

# A method for assessing the effectiveness of NHS budgeting and its application to a NHS Foundation Trust

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## Key findings:

- Senior doctors should be accountable in managerial and financial roles to enable robust strategic and operational planning and control to be optimised.
- Clear lines of accountability and authority for the budgeting and the service line reporting (SLR) systems – as well as understanding of the relevant roles – are essential requirements for organisational control both operationally and strategically.
- SLR should be the basis for strategic decisions and as a guide to strategy development.
- NHS trusts and foundation trusts require a coherent strategy – implemented throughout the organisation – for survival in a time of funding austerity.
- The checklist for effectiveness of budgeting systems, developed from the findings of this report, to be used to examine the adequacy of financial control mechanisms within provider healthcare organisations.

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## Introduction and objectives of the study

This report examines the complex nature of budgetary and associated financial systems, particularly SLR in NHS provider units. The relationship between these two systems and the issues that arise from their joint use are explored in the context of the research questions posed. NHS Trusts (NHSTs) are multifunction organisations made more complex by political issues in and outside of the organisation, which are influential to the findings of this study.

The objectives of the study were as follows:

- Determine the appropriateness of the current budgetary arrangements in the Trust and identify generic issues for other organisations.
- Identify the appropriateness of delegation of budget authority.
- Examine the lines of responsibility and accountability for resources.
- Explore the role of strategy in the budget process and the allocation of resources.
- Explore the role of SLR in conjunction with budgeting.
- Examine budget and managerial structures.
- Identify the role of the budgeting system in promoting improved operational performance in the organisation.
- Identify key behavioural issues.

NHS Foundation Trusts (NHSFTs) differ from NHSTs in having additional financial freedoms and their accountability is outside of the NHS management structure and is dealt with by monitor – a regulatory body directly accountable to parliament. This project involved an in-depth study of one NHSFT. However, both NHSTs and NHSFTs operate systems of budgeting which have broadly similar characteristics. Addressing the above objectives in one NHSFT will enable a judgement to be made about the criteria for judging overall effectiveness and utility of budgeting systems for both types of organisation in relation to the three criteria identified below. Thus for the remainder of this report, any comments made about NHSFTs can be regarded as applicable to NHSTs unless otherwise stated.

Management control systems, particularly budgeting provide more than a mere method of financial control and should have the following objectives illustrated below and subsequently discussed in respect of a framework for the analysis of this study:

**Strategy implementation** – The magnitude of the financial challenges faced by the NHS coupled with the changes in commissioning arrangements suggests there is an imperative for a much stronger emphasis on the development and

implementation of financially robust strategies. This puts a focus on strategic performance improvement. We would suggest comparisons with practices in the private sector where the pressures of globalisation have led to a focus on what is termed strategic cost management (Hoque, 2006). This implies a focus on strategic routes to cost improvement.

Such changes will demand innovations in practice and responsibilities, will be complex and often difficult to implement because of resistance from many quarters. These improvements will usually require significant organisational changes and the support and engagement of a senior doctor will be vital. Senior doctors will have key roles in facilitating the success or otherwise of such strategic initiatives and therefore it is key they are fully engaged in the process.

The budgeting system should be one of the key mechanisms by means of which the longer term strategy of the organisation is implemented. Changes to the budgets of the organisation should reflect the longer term resource trends identified within the strategy.

**Control and empowerment** – The budgeting system should be an instrument of effective managerial control but at the same time, should facilitate an appropriate degree of empowerment among NHS staff and managers. Such empowerment will facilitate decisions being taken nearer the point of action – e.g. the patient – and in the right circumstances, should result in better and quicker decisions. However, there are sometimes problems in doing this.

Firstly, the financial systems of the organisation may find it difficult to provide the information necessary for a much larger pool of budget holders. Secondly, it is not clear as to what the factors are that might facilitate the engagement of health professionals – especially senior doctors – in budgeting systems or the factors which deter them.

Furthermore, even where there is a degree of interest and willingness, it is not clear what is the capacity and capability of health professionals to have such involvement. Also, to what extent they have the necessary knowledge and capabilities to discharge that role effectively.

