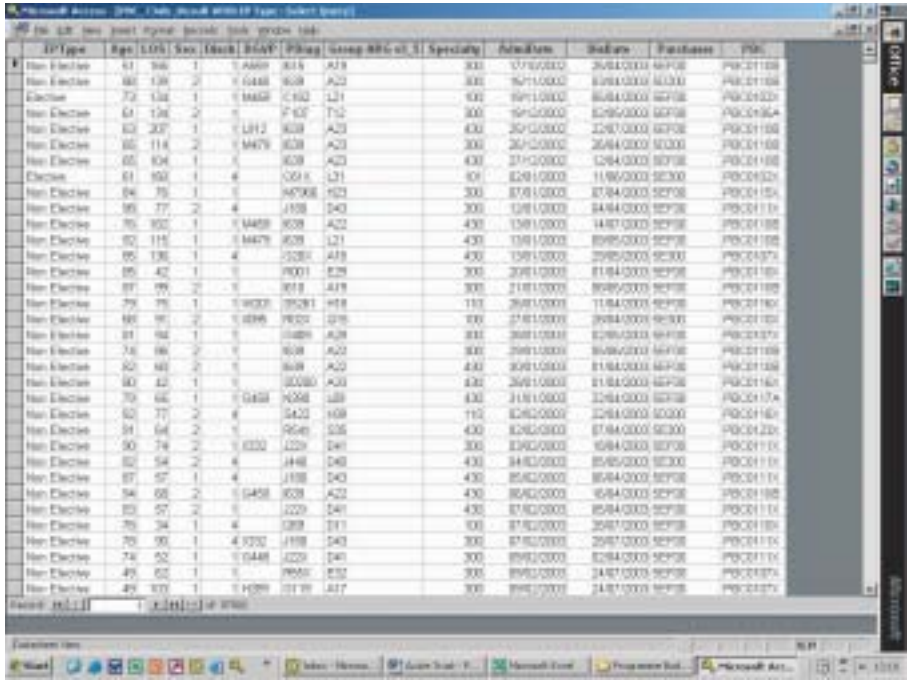
Exploring the Results of Programme Budgeting

The main benefits of Programme Budgeting will be achieved by PCTs and SHAs. Any benefits that could be gained by Trusts will be through comparing their results with either the results of similar sized Trusts, in similar demographic areas, or with the Trust's own results from previous years.

Examples

Figure 1:

This diagram shows the Access download. For this document some of the columns of data have been hidden.



A Guide to programme budgeting at hospital trusts

Figure 2:

This diagram shows the Excel file where the Access information was copied. Columns with irrelevant information for the Programme Budgeting exercise have been hidden. The 'purchaser' column shows the PCT code, the 'PBC' column shows the Programme Budgeting code and the 'Price' column shows the Trust's HRG cost. The tabs at the bottom of the spreadsheet show that separate worksheets were created for each PCT. The worksheet labelled 'Other' contains the activity and the costs for those PCTs that did not require a return. The 'Summary' worksheet is used to consolidate all of the returns on to one worksheet, which helps with the reconciliation process. The pivot table in columns 'AH' and 'AI' shows the Programme Budgeting categories and expenditure.

