FINANCE AND MANAGEMENT CASE STUDY

Final Test of Professional Competence examination
30 November 2005

PRE-SEEN MATERIAL

Pre-seen material for the Finance and Management Case Study is dispatched two weeks in advance of each examination sitting.

You should note that the purpose of this pre-seen material is simply to allow you to familiarise yourself with the case scenario, i.e. the organisation contained in the case and its regulatory background.

You are not expected to undertake any work on the pre-seen material prior to the examination and you will not be allowed to take in any notes to the examination. The pre-seen material will be provided again on the day of the examination itself.

For further information on the pre-seen material, please refer to your Techniques Guide.

PLENTYSIDE STRATEGIC HEALTH AUTHORITY

Background

The island state of Eden is renowned for its fertile soil and temperate climate and is a major exporter of flowers, fruit and vegetables. Its State Health Service (SHS) is delivered through 7 Strategic Health Authorities (SHAs), the most southerly of which is the Plentyside SHA. The River Plenty cuts a deep valley through the SHA and effectively divides it into two areas east and west of the river.

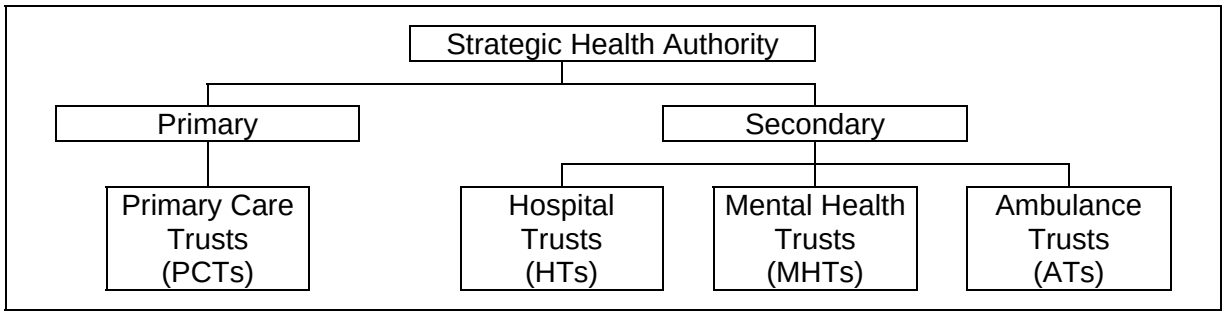
All Government bodies prepare accounts on a calendar year basis (to 31 December each year). The Eden £ has parity with £ Sterling and there is no VAT in Eden.

Strategic Health Authorities and Service Delivery

The SHAs are responsible for developing strategies and ensuring that the organisations delivering local health services perform well. These local organisations are categorised as either primary or secondary care providers.

- Primary — Provided by people that patients normally see when they first have a problem, such as general practitioners, dentists or opticians.
- Secondary — Emergency or specialist services provided normally in a hospital setting, where conditions cannot be dealt with by primary providers.

The main providers of primary and secondary care are detailed below.



PCTs are also responsible for commissioning care services from the secondary Trusts. All the Trusts involved are independent bodies with their own organisational structures and management arrangements, but all are required to work closely together in ensuring the provision of comprehensive health services within the SHA.

Plentyside Strategic Health Authority

To facilitate the discussion of local issues, to monitor the delivery of targets and to ensure accountability, the SHA splits its area into four health economies as follows, with two in the east area and two in the west. Health economies differ in size and each consists of a number of PCTs and HTs as follows.

Area	Population	Health Economy	PCTs No.	HTs No.
East	570,000	Gardenshire	6	8
	290,000	Shrubland	2	3
West	360,000	St Parfits-in-Paradise	3	3
	750,000	Riverside	6	9
	1,970,000		17	23

There are two MHTs, one covering the area east of the River Plenty and the other covering the area west of the river. There is one AT covering the whole SHA.

PLENTYSIDE RENAL STRATEGY GROUP

Renal Strategy Group

Within HTs, there are a number of specialist services (specialties), such as cardiac services, plastic surgery, and renal (kidney) treatment, and it is not unusual for SHAs to set up zonal commissioning teams for specific specialties, subscribed to by all PCTs within the SHA area. Pooling arrangements like these are Government supported as they avoid duplication of provision and make the best use of limited specialist resources. Within Plentyside, renal services (nephrology) is dealt with on a zonal basis and managed through a Renal Strategy Group (RSG).

