

Barts and the London has improved the accuracy of its reference costs by allocating the cost of its CT scanner to A&E

WHEN THE GOVERNMENT introduced capital accounting and asset registers a decade ago, it discovered warehouses full of unused World War One single-shot rifles among the outbuildings and equipment it never knew existed. Since then, all government departments, including health, have sold off excess land and unused buildings and trimmed their asset bases.

Nowadays the emphasis is on knowing what and where an organisation's assets are – easy with buildings but more complex with equipment that can be moved – and knowing the value of those assets so that their use, maintenance or disposal can be planned to produce the maximum benefits.

This will be increasingly important under payment by results as organisations strive to gain a better understanding of their costs and which areas of their business are profit- or loss-making.

Across the NHS, detailed understanding and use of asset information is patchy, but trusts at the forefront of using their asset registers are accurately breaking down the capital charges they pay and allocating them to the clinical services that use them.

Getting to that stage is not easy. Dot Lanham, financial accountant at Frimley Park Hospital NHS Foundation Trust, previously had experience at the much smaller Andover War Memorial Hospital. Her experience is typical.

'There was some bespoke software written for the NHS by one of the big consultancy firms but that was out of date,' she says.

USE OF ASSET INFORMATION IN WALES

A research project entitled 'Managerial behaviour and decision-taking under resource accounting and budgeting (RAB): the impact of depreciation and capital charging in the NHS in Wales' is nearing completion, writes *Howard Mellett*. This work is being carried out by Glamorgan Business School and Cardiff Business School. It is funded by the Institute of Chartered Accountants of Scotland and is being undertaken in cooperation with HFMA Wales.

The study investigates the impact of RAB on the management of the capital asset base of NHS trusts, including the generation and use of information about capital assets, especially that based on accounting techniques. The final report will be published later in 2006 and the findings so far suggest that financial information about the stock of capital assets and their related charges has not permeated throughout trusts.

Howard Mellett is professor and head of accounting section at Cardiff Business School



Sweating assets

Under payment by results, NHS trusts that can make better use of their assets will have an advantage. But this will demand a much greater understanding of their equipment and buildings, as Chris Wheal reports

'Spreadsheets are cumbersome and there's a big problem in that if you type in a complicated formula and get it wrong you wouldn't know without going through every cell, which is time-consuming.'

Frimley Park has opted for NHS-specific software from Real Asset Management. This uses commercial-style techniques and technology, making it simple to draw up and annually check asset registers, automatically moving items to different locations if that is where they are found and flagging up any items missing from previous years.

'We print off a report by location for managers, telling them what is theirs,' says Ms Lanham. Managers sometimes come back seeking to get rid of items or pointing out ones that have broken and are not used.

But the software has been written to allow for the NHS modified cost accounting. In the private sector the purchase price of an item is the historic cost used in the accounts but in the NHS some assets have to be increased in value to take into account the cost of replacement.

Each year the government says how much certain assets must rise by. All that has to happen is for those figures to be entered once and the software recalculates the value of each of the assets on the register. Each trust then gets charged for its capital – as a substitute for borrowing interest charges.

In general, these capital charges are seen as overheads and apportioned across a trust's activities. But there are moves to directly allocate the relevant capital charges to each service or clinical unit.

Roger Tester, deputy director of investment at Barts and the London NHS Trust, has begun this. 'If a piece of equipment is only used principally in

specific specialties or procedures then its costs should be allocated to those areas,' he says. An example is high-cost imaging equipment. 'We have a CT scanner used very heavily by A&E,' he says. 'We think this is one of the reasons the reference cost for Barts and the Royal London A&E appears high compared with some other trusts. Other trusts may well be spreading the costs over all imaging users, or perhaps are operating a lower intensity A&E service.'

The discrepancies in current practice suggest the costing manual – containing the current guidelines – is not definitive enough.

'We have to move towards more consistent and better costing,' Mr Tester says. 'Where variances appear between our own and others' costings, we're happy to justify our costing treatment. Unless we do, payment by results and tariffs will always lack credibility with clinicians if they choose to look in detail at how we've costed their services.'