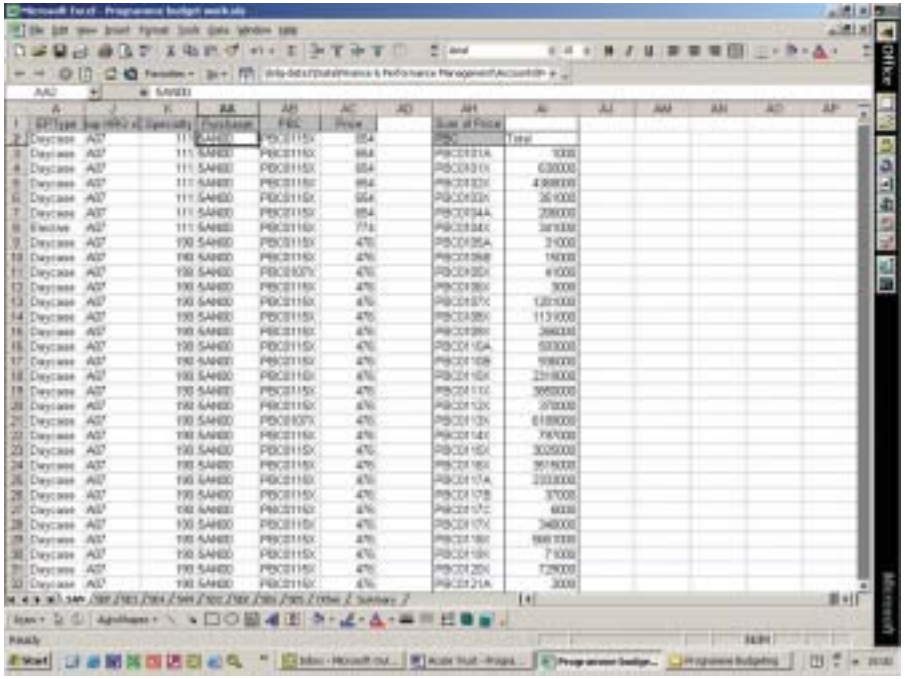
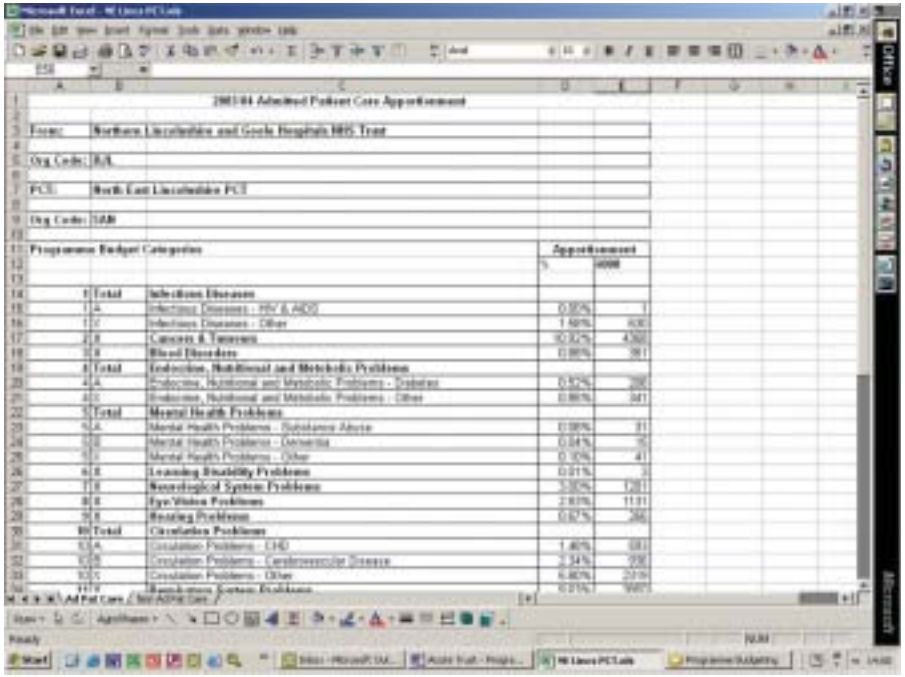


Figure 3:

This diagram shows an example return made by Northern Lincolnshire and Goole Hospitals NHS Trust. The tabs at the bottom of the spreadsheet show that the 'Admitted Patient Care' and 'Non-Admitted Patient Care' were submitted on separate worksheets.



A guide to programme budgeting at primary care trusts (PCTs)

Introduction

The aim of the Programme Budgeting process from a PCT perspective is to provide a breakdown of how it spends its total allocation across the 23 Programme Budgeting category headings.

This does not mean that the PCT has to establish new large, complex systems to record every item of expenditure to enable it to be allocated to the appropriate heading. It merely means that for the majority of its expenditure, the PCT will have to collate information provided to it by other bodies. It is therefore important for a PCT to identify where its information sources are at the start of the process so that it can concentrate on those areas where internal analysis will be required.

Completion of the Programme Budgeting Return for PCTs

While the Programme Budgeting return details PCT expenditure across the Programme Budgeting categories it should not be seen as purely a financial return. It is therefore important to involve as many people as possible in the process, both in the allocation of the expenditure across the 23 categories prior to the submission, and also in taking forward any investigative work following the publication of the national results.

PCT Checklist - you will need the following:

- Timetable of key dates (published annually)
- PCT's ASFs from Annual Accounts (plus Trial Balance, other supporting documents to the ASFs)
- Listing of providers from whom information will need to be requested including the contact details of the Programme Budgeting leads
- Listing of all host / lead commissioning arrangements including services/ providers covered
- Listing of key individuals within the PCT with whom discussion about apportionment of costs may be required - for example, commissioners, budget holders etc
- Blank copies of the Programme Budgeting returns, preferably in an Excel file so that the cells can be populated as and when the information becomes available
- Computer including CD and large screen monitor.

From a PCT perspective the net operating cost identified within the Programme Budgeting return should balance to the net operating costs figure reported in the annual accounts - ASF01 Main Code 01 Sub Code 200. This therefore forms the control total.