**Performance improvement** – The budgeting system should be a key driver of continuous performance improvement in the organisation. In order for performance to improve, budgets must be set within the organisation in a manner which is rational and transparent, and adequate feedback on financial performance is provided. In our view, while there will always be a place for operational cost improvement – doing the same things but at lower costs – it is possible that such a focus will now provide diminishing returns. As noted above, the magnitude of the financial challenges faced by the NHS suggests there is an imperative for a focus on strategic cost improvement – doing



things differently to improve outcomes at lower cost. The SLR initiative should also have a key role here (Harradine and Prowle, forthcoming).

We suggest it is against these three criteria that the effectiveness of a modern budgeting system should be judged. In recent years, NHSTs have gone through many changes and faced many challenges. An effective budgeting system will help Trusts deal with these challenges but it is not clear how effective Trust budgeting systems are in practice.

### Contextual background of the study

Financial control in the UK National Health Service (NHS) is currently at the forefront of political debate with regard to the financial regime proposed by the current coalition government. They state that providing much of the budget for the NHS to General Practitioners (GPs) means they can purchase and therefore provide the funding for those organisations providing the healthcare within a market environment. This fundamental change in the funding mechanism in a market environment, along with a cost reduction target for the NHS over the next four years of approximately £20b will require tight financial control in NHS Trusts to secure their long-term survival. It is against this background of necessity for financial control in these organisations that this study is contextualised.

Budgeting systems are a key component of financial management in NHSFTs and NHSTs. Furthermore, in recent years the budgeting systems in most NHSFTs and many NHSTs, have been complimented by the introduction of SLR (Monitor, 2006, Harradine and Prowle, forthcoming). This promotes the examination of the financial contribution – the comparison of

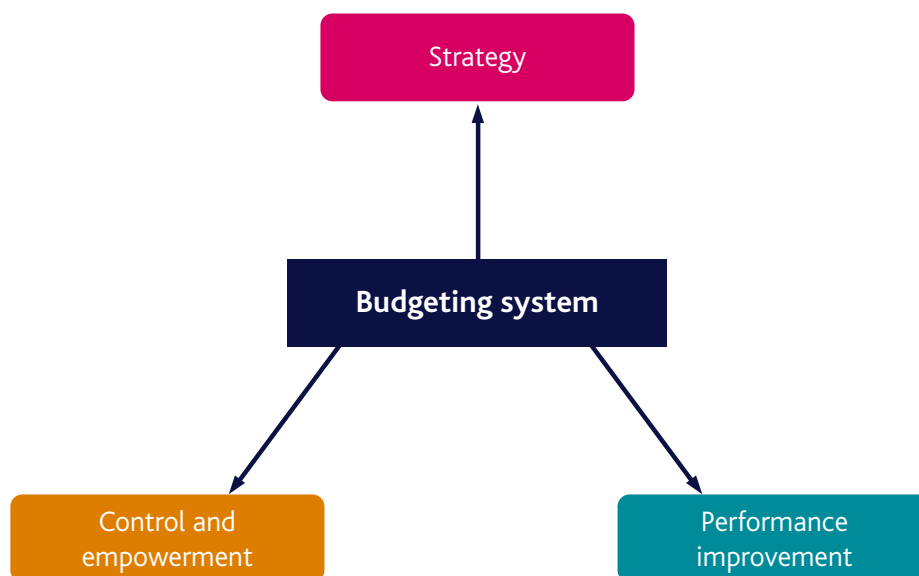
income with the associated costs – provided by different aspects of the services. SLR offers an alternative view of performance to that of the budgeting system, which is primarily cost control driven within healthcare organisations, by examining the relationship for a service of cost and income. However, we believe the findings of this study are applicable to all types of NHS provider units.

### Research description

The study has involved an in-depth study of one NHSFT which aimed to provide an understanding of the budgeting issues associated with such an organisation. This is so generalisations may be made to assist the development of a methodology for the evaluation of budgeting systems in other organisations.

The NHSFT examined was established as an NHS Trust in 2001 and subsequently became a foundation trust during early 2007. It has a turnover of £180m and employs some 3,000 staff. Its financial performance was considered to be good at the time of selection for this study and in most other respects the NHSFT appeared to have performed well.