COSTING IN CONTEXT

That's not to say Mr Tester supports a strict diktat from on-high about every minor detail. Organisations must see the benefit of what they are being asked to do. So how far do you go? Allocating individual scalpels and other surgical instruments would probably be too extreme, but even allocating the costs of large buildings could be counter-productive.

Good practice would dictate that managers only be allocated costs they can influence. If they can save money or use an asset more efficiently, it makes sense to allocate them the full cost of it. But buildings are often just huge legacy costs and managers simply can't reduce the associated capital charge.

Managers allocated their proportion of building costs could retort they would like to be moved to another, cheaper building. And it is arguably counter-productive to pass on charges for dedicated, purpose-built units because the capital charges are fixed and would swamp those for equipment. That could mean a 100% improvement in the use of the equipment would be almost unnoticeable in the overall picture.

Allocating charges should provide an incentive for better management and more

accurate costing, or there would seem to be little point. Dumping unmanageable costs on managers will only demotivate them.

But in other areas there could be savings from greater understanding of assets and their use. 'Should departments have dedicated equipment of their own or can there be an equipment library with items drawn out when needed?' asks Mr Tester. 'Barts and the Royal London have been able to move some ultrasounds into an equipment library and thus improve utilisation.'

He says this also ensures maintenance is carried out regularly and is planned.

Ms Lanham can see the benefits. When she worked in a small hospital she was able to allocate proportions of gas and electric bills to individual departments, which managers liked. To allocate capital charges makes sense to her.

'We're not quite that sophisticated yet but ultimately it would be nice to use the information that way,' she says. 'People are only accountable if they can see the cost of it. When a department puts in a bid for equipment they do get told what effect that will have on capital charges, but because it doesn't actually go on their department's budget they don't really need to pay that much attention,' she says.

Implementing this charging regime will not be a cure-all. Much of the NHS's equipment is so old it has long been written down to zero value. But even this can be useful information. If an unused asset is attracting no capital charges it may be worth keeping as a spare for when a more heavily used asset breaks down. But if it is still attracting capital charges, departments may want to think about disposal.

Mr Tester has one other word of warning: embarking on this process comes with its own costs in terms of time and money. With all the competing priorities around, a trust has to be sure this is important and will make a difference. Something else will have to give.

'Everybody tells us what more we should be doing,' he says. 'But nobody tells us what to stop doing.'

Chris Wheel is a freelance journalist

SCOTLAND'S NATIONAL VIEW

The NHS Scotland Property and Environment Forum is rolling out a national strategic asset management system known as the property management system (PMS), *writes Stuart Brown*. This is intended to provide NHS Scotland boards with a uniform method of collecting and analysing asset information and generating and appraising options for change.

The system recognises that assets should be driven by the service need, so it performs service analysis using modelling techniques based on demography and the impact of strategic issues and service change. Users can consider the throughput of caseload in relation to asset provision, and the anticipated changes of throughput over the next 10 years. The system allows activity modelling of heavy users of space, such as clinics.

The system also allows the setting of the strategic context by encouraging organisations to consider local policy, national policy and strategic issues and priorities, setting the strategic direction for the NHS organisation.

Asset management control

PMS considers core property data, physical condition, statutory compliance, health and safety, the Disability Discrimination Act, space usage, functional suitability, and the environment. Works are prioritised by their risk category, ensuring funding is spent on areas with the highest risk. The system allows high-risk, low-cost items to be flagged up first, ensuring maximum impact for the expenditure.

The system encourages continuous improvement in asset management by allowing information to be updated in cycles. It can allow planning and strategy up to 10 years ahead, ensuring forward planning in asset management driven by service change.

The system will be used by all NHS Scotland boards and has been adopted in several. It will be a mandatory requirement of a forthcoming Scottish Executive health department property management policy.

The NHS Scotland Property and Environment Forum is developing asset management toolkits and minimum datasets for use in joint ventures and joint premises developments between the NHS, councils and public sector partners. Similar to England's LIFT model, in Scotland it applies to all services and will be known as HUB.

Stuart Brown is property and capital planning adviser, NHS Scotland Property and Environment Forum Executive