Introduction to NHS Finance

Monday 20th February
2017
Welcome & Introductions
PURPOSE

• Part 1
  • An introduction to the scale and structure of the NHS
  • NHS in context
  • Where the money comes from
  • Where it’s spent

• Part 2
  • The main components
  • What the different organisations do

Please ask Questions!
INTRODUCTION TO THE NHS

Stuart Wayment FCMA, CGMA
HFMA KSS – February 2017
3.5 A matter of balance: control and empower

Figure 4 The role of the finance function

CONTROL
- One view of the truth
- Accountability and Scorecards
- Cost control

EMPOWER
- Culture and environment
- Devolved decision making
- Rewarding innovation and failure

Source: Microsoft
What is the NHS?

- The National Health Service - set up in 1948
- Provides healthcare to all based on need not ability to pay – “Free at point of need”
- Largest employer in Britain – Worldwide 5th Largest
- Always more demand than supply.
<table>
<thead>
<tr>
<th>Employer</th>
<th>Employees</th>
<th>Headquarters</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States Department of Defense</td>
<td>3.2 million</td>
<td>United States</td>
</tr>
<tr>
<td>People's Liberation Army</td>
<td>2.3 million</td>
<td>People's Republic of China</td>
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<tr>
<td>Walmart</td>
<td>2.1 million</td>
<td>United States</td>
</tr>
<tr>
<td>McDonald's</td>
<td>1.9 million (including franchises)</td>
<td>United States</td>
</tr>
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<td>National Health Service</td>
<td>1.7 million</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>China National Petroleum Corporation</td>
<td>1.6 million</td>
<td>People's Republic of China</td>
</tr>
<tr>
<td>State Grid Corporation of China</td>
<td>1.5 million</td>
<td>People's Republic of China</td>
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<tr>
<td>Indian Railways</td>
<td>1.4 million</td>
<td>India</td>
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<tr>
<td>Indian Armed Forces</td>
<td>1.3 million</td>
<td>India</td>
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<tr>
<td>Hon Hai Precision Industry (Foxconn)</td>
<td>1.2 million</td>
<td>Taiwan</td>
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NHS Finance Overview
The Kings Fund
Ideas that change health care
**NHS values and the Constitution**

The NHS values describe what we aspire to in providing NHS services, to facilitate co-operative working at all levels of the NHS. The NHS values were derived from extensive discussions with staff, patients and the public, and provide a framework to guide everything that we do within the NHS. The NHS Constitution was published by the Department of Health in 2011. It is the first document in the history of the NHS to explicitly set out what patients, the public and staff can expect from the NHS and what the NHS expects from them in return. The Constitution cannot be altered by government without the full involvement of staff, patients and the public, and so gives protection to the NHS against political change.

For details on the NHS Constitution or to download a copy, go to: www.nhs.uk/nhsconstitution

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**An overview of the Health and Social Care Act 2012**

The Health and Social Care Act 2012 introduced radical changes to the way that the NHS in England is organised. The legislative changes from the Act came into being on 1 April 2013 and include:

A. A move to clinically led commissioning. Planning and purchasing healthcare services for local populations had previously been performed by England’s 152 primary care trusts (PCTs). The Act replaced the PCTs with 211 clinical commissioning groups (CCGs), led by clinicians. CCGs now control the majority of the NHS budget, with highly specialist services and primary care being commissioned by NHS England.

B. An increase in patient involvement in the NHS. The Act established independent consumer champion organisations locally (Healthwatch) and nationally (Healthwatch England) to drive patient and public involvement across health and social care in England. Healthwatch network has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

C. A renewed focus on the importance of public health. The Act provided the legislation to create Public Health England (PHE), an executive agency of the Department of Health. PHE’s aim is to protect and improve the nation’s health and to address health inequalities.

D. A streamlining of ‘arms-length’ bodies. The Act conferred additional responsibility on the National Institute for Health and Care Excellence (NICE – formerly the National Institute for Clinical Excellence) to develop guidance and set quality standards for social care. The Health and Social Care Information Centre (HSCIC) was also tasked with responsibility for collecting, analysing and presenting national health and social care data.

E. Allowing healthcare market competition in the best interest of patients. The Act aimed to allow fair competition for NHS funding to independent, charity and third-sector healthcare providers, in order to give greater choice and control to patients in choosing their care. To protect the interests of patients under these new arrangements, Monitor was established as the sector regulator for health services in England. Monitor issues licences to NHS-funded providers, has responsibility for national pricing and tariff (in conjunction with NHS England) and helps commissioners ensure that local services continue if a provider is unable to continue providing services.

Find out more about the changes resulting from the Act at: www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets
Finance in the NHS: your questions answered

Where does the money come from?
The money for the NHS comes from the Treasury. Most of the money is raised through taxation.

How does NHS England decide how much each CCG gets?
CCG budgets are allocated on a 'weighted capitation' basis. This means that budgets are set based on the size of the population, and adjusted for other factors: the age profile of the population; the health of the population; and the location of the population.