The organisation is divided into four divisions – three clinical divisions and one support division. The three clinical divisions – clinical support services; emergency care and medicine; and planned care and surgery – are all accountable to the trust director of operations. Each of the divisions identified has its own director of operations, specific to that division. The service director and service managers are accountable to each division and the director of operations. In the majority of cases the service directors of the predominantly clinically based divisions were senior doctors.



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The study involved the following approach:

- A review of published literature on budgeting systems both in the NHS and in general.
- Review of appropriate documentation on the budgeting system of the pilot Trust.
- Interviews – this involved interviews with Trust middle and senior managers and senior doctors in a sample of clinical directorates. This has involved taking two vertical slices through the directorates and interviewing staff at each level in the organisation. Eighteen staff were interviewed, namely non-executive director with responsibility for financial control; chief executive; director of finance; six managers at different levels of the organisation; six members of the finance function; and three senior doctors with budgetary responsibilities.
- Budget holders were asked to complete a questionnaire.

Furthermore, between them the authors have more than fifty years practical experience of financial management in the NHS as well as related experience in other organisations in the UK and overseas.

## Findings

This section summarises the key findings from the study concentrating on the issues of budgeting within the organisation. In addition, there are a separate set of findings concerning the important issue of the involvement of doctors in budget management.

### The role of budgeting in the implementation of strategy

There were a number of findings here:

**Lack of strategy** – The NHSFT, although required to have clear strategic objectives – particularly those concerning financial performance – was found to be limited with regard to strategic planning at the appropriate levels of the organisation. Consequently, the implementation of any strategy incorporating the associated financial strategy was problematic. Many high level managers of the organisation were aware there was a lack of strategy and stated it was 'in the process of development'.

This lack of a coherent strategy caused issues with regard to the allocation of resources within the organisation. This is because it was based on previous expenditure patterns which were unlikely to reflect the strategic direction of the organisation. It was noted the lack of direction caused problems for budget holders who said they perceived this as an issue with regard to the planning for their services. In particular, when dealing with the cost improvement programmes (CIP), which imposed targets on the NHSFTs designed to elicit funding to be used for future developments.

**The timing of the study** – The last two months of 2010 – was a time of considerable uncertainty for managers in the NHS as the NHS's future had not yet been officially announced by the coalition government. It was known there would be a fundamental change in NHS structure and that funding would not be based on the degree of growth experienced in the previous ten years. However, details of the reform were not known. This degree of uncertainty may have been a contributory factor to the lack of clear strategy for the organisation. However, there was evidence this was an area of management that had been neglected for some time.

**Cost improvement** – This is a major strategic priority throughout the NHS. Many commentators have identified the savings expected from the NHS, for the period of the current parliament, are greater than historically achieved in any other healthcare system. The CIP for the NHSFT were – depending upon the service area – approximately 7% for the current year and it was stated by managers that similar amounts were expected for forthcoming years.

There were examples where managers had been approaching this significant issue on an annual basis and not as a long term programme of savings which would achieve the target over a number of years. There were examples where vacancies were being held to meet the saving target for the current year. However, the chief executive did indicate that in future years, there would be a more strategic approach to CIP based around long-term projects. All savings from the CIP were removed from budgets and contributed to achieving the NHSFT's overall targets. Other than achieving a break-even position on their budgets, there were no budgetary incentives for managers to perform to achieve these targets or indeed exceed them.

**Service line reporting (SLR)** – This has been an aspect of the accounting information used within the organisation for the past three years as a condition of becoming an NHSFT. The system provides information on the performance of service lines, which at the research site, were mainly clinical specialties as is the case for most organisations currently using the system. SLR provides financial information concerning the costs incurred by the specialty and the associated income. Therefore, the service line is able to demonstrate the degree to which a contribution is being made to the organisation in respect of its activities. For the first time in this particular organisation, it enabled an understanding of which specialties were making a positive or negative contribution.

The SLR information was provided to the service directors who were predominantly senior doctors and their associated management teams as well as the senior tiers of management within the organisation. There were several instances where managers and senior doctors who were responsible for the service line had little understanding of the content of the

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reports. Training had been provided at the inception of the system however, this would appear to not be adequate in certain cases.

However, strategically the main issue was that the reports were used as an adjunct to the budgeting system and the strategic value of the SLR was not universally recognised by their users. There was confusion as to their importance with regards to financial control and their status compared to that of the budgeting system. The SLR identifies the services that provide the greatest and least contribution from their activities and therefore provide information that can assist in developing and reducing services.