Much of the information used to populate the PCT returns is received from external sources such as providers and the Prescription Pricing Authority or can be directly allocated from the PCT's annual accounts as prescribed within the guidance.

It is therefore useful to start by allocating those costs taken from the ASFs that are directly attributable to a Programme Budgeting category. A spreadsheet could be used to set out the ASF information to be allocated and detail whether the expenditure can be directly attributed to a Programme Budgeting category or whether further analysis is required.

This spreadsheet will then also form part of the audit trail and procedure note giving details of where all the information used has been obtained.

An example of information contained within an audit trail spreadsheet is shown below:

ASF08	Sub Code	Directly attributable	Further analysis
G/PMS, APMS and PCTMS	100	Yes - Programme Budgeting Category 23	
Prescribing Costs	110	Further analysis required	Apportionment %s to be provided by PPA

Allocation of Secondary Healthcare Expenditure

With regard to the purchase of healthcare, it is a PCT's responsibility to request a Programme Budgeting breakdown (admitted patient care and non-admitted patient care reports) from its providers. It is therefore important to identify from whom such reports will be required. To do this it is worthwhile listing all the relevant providers in order of value - this will enable you

to identify those providers that you need to contact to request programme budgeting information from and those that you do not. Current guidance states that at least 70% of a PCT's secondary healthcare expenditure should be directly allocated via submissions from providers. By listing your providers in value order you can easily identify how many providers you will need to request the information from.

Where your PCT either purchases services via a consortia or through a lead commissioning arrangement you will need to have dialogue with the relevant Programme Budgeting leads within the other organisation(s) to determine who is to request the information from the providers to feed into the PCT submission. Where your PCT acts as a lead commissioner you will need to work with the other commissioning organisations and the service provider to ensure that the information is made available to feed into each commissioner's return within the required timescales.

It is important to meet with the PCT's commissioners of secondary healthcare services as they will have detailed knowledge of the services purchased and from whom. This will enable a number of specialist service providers to be identified and the costs of purchasing those services to be directly allocated to the Programme Budgeting category. For instance expenditure with the provider The Royal Marsden, London can be directly allocated to Programme Budgeting category 2, Cancers and Tumours.

Allocation of Community Services Expenditure

The guidance acknowledges that for a number of community services, robust activity data that enables attribution of cost to Programme Budgeting categories may not be available.

Where community services are provided directly by the PCT it is worth in the first instance speaking to the PCT's information service to determine exactly what information is available and whether any of it could be used to inform the allocation of costs. Where the information does not support the allocation of costs you will need to speak to the service leads to get an understanding of the types of work undertaken by the staff groups and determine the best method for determining how the expenditure should be allocated.

The guidance suggests using sampling techniques to try to get a feel for the percentage of work carried out on a routine basis to then inform the apportionment. You should involve service leads in determining the most effective method of sampling for that staff group. There is no point in setting up a comprehensive questionnaire that needs to be completed if the staff group concerned is unlikely to use it.

Allocation of Other Expenditure - Directly Attributable

There will be a number of other items of expenditure that relate either to services that the PCT directly provides or commissions from non healthcare providers which can be directly attributed to a Programme Budgeting category. For instance, where a PCT has a drug action service the costs associated with this service can be directly attributed to programme budgeting category 5 sub category A - Mental Health Problems, substance misuse.

Such items of expenditure should be discussed with the relevant budget holder to determine the most appropriate programme budgeting category or split across a number of programme budgeting categories.

Allocation of Other Expenditure - Central Management/Administration Costs

For central management costs - such as commissioning and public health - the costs should be discussed with the relevant budget holder to determine the most appropriate basis for allocation / apportionment. It may be that some staff costs can be directly attributed to a programme budgeting category given the specialist nature of the post. For instance a dental practitioner commissioner would have their costs attributed to programme budgeting category 12 - Dental Problems. Others will work across a range of programme budgeting categories and so will need to be apportioned across that range. For instance mental health and learning disability commissioners will have their costs apportioned across Programme Budgeting categories 5 and 6. However, the proportion of time spent by that individual may not be directly related to the value of the commissioned services so it is worth checking this out directly with that individual.

For those central management costs where the expenditure split across Programme Budgeting categories cannot be easily identified, a suitable basis of apportionment will need

to be agreed. For other commissioning costs, the split may be based on the same percentages as the returns made by the providers. Finance costs may initially be apportioned using the 99% rule.