The RSG was established in 2002 and its purpose is to identify the demand for renal dialysis from the PCTs, to plan the service and to agree the investments required to deliver renal services to the SHA population as a whole through the renal units within the area's HTs. As part of a current agreement, the RSG is supported by a specialist commissioning team comprising the Chief Executive, Director of Finance and Director of Planning, Information and Performance from Royal Riverside University HT (UHT). These officers work closely with the RSG and are responsible for providing administrative support, as well as the handling of finances for the joint arrangements.

Renal Care

Kidneys remove impurities from the body via urine and, once kidney damage occurs, this function is compromised. End stage renal failure (ESRF) occurs when a patient's kidneys are no longer functioning sufficiently and, in these circumstances, there are three main forms of treatment.

- Haemodialysis (HD) is a form of treatment in which the blood is pumped by a machine outside the body and purified through an artificial filter (dialyser), using dialysis fluids. For ESRF patients, each dialysis session lasts for about 3½ hours and each patient usually needs three sessions per week.
- Peritoneal Dialysis (PD) is the treatment of ESRF in which the patient's own peritoneum (membrane lining the abdominal cavity) is used to purify the blood by draining dialysis fluids in and out of the peritoneal cavity. No dialysis equipment is required for this and PD takes place in the patient's home.
- Transplantation is the replacement of a diseased kidney with a healthy kidney from another person (donor).

Drugs & Dialysis Fluids

The two main products used in the treatment of ESRF are as follows –

- Erythropoietic agents (EPO) are drugs used extensively with renal patients to manage anaemia. They need to be kept refrigerated.
- Dialysis Fluids; contain glucose and other substances, and are used in large quantities in both HD and PD.

PLENTYSIDE RENAL STRATEGY GROUP

Supply and Demand

In renal dialysis terms, demand and supply are measured as follows –

- Demand
  - Each renal dialysis treatment lasts for 4 hours (including machine cleaning time). This is called a session
  - Each renal dialysis patient requires such treatment 3 times per week – 3 sessions
  - 3 sessions equals 1 patient slot – the number of sessions required to treat 1 patient per week
- Supply
  - A renal dialysis machine and ancillary equipment equals 1 station
  - A station is used for 6 days per week to provide 2 or 3 sessions (shifts) per day
  - A station working a 2-shift pattern provides 12 sessions or 4 patient slots per week
  - A station working a 3-shift pattern provides 18 sessions or 6 patient slots per week
  - A station therefore provides 2 patient slots per shift

Renal Service Provision

- Renal services are provided on a "hub and spoke" basis with two main hospitals, supported by a number of satellite operations.
- The two main hospitals, Bowpark in the east and Royal Riverside in the west, deal with the high dependency ESRF cases, where patients have a number of complex health problems and very specialised care is required.
- The satellites handle patients with progressive kidney disease, requiring dialysis and general support. Some patients manage their dialysis treatment at home.
- If patient demand exceeds supply in terms of patient slots, the excess has to be managed on an ad hoc basis, by the two main hospitals, outside normal operational hours, usually during the night and at additional cost. In these circumstances, both patient service and finances suffer. Therefore, the use of ad hoc slots has to be kept to a minimum as they take resources needed for other operational purposes.

Renal Service Standards

National guidelines, the "State Service Framework for Renal Services" (SSF), have recently been published. These outline quality standards for patient treatment and also require more focused planning for the future.

PLENTYSIDE RENAL STRATEGY GROUP

Finance & Funding - General

The SHS is in the very early stages of phasing in new funding arrangements between primary and secondary providers entitled "Fiscal Flows". National tariffs, regionally adjusted, will be set for groups of diseases requiring similar diagnosis and treatment, thus removing the need for PCTs to negotiate prices with providers in some treatment areas and allowing a greater focus on quality, efficiency and choice. Initially renal disease will not be one of those covered by the new arrangements, but indicative tariffs are being researched and issued for all specialities so that providers can make preparations. Currently, there is an agreement that the RSG's average unit cost per patient slot per year is the tariff used for calculating charges to PCTs.