In the context of the current plans of the coalition government – concerning the growth of market mechanisms in the NHS where competition can and is likely to be based on price/cost – information on the contribution being made by services would strategically be of benefit to the organisation. One of the interesting observations from the study was the potential for conflict of the two systems. This is explored later in sections ‘Confusion as to the role of SLR’ and ‘Control issues of SLR.’

**Clinical involvement** – The involvement of senior doctors in budgeting and management is a long standing issue of debate in the NHS (Nugus et al., 2010, Lapsley, 2001). In the NHSFT, senior doctors holding managerial positions within the organisation, were only involved on an extremely limited basis in those strategic issues of the organisation concerning the contracting process. This is particularly an issue when dealing with the funding providers where the senior doctor’s expertise could and should be invaluable.

This particular point becomes increasingly important with the advent of much of the NHS budget (£80b annually) being at the disposal of the GPs to purchase healthcare services for their patients.

### Control mechanisms and the empowerment of staff

Key findings were as follows:

**Information flows** – The operational information provided to managers in the NHSFT was stated by the recipients to be of good quality. The use of a dashboard approach was considered by the research team to be impressive, when compared to other organisations regardless of sector. The control information under this system was provided to managers, usually a week after the end of the month for which it was represented. The information was provided in a variety of graphical formats and was stated by managers to be useful in the management of their services. The interviews and questionnaire data indicate a high degree of satisfaction with the performance of finance professionals within the organisation and the information provided.

**Lack of responsibility** – Considerable examples were identified

of managers being responsible for budgets for which they had little control. In some cases it was identified that the control processes in regards to authorising the filling of posts or purchasing equipment meant that managers had little authority over the majority of their responsible budgets. This was identified as an issue almost 30 years ago by one of the authors of this report and it is a concern that it is still the case today (Lapsley and Prowle, 1977).

**Level of budget holding** – Devolving budget holding in the organisation is a way of empowering staff at lower levels to make decisions in such a way that improves both the speed and quality of decision making. However, such devolvement must be done on the basis that effective financial control will not be compromised.

In the NHSFT being studied, budgets were still being held at a fairly high level and there is ongoing debate about the appropriateness of further devolution. This debate is to some degree compromised by the difficult financial environment facing the Trust in future years and the fear of losing financial control through greater devolvement.

**Conflicting duties** – It has long been recognised that managers within organisations have many competing priorities and duties and that the financial position of the organisation, or sub-unit, is therefore one amongst many others. This was a particularly acute observation at the NHSFT under review. The majority of senior managers interviewed who were representative of their colleagues, were from clinical backgrounds with clinical responsibilities within the organisation as well as their financial duties.

Many managers identified that there was potential for conflict when dealing with declining resources. Managers in every instance stated their clinical priorities were clearly more important than their financial responsibilities, although an appreciation was identified that finance was an important aspect of their role. One senior manager exemplified this point when she stated that the consequences were greater for a manager if there was a major clinical problem resulting in deaths compared to the repercussions of a major financial problem. This issue was compounded by a lack of understanding of the financial issues and the financial regime of the organisation. This was identified at all levels within the organisation.

**Confusion as to the role of SLR** – There was confusion with many budget holders as to the role of the SLR system. Managers stated they were not sure as to the monitoring system on which their financial performance was ultimately to be judged: the budgeting system or the SLR system? It was stated by most senior managers that it was the budgetary position which had predominance however there was not a clear understanding of this evidence at the operational levels of the organisation. In

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3 Verganti, R. (2009) *Design-driven innovation: changing the rules of competition by radically innovating what things mean*, Harvard Business School Press; and Christensen, CM., Raynor, ME. (2003) *The innovator’s solution: creating and sustaining successful growth*, Harvard Business School Press.

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some cases this caused confusion at the operational level as to which of the performance targets was to be achieved.

**Control issues of SLR** – The objective of this study was not to explore issues of SLR in depth however some observations regarding control are worthy of note. SLR offers an alternate approach to control within the organisation – potentially maximising contribution as opposed to the fixed budget approach used in most NHS organisations. The fixed budget approach offered the organisation a system which was simple and had been used within the organisation. It enabled a budget to be set that allowed the organisation to delegate responsibility to managers for areas and attempt to hold them to account. The budgeting system generally appeared to be understood by most managers within the organisation.