Throughout the guidance reference is made to materiality. This does not mean that because an item of expenditure is small it should merely be apportioned using the 99% rule. If it is easy to identify which Programme Budgeting category the item should go to then it should be directly attributed to that category or categories. However, where an item of expenditure is deemed not to be material and does not obviously link to a programme budgeting category or categories then for that year's return the item should be apportioned using the 99% rule.

During the completion of the Programme Budgeting return, it is therefore worthwhile keeping a listing of all costs where it is felt that the basis of the apportionment could be improved; those costs which have been apportioned using the 99% rule; and those costs that have been allocated to programme budgeting category 23 - Other.

This will then highlight areas where further work may be required in-year either to improve the quality of the reporting information, establish more robust sampling techniques, or obtain a greater understanding of the expenditure from those most closely involved with it. In that way the PCT can ensure that it is making every effort to improve the quality and therefore meaningfulness of the Programme Budgeting Return on a year-on-year basis.

Future Issues for Programme Budgeting

Practice-Based Commissioning

With the devolution of commissioning responsibility down to practice level through practice-based commissioning there may be a need / requirement to break down the Programme Budgeting return to practice level so that it can be incorporated into their strategic decision making.

Also with practice-based commissioning it is likely that alternative approaches will be

established to provide services for specific client groups. It will therefore be necessary to work with the practices to ensure that the services set up have appropriate recording systems in place that will enable the expenditure to be allocated to the appropriate Programme Budgeting category.

Increased Usage of the Independent Sector and Choice

To ensure greater plurality and choice for patients it is likely that over the coming years PCTs will purchase much more activity from the private sector. This expenditure will need to be analysed across the Programme Budgeting categories. Private sector providers are not currently bound by the same rules and reporting requirements as NHS hospital Trusts, so PCTs will need to identify ways of ensuring that the expenditure that takes place with these providers can be analysed appropriately.

Under Choose and Book, patients will have much more choice over the type of care they receive and where that care takes place. This may have a significant impact on current patient flows which could in turn result in a significant change in the number and value of service level agreements that a PCT has. This will need to be taken into account when determining the number of providers that must be contacted to request the admitted and non-admitted patient care reports. The commissioning team will need to be involved in this process.

Exploring the Results of Programme Budgeting

It is important in the early years of Programme Budgeting that the information generated is used cautiously given the lack of robust information systems to enable accurate allocation of costs to the Programme Budgeting categories both locally and nationally. However, it is important that the results of the Programme Budgeting return are shared widely within the PCT to prompt discussion and further analysis.

On page 22 there is a table which shows a comparison of the PCT's published information against that of its cluster group of PCTs, the average of its host SHA and the national average. This gives the spend per 100,000 population to enable direct comparisons to take place

A guide to programme budgeting at primary care trusts (PCTs)

without the population size distorting the analysis.

By presenting an analysis of the information in this tabular form it is very easy for the PCT to see exactly how its expenditure across the Programme Budgeting categories compares to that of others.

While this analysis enables the PCT to identify variations from the cluster group, host SHA and national averages it does not provide any answers as to why, and whether that variation is good, bad, or as expected taking into account the particular needs of its local population. It is therefore important that this information is discussed with relevant individuals within the PCT such as public health colleagues to determine whether there are any local factors that need to be taken into account when the results are reviewed.

Where there are significant variations from the averages that cannot be explained through local knowledge of the services provided and the population served, the source data for the return will need to be reviewed to determine whether the information used is robust for the PCT and also whether it is likely to be robust at a cluster / national level.

Where the information contained within the Programme Budgeting analysis is found to be reliable then it, together with service reviews should be incorporated into the PCT's commissioning strategy when assessing future need and investment decisions.

PCT Comparison of Expenditure by Programme Budgeting Category using 2003/04 Submitted Data (opposite).