Renal Development Funding & Revenue Costs

Most new renal developments are Private Finance Initiative (PFI) schemes and do not require SHS capital funding. However, additional revenue resources are required to finance the running costs of developments and the zonal approach to specialties is an advantage in attracting such finance.

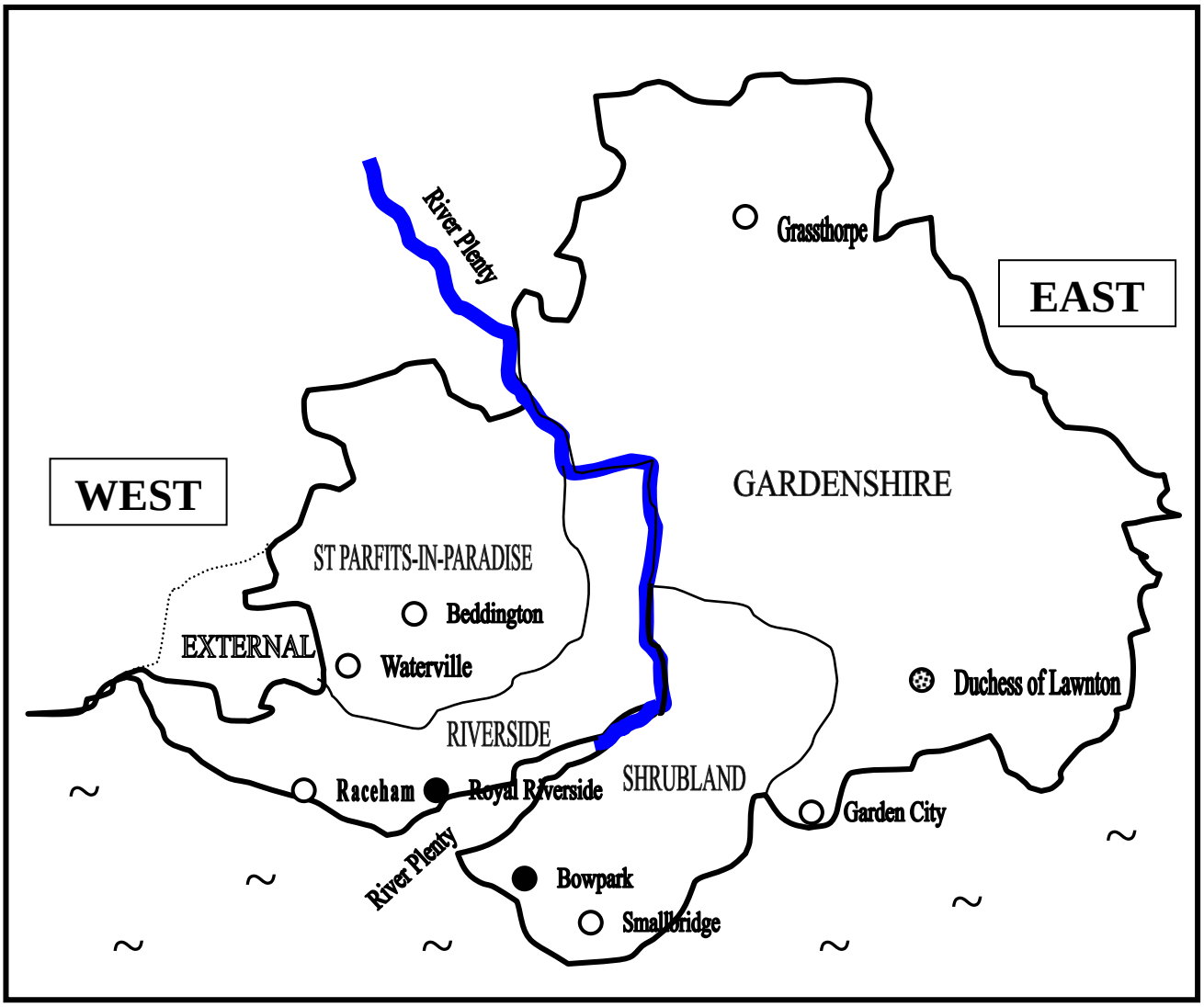
The running costs of renal units, once operational, are made up of the following.