The SLR approach however, offered a different view of the financial performance of the organisation. In many cases this cut across the delegated authority of the budget holders and caused some confusion as to accountability as discussed above. The SLR also opened the debate concerning income: where the responsibility for increasing income was to reside and also where the benefit of income earned was to be assigned. This question offered an interesting decision for NHSFTs in terms of accountability for income and potentially the organisational structure that is required to deal with SLRs. This is likely to be different from the general functional approach found in most provider healthcare organisations.

The NHSFT in the study had devoted considerable resources to the development of the system for SLR in terms of cross-charging systems and methods of apportionment for some support services and overheads. Studies examining clinical/management budgeting and specialty costing found such approaches to be generally counter-productive in a health environment, particularly when dealing with senior doctors. This is because any failings in the information provided caused a lack of confidence in the system resulting in the approaches being abandoned at some stage. This is an issue that needs to be addressed by all NHSFT using SLR. However it must be noted, this was not an issue at the research site. It is suggested by the authors that this is only likely to occur when managers/senior doctors are held to account for SLRs and sanctions or reward for good performance are an issue.

## Performance improvement

The budgeting system and particularly the budget setting process provides an opportunity to improve operational performance in the NHSFT. The following findings emerged in this study.

- **Resource allocation and motivation** – The method of allocating resources between departments and activities caused motivational issues with regard to the fairness of the process. The budgets for service areas were based on the previous year's expenditure thereby perpetuating previous practices and doing little to address underlying funding or performance issues. This was recognised as a problem by senior finance staff but they stated the approach had been taken to reflect the 'reality' of the spending patterns and the approach would be reviewed in future years.
- **Comparative performance** – The authors found little evidence from this study that budget managers had any real perception of how well their services were performing – particularly in financial terms – in comparison with other NHS provider units or other types of relevant organisations. We saw no evidence of attempts to improve the unit costs of operational activities by comparing performance with other providers. There is considerable information available on comparative performance within the healthcare sector, however there was little evidence at the research site this was being used to gain a better understanding of the organisation's performance.
- **Workload budgeting** – It is common in many organisations for the budgets of a department to be flexible and for them to be varied each month according to changes in workload. While there are many departments in an NHSFT (e.g. pharmacy, pathology) where the level of workload is outside the control of the department itself and is subject to other forces, we saw no examples of such budgets being flexed accordingly. The lack of such an approach can reduce the degree of confidence in the budgeting system.
- **Financial reserves** – The NHSFT had considerable financial reserves which were held centrally. Operational budget holders interviewed said they knew of the existence of the organisation's reserves but not the size or their specified use. The majority of budget holders expressed the view that these reserves would be used to assist the organisation to reach its financial targets should they – the budget holders – overspend on their individual budgets and in total. This may or may not be true but clearly, the belief that it is true inhibits the attitude of budget holders to financial control. It also weakens the control aspect of the organisation's budgetary system and reduces the impetus to improve performance.

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4 Halberstam, D. (1987) *The Reckoning*, Bloomsbury Publishing Ltd, pp236.

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## The role of senior doctors in the budgetary process

The role of the senior doctors in the management and financial control of the organisation poses some interesting issues at the heart of the NHS and in the findings. Furthermore, this concerns the important staff group that are to be explored separately in this section. The position of those doctors in occupying service director's posts appeared to be particularly problematic and are discussed below.

**Accountability of service directors** – There was little clear understanding of the role of service director, particularly when the role was occupied by a senior doctor. These posts on all structure representations within the organisation appear to be the accountable post for particular services. However in practice, this did not appear to be the case. The issue is exemplified by the monthly monitoring meetings, usually chaired by the director of finance, to review the performance of particular services.

The managers from the service under review who attended these sessions would be the service managers. They would usually be accompanied by the accountant allocated to the particular service from the finance function, but never the service director – a position usually held by a senior doctor. These robust meetings explored the reasons for variances in terms of financial and non-financial performance.