Programme Budget Category	Spend per 100,000 Population					
	PCT	Cluster Maximum	Cluster Minimum	Cluster Average	Host SHA Average	National Average
	£	£	£	£	£	£
1 Infectious Diseases	1,576,110	1,947,997	902,596	1,356,053	1,586,550	1,786,473
2 Cancers & Tumours	6,696,936	8,073,108	3,895,161	5,817,225	6,458,875	6,452,833
3 Blood Disorders	1,576,724	2,121,148	560,242	1,200,929	1,181,321	1,402,867
4 Endocrine, Nutritional and Metabolic Problems	3,353,987	3,602,584	2,061,444	2,728,194	3,233,792	2,873,546
5 Mental Health Problems	9,689,706	16,849,274	6,628,479	10,977,020	11,623,954	13,244,492
6 Learning Disability Problems	2,152,587	7,818,083	334,013	3,608,144	2,852,892	3,764,900
7 Neurological System Problems	2,120,696	4,653,692	1,243,898	2,803,776	3,215,445	2,963,555
8 Eye/Vision Problems	3,228,267	3,228,267	1,700,754	2,444,354	2,794,128	2,446,295
9 Hearing Problems	635,350	981,602	352,661	581,625	523,421	569,837
10 Circulation Problems (CHD)	11,104,526	13,021,604	8,709,278	10,972,355	11,679,461	10,936,329
11 Respiratory System Problems	4,727,718	8,083,119	3,946,926	5,709,991	5,802,438	5,423,048
12 Dental Problems	1,507,424	4,032,200	245,488	1,066,940	1,097,496	1,069,678
13 Gastro Intestinal System Problems	6,612,304	9,406,702	4,179,892	6,796,695	7,017,129	6,312,549
14 Skin Problems	1,941,008	2,998,297	1,679,109	2,067,621	2,105,385	2,083,144
15 Musculo Skeletal System Problems (excludes Trauma)	6,376,194	9,822,204	4,394,762	6,447,034	6,512,121	6,092,928
16 Trauma & Injuries (includes burns)	7,764,030	7,764,030	3,875,853	5,735,071	6,437,071	6,187,586
17 Genito Urinary System Disorders (except infertility)	4,611,809	6,483,741	3,017,129	4,841,591	5,306,537	5,497,080
18 Maternity & Reproductive Health	6,354,117	7,877,387	2,595,250	5,147,580	4,958,675	5,196,781
19 Neonate Conditions	1,571,204	1,571,204	80,142	921,357	951,717	1,166,026
20 Poisoning	672,147	1,511,338	533,182	989,560	937,625	961,355
21 Healthy Individuals	1,177,483	3,306,790	-74,441	1,663,761	2,031,398	2,018,582
22 Social Care Needs	1,256,595	6,725,488	135,793	1,808,214	4,455,462	2,468,794
23 Other Areas of Spend/Conditions	13,016,709	20,820,492	9,273,586	12,501,201	12,396,589	13,606,278
24 Total	99,723,632	109,362,020	89,855,048	98,186,293	105,159,484	104,524,957

Cluster Group: Mining and Manufacturing*Manufacturing Towns*Manufacturing Towns-A

A guide to programme budgeting at health authorities

Introduction

Strategic Health Authorities' (SHAs') role in Programme Budgeting is twofold. They need to analyse their own costs to contribute to the national exercise. However, they also have a role in managing the process in their patch and making sense of the results. These different roles are both considered in this section.

Completion of the Programme Budgeting Returns for SHAs

SHAs are required to join in the Programme Budgeting exercise each year. Like PCTs, they are expected to allocate all the expenditure from their annual accounts across the 23 Programme Budgeting categories. However, the nature of work at SHAs means that there is very little expenditure that can be directly allocated to clinical services.

SHA Checklist - you will need the following:

- Blank copies of the Programme Budgeting returns, preferably in an Excel file so that the cells can be populated as and when the information becomes available
- A copy of your most recent HAA draft accounts
- A copy of your own internal budgets (to be reviewed when you try and allocate costs directly to Programme Budgeting categories)
- Knowledge of deadlines - be aware of the deadlines of all the organisations and when you will need information from other people.

Responsibility for some national services is given to specific SHAs, so local SHAs may have some expenditure that is unique to them. With this in mind, SHA staff should take time to look closely at what actually happens in the SHA and decide if there is local information that can match their expenditure to Programme Budgeting categories. Examples of apportionment bases might be:

- Clinical staff numbers supported by SHA staff
- The value of budgets monitored by the authority in each Programme Budgeting category
- Identifying some Programme Budgeting categories which are not supported by some SHA expenditure (and so can be excluded from the apportionments), therefore targeting expenditure better.

If there is no valid information then it is worth asking managers what could be collected in future.

The remainder of this section sets out the current requirements of Programme Budgeting for SHAs. Given that it is straightforward to follow the DoH guidance, SHAs should look to see if they can go beyond the minimum requirements by using their understanding of the services they provide. Some suggestions of potential areas for development in the apportionment bases used by SHAs are also discussed.

SHA finance staff are fortunate that, for Programme Budgeting at least, the requirements to complete the DoH return are not difficult.

The key steps are given below.

Control total

- Once final accounts are complete, start with the total expenditure shown on HAA 01.
- The gross expenditure total in the first column comes from HAA01 Main Code 01 Sub Code 120.
- The total for the income column comes from HAA01 Main Code 01 Sub Code 150.
- The net of these two figures will match HAA01 Main Code 01 Sub Code 200 which is the control total for the net operating costs in the final column on the Programme Budgeting return.