- Standing - charges per patient slot covering most general operational costs such as nursing support, administration, premises and PFI charges;
- Staffing - charges in respect of additional specialist staff such as renal consultants and renal engineers plus peripatetic support staff;
- Variable - supplies including EPO, dialysis fluids and other consumables.

Site Map

The map over the page details the four health economies, the two lead hospitals and the other current and planned satellite renal centres. In the main, these renal centres just treat patients within the SHA zone and within their own area (east or west). However, as part of long-standing national arrangements, a small number of patients, external to the SHA but on its western borders, are treated in the west-based centres. The population of this "external" area covered is 117,000.

PLENTYSIDE
RENAL STRATEGY GROUP



- Main Hospital
- Satellite
- Hybrid, including clinic facilities

PLENTYSIDE RENAL STRATEGY GROUP

Structure & Management

The RSG is effectively a "virtual" organisation, but has specific responsibilities as regards the commissioning and delivery of renal services throughout the Plentyside zone and the included area external to the SHA. There are nine RSG members, representing constituent bodies, and the recently appointed Chair is Ms. Ros Berry.

Name	Position	Representing
Ros Berry	Chief Executive	Central Shrubland PCT
Ben Arner	Director of Planning	South Raceham PCT
Dr Pat Atoe	General Practitioner	Beddington PCT
Dr Harry Cotbean	General Practitioner	Garden City PCT
Pammie Granite	Public Health Officer	North Grassthorpe PCT
Nick Terrine	Consultant	Waterville HT
Clement Tyne	Assistant Director of Finance	Smallbridge HT
Ava Cardoe	Professor of Nephrology	Riverside UHT
Piers Nipp	Clinical Director Nephrology	Bowpark HT

Progress

The former Chair, who had overseen the establishment of the RSG, was more concerned with operational than strategic issues. After a number of heated meetings, the situation reached a head when the 2005 and 2006 forecasts showed a growing deficit in patient slots for dialysis in both the east and west health economies and a significantly increasing overall unit cost per patient slot. Amid continuing wrangling, the Chair resigned, to be replaced by Ms Ros Berry, who recently relocated to the area after a period of secondment at the State Health Department and is well known for her financial acumen and strategic approach. Ms Berry is eager to address the RSG's current problems through a better spirit of cooperation and a more forward-looking attitude. She is well-known as a supporter of zonal service provision on the grounds that such pooling arrangements make the best use of limited resources, produce less volatility in terms of costs and, hence, provide greater financial certainty for the constituent bodies.

Current Renal Supply Development Plans

The 2005 and 2006 forecasts for demand, supply and costs are shown below and incorporate the following agreed developments.

- Bowpark — An extension to the current facility providing an extra 8 stations on a 3 shift per day basis came into service from 1 July 2005
- Garden City — This hospital is to be closed and its provision of 11 stations on a 2 shift per day basis, plus existing specialty staff, will be transferred to a new facility at The Duchess of Lawnton from 1 January 2006.
- Raceham — A new facility providing 10 stations on a 2 shift per day basis is planned to come into service from 1 July 2006.

RENAL STRATEGY GROUP – DEMAND FORECASTS

2005 Demand (Patient Slots)

Health Economies		B/F 1-Jan	New	Transplants		Deaths	C/F 31-Dec	Ave[1]
				Failed	New			
			+	+	-	-		
East	Gardenshire	121	63	8	15	24	153	137
	Shrubland	130	32	4	8	26	132	131
		251	95	12	23	50	285	268
West	St Parfits-in-Paradise	92	40	5	9	18	110	101
	Riverside	288	83	10	19	58	304	296
	External	18	13	2	3	4	26	22
		398	136	17	31	80	440	419
Total		**649**	**231**	**29**	**54**	**130**	**725**	**687**

2006 Demand (Patient Slots)

Health Economies		B/F 1-Jan	New	Transplants		Deaths	C/F 31-Dec	Ave [1]
				Failed	New			
			+	+	-	-		
East	Gardenshire	153	64	8	15	31	179	166
	Shrubland	132	32	4	8	26	134	133
		285	96	12	23	57	313	299
West	St Parfits-in-Paradise	110	40	5	9	22	124	117
	Riverside	304	84	10	19	61	318	311
	External	26	13	2	3	5	33	30
		440	137	17	31	88	475	458
Total		**725**	**233**	**29**	**54**	**145**	**788**	**757**