This approach poses the problem for the organisation as to accountability and from discussions at all levels, it appeared there was no clear view as to who was accountable for the performance of a particular service. This is a significant issue for budgeting, considering it was a widely expressed view by most managers that medical staff had a considerable influence over how resources were used within the organisation. Yet when in the post of service director, they were not accountable for the service. This is regarded as a key issue examined in the study.

**Lack of engagement** – The engagement and degree of commitment of senior doctors to the management process – although based on a limited sample of senior doctors in the role of service director – differed significantly. This was due to several factors including:

- Limited time allowance for managerial duties.
- Financial rewards for managerial roles were negligible considering the earning capacity of senior doctors in their clinical role.
- The temporary nature of managerial roles – they usually last for four years before the senior doctor reverts back to full-time clinical duties.
- Cultural attitudes to management roles and managers by senior doctors.

The benefits of having doctors in management roles was exemplified by one service director who, owing to his understanding of the working practices of his colleagues, said that he was able to make savings within his clinical specialty of approximately £200,000. This was during his first year in the role with an expectation that the recurrent savings would exceed £300,000 per annum. These savings were from senior colleagues pay and required adjustments to their workload planning and additional payment rates. The service director stated there were possibly similar practices in other specialties, which might deliver further savings. However, this action not surprisingly, resulted in the service director becoming unpopular with colleagues within his specialty. He doubted that others in a similar role would want to take similar actions to those he had taken considering the implications to relationships with colleagues.

It would appear there are barriers to senior doctors being involved in the management process, which have been present since the inception of the NHS. However the benefits available from their involvement would appear to be considerable. The inclusion of this staff group would appear to be fundamental to the financial management of such organisations. However there is a history in the UK of this inclusion being fraught with difficulties, particularly in times of financial restriction when there is the possibility that senior doctors may be required to be involved in cutting or restricting access to services.

## Conclusions and recommendations

The main conclusions, findings and recommendations identified are developed from the findings from the case study organisation. However, there are generic issues that are likely to relate to similar organisations in the sector and beyond.

There was a lack of a coherent strategy identified in the implementation of the budgeting system, as typified by the approach to CIP. This was said in part to be due to uncertainties in the organisation's environment at the time of the research project. However, the NHSFTs in the era of competition, resulting from the coalition governments proposals', will need a coherent strategy to enable survival in their new environment. Such strategies should be the basis for resource allocation and budgeting within the organisation and the predominant determining factor for decision making.

The advent of GP budget holders will require a significant understanding of the organisation's environment to enable strategy development, which can then be put into action throughout the organisation via the budgeting system. It is suggested that to maximise the benefits of budgeting and SLR for the organisation, there should be a clear strategy driving these systems. For the organisation to implement its strategy, it is heavily reliant on these activities. This symbiotic relationship



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between strategy and financial systems is at the heart of survival for an organisation in a competitive environment.

Service line reporting should be the basis for strategic decisions and as a guide to strategy development. There is a need for managers at all levels of an NHSFT to understand the roles of budgets and SLR. They also need to understand their relationship and relative importance in both control and decision making. Therefore there is a clear need for the training of users of such information and an understanding of the motivational aspects of such systems by all levels of management.

Clear lines of accountability within the organisation, the budgeting system and the relationship with SLR required attention. It is the view of the research team that this was an issue for the NHSFT examined in this study owing to the structure and, particularly, the role of service directors. However other studies reviewed by the team indicate accountability within healthcare organisations is a generic issue. It is suggested that the issues of accountability are tied to determining the roles of senior doctors in the management process and are identified as a major issue in the 'Findings' section of this report.

Managers were deemed by the organisation to be responsible for budgets, however in many instances they had little authority to use their budgets, indicating a lack of trust and real delegation. This issue should be addressed and will require training and potentially a culture change. The lack of delegation is evidenced by the processes in place to authorise expenditure and also with the treatment of the organisation's reserves. These are issues that are potentially a problem for organisations which require tight control of finances and therefore attempt to centralise control. In complex organisations such as an NHSFT the research team consider this likely to result in dysfunctional behaviour.

The role of doctors in the management of hospitals has been an issue since 1948 – the birth of the NHS – and a definitive solution has never been established. Different approaches have been attempted but for reasons of role conflict and inadequacies of information systems these have all failed to progress or gain universal adoption. This particular project offers some interesting insights into this issue, particularly the degree of financial control that may be obtained by the engagement of medical staff in the management of the organisation. There is currently little incentive for a senior doctor to be involved in the general and financial management of the organisation. Those doctors interviewed currently in service director posts stated they did so for a variety of reasons such as: to avoid being bored with a clinical role – no one else was interested – to make a difference in healthcare.