Analysis of the control total

- The only requirement is to enter workforce development confederation (WDC) expenditure against category 23b (Other).
- The total for WDC expenditure comes from HAA06 Main Code 07 Sub Code 265 in the accounts. This is the national approach - there is no discretion.
- All other expenditure should be apportioned on the basis of local knowledge, but can be entered as category 23 'Other' against the heading 'Strategic Health Authority (Unallocated Programmes)'.

A guide to programme budgeting at health authorities

At this point, you could stop and send in the return. However, the following sections suggest opportunities to make the process more relevant and ultimately more accurate.

Further Analysis of SHA Budgets

A close look at budgets could identify many ways to avoid allocating all costs and income to 'other'. For example:

- Are there any direct matches with the Programme Budgeting categories? For example, South Yorkshire SHA has the national budget for Dental SIFT, so this can be directly allocated to category 12, Dental. Other SHAs may have staff that lead on dental training and so their costs could be apportioned accordingly.
- Many SHAs may have departments whose work relates wholly or partly to cancer, or chronic diseases such as coronary or respiratory problems which also appear in the Programme Budgeting analysis.
- Staff involved solely or mainly on capital projects could allocate their salary costs according to that year's capital programme.
- Medical SIFT. The numbers of junior doctors in each specialty are well known by hospitals. Either the cost of the posts or the whole time equivalents would be a reliable method for apportioning Medical SIFT.
- Some budgets could be reviewed to see if they can be weighted sensibly. For example, public health may have a weighting towards category 21, Healthy Individuals. Strategy leads for certain clinical areas could be apportioned in relation to their workload. For example, some staff may lead on mental health and so could be allocated to category 5, Mental Health Problems.

Any figures that you identify on budgets for direct allocation will of course need an uplift for overheads before being entered on the Programme Budgeting return.

Future Issues for Programme Budgeting

In the same way as we suggested an apportionment approach for Medical SIFT, there may be information available now in the health community for allocating NMET (Non Medical Education and Training) and MADEL (Medical and Dental Education Levy).

Consider how you might apportion workforce development expenditure. You are not allowed to do this under the current guidance, but it would help to be 'ahead of the game' and be ready to respond when more detail is asked for from Programme Budgeting. Much of the training will relate to specific areas. There should be scope for reviewing activity data from the WDC in preparation for an apportionment of these costs in future.

National Programme for IT. These costs may need separate identification in future developments of Programme Budgeting for SHAs. Does your coding structure allow you to identify these separately?

Exploring the Results of Programme Budgeting

As with all finance work, clear working papers are important so that you can justify your figures. You should be able to explain all the entries on the Programme Budgeting return via an audit trail back to either your HAA draft accounts, or to another source such as your budget statements.

For reasonableness, you could compare your results with neighbouring SHAs or with your own results from the previous year. Ideally, you should do this before submission so that any errors that you spot can be corrected.

Activities for SHA leads

Managing the Process - Roles, Responsibilities and Good Practice for SHA Leads

As well as going through the process of apportioning their own costs to the national Programme Budgeting figures, SHAs have a different role in analysing the outcomes of the

exercise. Programme Budgeting policy leads need to look at local figures compared with national averages. They need to understand the reasons for cost variations and promote the use of the results in commissioning decisions.

The managing SHA will have an identified lead member of staff to manage the Programme Budgeting submission each year. Basically the role is twofold:

- To performance manage the process so that organisations meet national timetables and requirements and to look to raise the overall standard of returns
- To act as a communication conduit to/from DoH and NHS Trusts/PCTs, thus supporting local organisations.

The process includes Foundation Trusts, so they will receive the same information and support from the SHA as other Trusts. Action taken by SHA leads could include:

- Producing and maintaining a list of Programme Budgeting contacts in each organisation
- Publicising the timetable
- Monitoring achievement of key milestones in the submission
- Circulating information and best practice guidelines
- Encouraging improvement in the accuracy of Programme Budgeting. For example, collecting sample data from community services for use as an apportionment basis.

SHAs should also consider how to develop the methodology as a whole. Are there new sources of information available to apportion costs?

For example, the non-admitted patient care report from a provider is not tailored to individual PCTs. There may be local information which allows PCTs to work with providers

and make these reports more relevant to individual PCTs.

There may be scope to compare admitted patient care and non-admitted patient care reports from Trusts for validation purposes. The results could be compared to the previous year, from one Trust to another or checked against reference costs information.