NOTES

- The only actual demand figures are those brought forward (B/F) on 1 January 2005; all other figures are projections.
- The actual average demand in 2004 was 644 patient slots.
- The incidence of new patient slots is based upon prevalence estimates expressed as "patients per million" (ppm) and applied uniformly to the whole SHA and the external area.
- The number of transplants (new and failed), and deaths are estimates for the whole SHA and external area allocated as follows -
  - transplants - pro rata to population
  - deaths - pro rata to figures B/F at 1 January.

[1] Average = (B/F + C/F) ÷ 2 (rounded up)

RENAL STRATEGY GROUP – SUPPLY FORECASTS

2005 Supply (Patient Slots)

Hospital/Satellite		Shifts Per day	Slots [1] Per Shift	As at 1-Jan Stations	As at 1-Jan Slots [2]	New Stations No.	New Stations Part Yr	Stations C/F	In Year Slots[3]
East	Bowpark	3	2	7	42	8	0.50	15	66
	Garden City	2	2	11	44			11	44
	Grassthorpe	3	2	8	48			8	48
	Duchess of Lawnton	-	-	-	-			-	-
	Smallbridge	2	2	5	20			5	20
	Home Dialysis	-	-	-	65			-	65
				31	219	8		39	243
West	Beddington	2	2	6	24			6	24
	Raceham	-	-	-	-			-	-
	Royal Riverside	3	2	44	264			44	264
	Waterville	3	2	12	72			12	72
	Home Dialysis	-	-	-	60			-	60
				62	420			62	420
				93	**639**	**8**		**101**	**663**
				Average Demand					**687**
				Demand met by Ad Hoc Slots					**24**

2006 Supply (Patient Slots)

Hospital/Satellite		Shifts Per day	Slots [1] Per Shift	As at 1-Jan Stations	As at 1-Jan Slots [2]	New Stations No.	New Stations Part Yr	Stations C/F	In Year Slots[3]
East	Bowpark	3	2	15	90			15	90
	Garden City	2	2	11	44	-11	1.00	-	-
	Grassthorpe	3	2	8	48			8	48
	Duchess of Lawnton	2	2	-	-	11	1.00	11	44
	Smallbridge	2	2	5	20			5	20
	Home Dialysis	-	-	-	65			-	65
				39	267	-		39	267
West	Beddington	2	2	6	24			6	24
	Raceham	2	2	-	-	10	0.50	10	20
	Royal Riverside	3	2	44	264			44	264
	Waterville	3	2	12	72			12	72
	Home Dialysis	-	-	-	60			-	60
				62	420	10		72	440
				101	**687**	**10**		**111**	**707**
				Average Demand					**757**
				Demand met by Ad Hoc Slots					**50**

[1] Per shift per week (6 days x 1 shift = 6 sessions ÷ 3 sessions per patient = 2 patient slots per shift week)

[2] Slots brought forward from the previous year, allowing for the effect of developments in the previous year.

[3] In-year slots = (Opening stations x shifts per day x slots per shift) + (new stations x part year effect x shifts per day x slots per shift)

RENAL STRATEGY GROUP – COST FORECASTS

2005 Costs & Unit Costs (per Patient Slot) [1]

Hospital/Satellite		Patient Slots		Base	Additional Costs			Revised	Unit [2]
		B/F	New	Cost	Standing	Staff	Variable	Base	Cost
				£000	£000	£000	£000	£000	£
East	Bowpark	42	24	1,800	864	70	96	2,830	42,879
	Garden City	44		1,250				1,250	28,409
	Grassthorpe	48		1,450				1,450	30,208
	Duchess of Lawnton	-		-				-	-
	Smallbridge	20		550				550	27,500
	Home Dialysis	65		1,640				1,640	25,231
		219	24	6,690	864	70	96	7,720	31,770
West	Beddington	24		750				750	31,250
	Raceham	-		-				-	-
	Royal Riverside	264		10,450				10,450	39,583
	Waterville	72		2,100				2,100	29,167
	Home Dialysis	60		1,510				1,510	25,167
		420	-	14,810	0	0	0	14,810	35,262
		639	**24**	21,500	864	70	96	22,530	33,982
Demand met by ad hoc slots		5	19	160	608			768	
General Costs [3]				1,400		28		1,428	
Total		**644**	**43**	**23,060**	**1,472**	**98**	**96**	**24,726**	**35,991**