This study offers evidence that such involvement is a vital component in strategic and financial control in terms of operational and strategic issues in the forthcoming competitive healthcare environment. In order to facilitate such involvement incentives need to be available to doctors to take on these roles and reduce the hygiene factors preventing involvement. Such an initiative is required to start at a national level and then followed locally to review the terms and conditions of employment for senior doctors. This is in order to make managerial roles attractive and to reduce the burden of role conflict in terms of managerial versus clinical priorities. The above approach to this issue will be strengthened synergistically by appropriate training programmes. Such a change will also require a considerable cultural shift, which is unlikely to occur quickly therefore this should be seen as a long-term solution.

The above recommendations provide a typology to examine the budgeting arrangements of NHSTs and NHSFTs, to assist them in meeting the demands of their changing funding regime and accountability framework. The authors have developed a checklist for effectiveness of budgeting systems, based on this study. It is hoped this will assist further similar reviews in healthcare organisations.

This is the study of one NHSFT and it is suggested the study is performed in other NHSFT to gain a higher degree of validity for the findings. It should be noted, by others attempting to explore such issues, to be aware of the significant efforts required for ethical approval from the NHS for such studies. It is believed this will and is causing researchers to avoid investigation of NHS organisations, which is to the detriment of the NHS and also to academic enquiry.

The authors wish to thank CIMA's General Charitable Trust for assisting in funding this project and the managers and staff of the NHSFT at the heart of this study for their assistance and patience. It is the authors' ambition that this study offers them some guidance in their future success and also other NHSTs in England facing similar problems.

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## Appendix 1

### Checklist for effectiveness of budgeting systems

#### Strategy implementation

- Does the organisation have a well defined strategy with strategic objectives which are SMART – Specific, Measurable, Achievable, Realistic, Time?
- Is the content of the strategy – and particularly the change requirements – known throughout the organisation and particularly among senior doctors?
- Does the organisation have a multi-year financial plan which underpins and supports the strategy?
- Can proposed trends in the strategy be observed as shifts in resources in the multi-year financial plan?
- What evidence is there that annual budgets reflect the changes which appear in the multi-year financial plan?
- Does the organisation have a clear strategic approach to cost improvement and is this promulgated throughout the organisation and particularly among senior doctors?
- How well is SLR information promulgated throughout the organisation and particularly among senior doctors?
- Do strategic decision changes in the organisation pay any cognisance of SLR information?

#### Control and empowerment

- To what extent are there situations where managers have responsibility for budgets but their degree of control over such expenditure is compromised for whatever reasons?
- Have any actions been considered or implemented to resolve the above deficiencies?
- Has the organisation – systematically and thoroughly – assessed the level of budget holding in the organisation?
- Has it concluded the current arrangements are adequate?
- Has it identified any areas where further delegation of budget holding might be deemed appropriate?
- In those areas, have the staff involved got the capacity and capability to effectively manage devolved budgets?
- Are the current budget reporting arrangements seen as representing best practice?
- What is the focus of financial control in the organisation – budgeting systems or SLR?
- Has any consideration been given to the reconciliation of the two systems?
- Has the future role of SLR and SLM in the organisation been clarified?

#### Performance improvement

- Is the current approach to budgetary resource allocation in the organisation seen as being broadly fair? Have other approaches been considered?
- To what extent do budget managers compare their financial performance with that of comparable organisations when setting budgets? What actions do they take?
- Is any form of workload based budget setting operating in the organisation? Is there scope for doing this?
- Is the level of centrally held financial reserves in the organisation too high? Can it be reduced by enlarged distribution of resources to budget managers?
- Are the right incentives/sanctions in place to encourage improved financial performance? If not, what can be done to improve this?
- Is the current approach to identifying cost improvement programmes seen as fair and sustainable?
- Are planned cost improvement programmes being successfully implemented and incorporated into budgets? If not, what can be done to improve?
- Does the organisation employ any form of priority based budget setting to identify activities of lower priority?

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