Systems such as the Quality Management and Analysis System (QMAS) could provide opportunities for apportioning GMS/PMS costs which currently are recorded on one line. SHAs should work with their own organisations and the DoH to promote improvements of this sort.

Interpreting the Results of Programme Budgeting across the SHA

The whole Programme Budgeting exercise focuses on financial inputs to local health services. To help explain and evaluate these investments we need:

- Measures of the need for the investments
- Measures of health improvements created by the investments.

This is an area for development. There is no formal process to produce exact requirements for investment in different areas of healthcare. The actual spend is dependent upon many factors such as underlying need, government targets, emergency activity arising in the year and historical patterns of investment.

SHAs can start to investigate the links between need and investment using information in the Exposition Book. Some of the data used in the calculation of weighted capitations can be matched with the Programme Budgeting categories. Examples from the appendices are summarised in the table on page 29.

Programme Budgeting category	Need indices available on table 5.6 of the 2003/04 Exposition Book
5, Mental Health problems	Mental Health need
18, Maternity and Reproductive Health, 19, Neonate conditions	Low birth weight
10, Circulation problems	Circulatory morbidity index
15, Musculo skeletal problems	Musculo skeletal morbidity index
7, Neurological system problems	Nervous system morbidity index

Other examples of indicators of health need that might be considered:

+ For all Programme Budgeting categories
  - Total waiting lists
  - Morbidity and mortality in the local community
  - Admission rates to hospital via HES data
  - Records about the incidence of certain diseases
+ For Maternity, number of ventilation and CPAP days per 1000 births
+ For Infectious Diseases, the prevalence of notifiable diseases.

Public Health should have this kind of information. By plotting Programme Budgeting expenditure against measures of need for each PCT, differences in the investments by each PCT can either be explained or challenged. Similarly, the efficiency of investments could be explored in some specialties by comparing the value of expenditure each year against the total activity performed.

As the accuracy of Programme Budgeting develops, the relevance of the need indicators will become more important. Eventually we will want indicators of need that match the activity underpinning the expenditure. Some of the indicators above will have a good correlation

with the Programme Budgeting category, but will not be a 100% match.

SHAs should be encouraged to match expenditure with measures of both activity and need in order to challenge the figures produced, to help validate the process and to show that Programme Budgeting is increasingly relevant to colleagues outside finance.

Case study

Various projects have begun around the country to show how Programme Budgeting can be used. They can be found at the Programme Budgeting website (web link given below).

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/FinanceArticle/fs/en?CONTENT_ID=4071362&chk=p9umg8

One of the examples is attached as 'Case Study 1' for information.

Case Study 1
Organisation: South East Sheffield PCT
Population: 160,000
Budget: £205m

Services provided: District nursing and health visiting. City-wide provider for community dental services, sexual health, asylum seekers health service and some specialised nursing services.

Background

South East Sheffield PCT was established on 1 April 2001.

The PCT commissions the majority of its services from providers using service agreements and legally binding contracts based primarily on the previous year's baseline. New money is added to achieve specific access and waiting time targets. The PCT, however, has now begun to question whether this incremental approach to commissioning is actually securing the maximum health gain for local residents from the available resources. In particular it is concerned that rolling over the service agreements makes it difficult for them to:

- Identify and remove any inefficiencies in the use of resources
- Make changes to patterns of service delivery
- Ensure that the pattern of expenditure is appropriate for health needs of the population.

Another concern is whether the existing commissioning process will satisfactorily support the implementation and management of new initiatives such as Patient Choice, the new general medical services contract and Payment by Results. Although these initiatives are still at fairly early stages of implementation, the PCT has identified them as providing opportunities as well as potential risks and wants to put in place sound strategies for managing them.

An Alternative Commissioning Model
In May 2003, the commissioning department proposed a new planning and commissioning model that was designed to better match service investment to health need.

A Health Care Strategy Group, consisting of senior managers and clinicians, would undertake a review of health care need based on known factors, such as morbidity and mortality, and expected developments (including NICE pronouncements and national service frameworks) over the next three years. A zero-based budget would then be built up for each clinical area (cancer, heart disease etc) for primary, secondary and tertiary care. Wherever possible this would be based on the national HRG tariff. At the same time, an assessment of current expenditure patterns across each of the clinical areas would be undertaken.

The healthcare budget for each clinical area would then be 'devolved' to clinical planning groups. Each group would be charged with examining any differences between current expenditure patterns and the zero-based budget. Where current expenditure exceeds budget the group would be tasked with identifying alternative models of service provision and demand management strategies to reduce expenditure to the budgeted level.

Where expenditure was below budget, the group would have to determine whether this was due to unmet need which required expansion of services, or due to cost effective service provision which released funding for other areas.