How is the budget for the NHS calculated?
The Treasury holds a Spending Review every two to three years, through which the budgets for all major public services are agreed. Health is a major national issue: it receives around £107 billion a year, compared with £53 billion for education and £25 billion for defence.

How is money paid to service providers?
Historically, service providers were paid an annual lump sum to provide a service locally. These were known as 'block contracts', and were not linked to the number of patients seen, the work actually carried out, or the quality of care provided. In 2003/04 the government introduced 'Payment by Results' (PBR), an activity-based system that reimburses providers for the work that they carry out, at an agreed national price. Currently, PBR represents almost 30% of NHS expenditure. Most of the remainder is covered by old-style block contracts and local variations on these. NHS England and local commissioners are working towards a payment system based on quality of care and health outcomes achieved.

How does the money flow from the Treasury to patient services?
The Treasury allocates money to the Department of Health, which in turn allocates money to NHS England. The Department of Health retains a proportion of the budget for its running costs and the funding of bodies such as Public Health England.

NHS England currently receives around £96 billion a year from the Department of Health (2012/13). Approximately £30 billion is retained by NHS England to pay for its running costs and the services it commissions directly: primary care (including GP services), specialised services, offender and military healthcare. The remainder is passed on to clinical commissioning groups (CCGs) to enable them to commission services for their populations.

Service providers are paid in a number of different ways (see opposite for further details). The diagram below illustrates the flow of money from the Treasury to CCGs.

How the money flows

HM Treasury

£107 billion

Department of Health

£96 billion

NHS England

£64 billion

Clinical Commissioning Groups

All figures based on HM Treasury Spending Review 2010

Centrally managed projects and services

Arms Length Body funding

Public health spending

Nationally commissioned services

Locally commissioned services
Where the money goes

- 50% Acute hospital
  - of which:
    - 27.5% Non-elective
    - 17.5% Elective and maternity
    - 5% Outpatients
    - 2.5% Other

- 2.5% Learning disabilities
- 10% Primary care
- 2.5% Dentistry
- 10% Prescribing
- 12.5% Community care
- 10% Mental health
Regulation and monitoring

Revalidation is the process by which clinicians have to demonstrate to their regulatory bodies (for example, GMC and NMC) that they are up to date and fit to practise. It is a way of regulating the professions and contributing to the ongoing improvement in the quality of care delivered to patients.

How does it work? Revalidation is based on local evaluation of the clinician’s performance through appraisal. All doctors already participate in an annual appraisal and maintain a portfolio of supporting information. Revalidation for nurses and midwives is expected to start in 2015.

Monitor is the financial regulator of foundation trusts. Monitor works to make sure that:

- NHS foundation trusts are well-led and well-run, so they provide quality care;
- Essential NHS services are maintained if a provider gets into difficulty;
- The NHS payment system promotes quality and efficiency;
- Procurement, choice and competition operate in the best interests of patients.

The Trust Development Authority (TDA) is responsible for ensuring that non-foundation trusts develop the capability to achieve independent foundation trust status. Key functions of TDA include:

- Monitoring performance;
- Assurance of clinical quality;
- Transition into foundation status;
- Appointment of chairs and non-executive members to the trust.

The National Quality Board (NQB) is a multi-stakeholder board established to champion quality and ensure alignment of quality goals throughout the NHS. It aims to bring together multiple organisations with an interest in improving quality to agree the NHS quality goals, while respecting the independent status of participants.

The General Medical Council (GMC) is the independent regulator of nearly 260,000 doctors in the UK and was established in the Medical Act 1958. The GMC:

- Sets the standards that are required of doctors practising in the UK;
- Decides which doctors are qualified to work in the UK and oversees their education and training;
- Ensures that doctors continue to meet these standards throughout their careers through a five-yearly cycle of revalidation;
- Can take action when a doctor may be putting the safety of patients at risk.

The General Dental Council (GDC) regulates all dental professionals including dentists, nurses, technicians and hygienists.

The General Pharmaceutical Council (GPhC) is the independent regulator for more than 70,000 pharmacists, technicians and pharmacy premises in the UK.

Healthwatch has been set up as an independent consumer champion for health and social care. Its purpose is to represent the public’s view on healthcare by gathering views on health and social care at both local and national levels. Every local authority in England has a Healthwatch. It is hoped that through the Healthwatch network the voices of people who use the NHS will be heard. Healthwatch will gather these views by conducting research in local areas, identifying gaps in services and feeding into local health commissioning plans.

The Nursing and Midwifery Council (NMC) regulates more than 679,000 nurses and midwives in the UK. Key responsibilities include:

- Setting professional standards of education, training, performance and conduct, and ensuring that these standards are upheld;
- Investigating nurses and midwives who are thought to fail short of its standards.

The General Optical Council (GOC) regulates around 26,000 optometrists, dispensing opticians, student opticians and optical businesses.