2006 Costs & Unit Costs (per Patient Slot) [1]

Hospital/Satellite		Patient Slots		Base	Additional Costs			Revised	Unit [2]
		B/F	New	Cost	Standing	Staff	Variable	Base	Cost
				£000	£000	£000	£000	£000	£
East	Bowpark	66	24	2,830	864	70	96	3,860	42,889
	Garden City	44	-44	1,250	-934	-140	-176	-	-
	Grassthorpe	48		1,450				1.450	30,208
	Duchess of Lawnton	-	44	-	1,144	140	176	1,460	33,182
	Smallbridge	20		550				550	27,500
	Home Dialysis	65		1,640				1,640	25,231
		243	24	7,720	1,074	70	96	8,960	33,558
West	Beddington	24		750				750	31,250
	Raceham	-	20	-	440	70	80	590	29,500
	Royal Riverside	264		10,450				10,450	39,583
	Waterville	72		2,100				2,100	29,167
	Home Dialysis	60		1,510				1,510	25,167
		420	20	14,810	440	70	80	15,400	35,000
		663	**44**	22,530	1,514	140	176	24,360	34,455
Demand met by ad hoc slots		24	26	768	832			1,600	
General Costs [3]				1,428		28		1,456	
Total		**687**	**70**	**24,726**	**2,346**	**168**	**176**	**27,416**	**36,217**

[1] Price base = 2005 projected outturn
[2] Unit Cost = Revised base ÷ (Patient Slots B/F + Patient Slots New)
[3] General costs = Costs of peripatetic support staff such as home dialysis nurses, dieticians etc.

ROYAL RIVERSIDE UHT

Management Structure

The Royal Riverside UHT is headed by its Chief Executive, Joe Ranium, who has been with the UHT for two years. The UHT's departments are headed by 5 executive directors and 11 clinical directors. The executive directors are as follows.

Director of Finance	Rhoda Dendron
Director of Human Resources	Polly Anther
Director of Planning, Information & Performance	Will Flower
Director of Nursing	Anne Nenomy
Medical Director	Perry Winkle

The Trust Board is chaired by Lady Lavender Mist and comprises the Chair and 5 non-executive directors plus the Chief Executive and 5 executive directors. The Chief Executive and all 16 executive and clinical directors make up the UHT Management Board, which meets monthly.

The Chief Executive is supported by an Assistant Chief Executive, with responsibility for communications and central support services, which include estates, hotel services, central administration support and supplies. Marie Gold was appointed to this post with effect from 1 September 2005. The previous post-holder retired at the end of December 2004, having been at the UHT for many years.

Financial Regulations

The UHT operates a standard set of Financial Regulations and Standing Financial Instructions (SFI) that provide for the usual controls over budgeting, expenditure, income, fixed assets, stocks and supplies. More specifically SFIs make provision that all contracts over £50,000 (per annum or single capital project) should be the subject of formal open tendering throughout Eden.

Personnel Procedures

In line with national legislation, Human Resources has in place various guidelines covering appointment procedures, disciplinary matters and absence reporting procedures.