The Health Care Strategy Group would review the findings and, where there were likely to be significant shifts in resources from one clinical area to another, would consider and consult on the impact on patients and staff before developing a change strategy.

Case study

Based on the agreed strategy, each service planning group would then develop a detailed programme of work to implement the required changes in health care provision within the 'devolved' budget. They would then be responsible for performance managing service delivery within their clinical area and for submitting regular progress reports to the Health Care Strategy Group.

The benefits of this new commissioning model would include:

- Service planning and provision based on need rather than demand
- Agreed long term objectives
- Clear decision making processes with teams based around care pathways rather than organisations
- Alignment of budgets with responsibility for service design and performance management.

Why was the plan not implemented?

The proposed new commissioning model was well received but, to date, has not been implemented due to the lack of available finance information. At present there is little available information on how much is spent in each clinical area across primary, secondary and tertiary care and so it is not possible to even start on the first phase of the new model.

The roll out of programme budgeting, however, will make this information available and South East Sheffield PCT will be making good use of the results to improve the commissioning process.

How will the programme budget information used?

The PCT plans to develop two maps. The first map, using data on morbidity and mortality will show the relative health needs of the local population. The second map, using data from the Programme Budgeting exercise, will analyse expenditure by clinical programme across primary, secondary and tertiary care. These two maps will then be considered in two ways.

Firstly the map of health need will be compared with the map of expenditure to identify whether current investment patterns seem appropriate. Questions will be asked about whether investment is targeted in the most appropriate clinical areas and whether it is in the right sector, for instance secondary rather than primary care.

Secondly the expenditure patterns of Sheffield South East PCT, taking account of relative health needs, will be compared with that of similar PCTs and with the national average. Where the PCT has a higher than average health need, this should be reflected by higher than average relative investment.

This cannot be undertaken in a completely objective way, because of the difficulties in comparing, for example, the need for orthopaedic services with the need for coronary heart disease services. Nevertheless, it should be possible to assess whether the pattern of investment is appropriate.

In the longer term the PCT will use the Programme Budgeting information to compare changes over time, both locally and nationally.

Who will use the programme budget information?

The Programme Budgeting information will be used by all staff to support the commissioning process but will be particularly welcomed by staff working in public health. The data on spending patterns will, for the first time, enable the public health department directly to influence patterns of investment by linking epidemiological information to commissioning and service investment. In particular, where patients are not presenting to their GP, the routine contract monitoring and waiting time information will not flag up a problem, but above average mortality will suggest the need for more investment in health promotion, screening and risk assessment. A better understanding of these types of issues will enable South East Sheffield PCT to tailor its future investments to those areas where it will deliver maximum health benefit.

For further information contact: Chris Ratcliffe, Deputy Director of Commissioning
Tel 0114 226 2424 Email chris.ratcliffe@sheffieldse-pct.nhs.uk

35

Glossary of terms

Abbreviation	Description
SHA	Strategic Health Authority
PCT	Primary Care Trust
WDC	Workforce Development Confederation
WTE	Whole time equivalents: the hours worked by a full time employee
NMET	Non Medical Education and Training: funding for training clinical staff other than doctors
MADEL	Medical and Dental Education Levy to fund specific training for doctors and dentists
GMS	General Medical Services
PMS	Personal Medical Services
QMAS	Quality Management and Analysis System. This is the software that is used to monitor the Quality and Outcomes Framework (QoF)
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
SIFT	Service Increment for Teaching: a payment recognising the input of consultant time to teach junior doctors

Draft account forms by NHS organisation

HAA	'Health Authority Accounts', Strategic Health Authority draft account forms
TAC	'Trust Accounts', draft account forms
ASF	'Accounts Summarisation Forms', PCT draft account forms

Published by the Healthcare Financial Management Association (HFMA)
Suite 32 Albert House 111 Victoria Street Bristol BS1 6AX

Tel (44) 0117 929 4789 Fax (44) 0117 929 4844 E-mail info@hfma.org.uk

This guide has been developed by the Yorkshire branch of the HFMA. The authors were Helen Kenyon, Assistant Director of Finance, North East Lincolnshire Primary Care Trust, Damian Kitchen, Performance Reporting Accountant, Northern Lincolnshire and Goole Hospitals NHS Trust and Steve Quint, Senior Finance Manager, South Yorkshire Strategic Health Authority.

Cover design was undertaken by Mark Foster.

We are keen to obtain feedback on ways in which the content, style and layout can be improved to better meet the needs of its users. Please forward your comments to technical.dept@hfma.org.uk or to the address above.

ISBN 1-904624-20-0