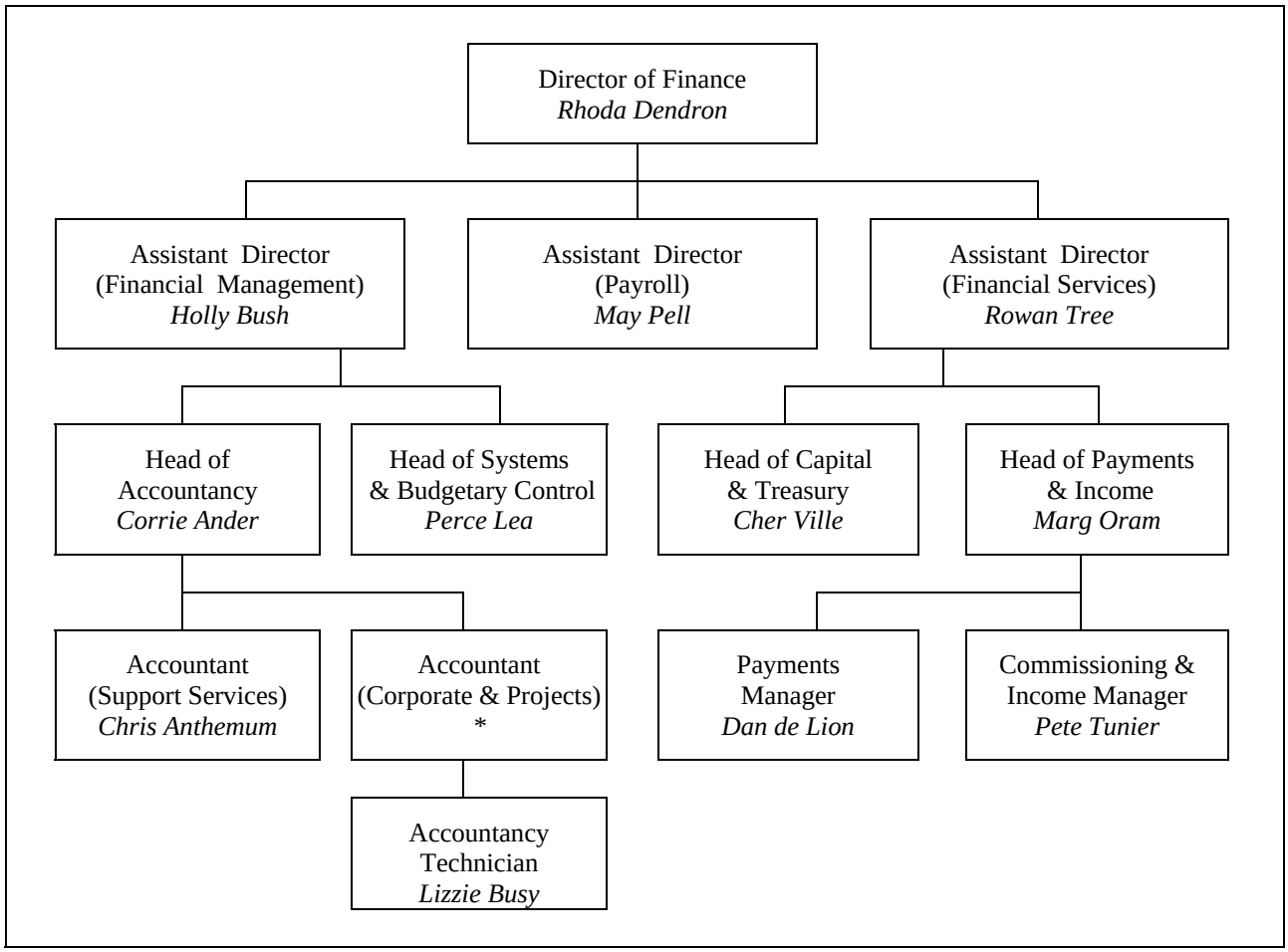
All vacant posts must be formally advertised and backed by a written job description and person specification. Selection procedures must involve Human Resources and appointments made must be without discrimination and on the basis of the best candidate for the post. There are written disciplinary procedures circulated to all staff, providing for the normal stages of disciplinary action from verbal warning to summary dismissal.

Human Resources, in conjunction with Payroll, operate sickness absence monitoring. All staff must notify managers of sickness absence on the first day of absence and managers are required to carry out post-sickness interviews with staff. Long-term absences should be referred to Human Resources to ensure the involvement of Occupational Health.

ROYAL RIVERSIDE UHT

Structure – Finance Directorate

The structure of the Finance Directorate is set out below. Financial Management in the main is devolved to the clinical directorates and accountancy support is provided to the Directorates. Whilst these accountants are not shown below, they still report directly to the Director of Finance. Those accountants working within the Finance Directorate deal with central and corporate issues. Internal audit is provided by an agency organisation.



* You are Kim O'Mile, the Accountant (Corporate & Projects)