The Health and Care Professions Council (HCPC) regulates a wide range of professions including art therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, social workers in England and speech and language therapists.
NHS IMPROVEMENT

(FORMERLY - MONITOR + TRUST DEVELOPMENT AUTHORITY)

• Regulate Providers
• Ensure **problems** solved by management
• **Support** change – experts
• **Change** management?
NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE- NICE

• Promotes consistent standards
• Aims to avoid “Postcode Lottery”
• Issues guidelines in 4 areas:-
  1. Medicines & treatments
  2. Clinical practice
  3. Health Promotion
  4. Social Care
Home Nations

- Different arrangements apply
- Closer Politics
- Boards
- No Purchaser/provider split
- No PBR
The NHS in Scotland, Wales and Northern Ireland

The healthcare service in **Northern Ireland** provides both health and social care and is administered by the Department of Health, Social Services and Public Safety.

- **The Health and Social Care Board** holds overall responsibility for commissioning services through five Local Commissioning Groups.
- **Five Local Commissioning Groups** are responsible for commissioning health and social care by addressing the needs of their local population.
- **Five Health and Social Care Trusts** have responsibility for providing integrated health and social care in their regions. The Northern Ireland Ambulance Service is designated as a sixth trust.
- **The Patient and Client Council** exists to provide a powerful, independent voice for patients, carers and communities.
- **The Regulation and Quality Improvement Authority** is an independent organisation that encourages continuous improvement through a programme of inspections.
- **The Public Health Agency** is an organisation with the remit to improve health and wellbeing, provide health protection and directly input into commissioning via the Health and Social Care Board.

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

The NHS in **Scotland** is completely devolved, meaning that responsibility for it rests fully with the Scottish Government. The Cabinet Secretary for Health and Wellbeing and Scottish Government set national objectives and priorities for the NHS that should be delivered and monitored via NHS Boards and Special NHS Boards.

- **Fourteen NHS Boards** – these replaced trusts in 2004 and cover the whole of Scotland. They are all-purpose organisations that are expected to plan, commission and deliver NHS services for their area. They take overall responsibility for the health of their populations and commission all services including GP, dental, community care and hospital care. These boards are expected to also work together regionally and nationally so that specialist healthcare – for example, neurosurgery – is correctly commissioned. At a local level the boards have representation or partnerships with community health and social care teams and there is close involvement of local authorities, patients and public.
- **Seven Special Boards** and a Health Improvement Board provide national services and scrutiny as well as public assurance of healthcare.

[www.show.scot.nhs.uk](http://www.show.scot.nhs.uk)

**Differences between the NHS in England and the other home countries**

- **Northern Ireland** has a fully integrated health and social care service; Scotland has passed legislation to achieve this goal.
- Scotland and Wales have integrated boards as opposed to trusts that commission services at a local level.
- Scotland has **SIGN** (Scottish Intercollegiate Guidelines Network) and not **NICE** for their clinical guidance.

**Population**

£ Healthcare budget

[www.wales.nhs.uk](http://www.wales.nhs.uk)
Figure 7: Identifiable spending on health in the four countries of the UK, per head (2014/15 prices)

NHS in Context

NHS is the 2nd largest government spending programme.

After ?
Borrowing

Borrowing has fallen steeply after the Treasury reclaimed interest payments it made to the Bank of England. The central bank has become the Treasury’s biggest lender following the purchase of almost a third of UK debt via its quantitative easing policy. Using the previous figures for borrowing, the annual deficit is expected to rise before it falls in 2014/15

**Total receipts**

- **£612bn**
  - **£108bn** Defence
  - **£103bn** VAT
  - **£39bn** Corporation tax
  - **£27bn** Business rates
  - **£47bn** Excise duties
  - **£27bn** Council tax
  - **£155bn** Income tax
  - **£107bn** National insurance
  - **£220bn** Social protection
  - **£53bn** Other

**Total expenditure**

- **£720bn**
  - **£40bn** Defence
  - **£97bn** Education
  - **£21bn** Transport
  - **£31bn** Public order and security
  - **£137bn** Health
  - **£16bn** Industry, agriculture and employment
  - **£23bn** Housing and environment
  - **£51bn** Debt interest
  - **£31bn** Personal social services
  - **£220bn** Social protection including tax credits

**Other**

- Including stamp duty, vehicle excise duty
- Other
- Including culture, sport, international development

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**Business rates**

Business groups say a series of steep rate increases made worse by a business rates appeals system. From April, the chancellor has frozen rates in a 2% increase. A revaluation planned for 2015 that could exclude 300,000 businesses has been delayed to 2017.

**VAT**

The third highest tax in terms of receipts after income tax and national insurance at around £110bn. A rise to 20% in January 2011 brought in an extra £11.7bn.

**Corporation tax**

Only worth about 9% of total tax receipts, corporation tax is due to decrease further in value if the chancellor cuts the current 24% rate to 20%, to take effect next year. The move will bring in £1bn less a year than if the rate had been kept at the 28% the coalition intended in 2013.

**Excise duties**

Duties on beer and cigarettes have already gone up under this government. More rises are expected as the chancellor seeks to close the deficit.

**National insurance**

An emergency rise in national insurance in 2013, raising an extra £8bn a year, is not likely to be rescinded after intense pressure from employers, despite rising unemployment restricting receipts to £102bn.

**Council tax**

There is much talk of changing the only tax on property, possibly creating new top-tier bands to capture million pound homes. A two-year freeze has limited receipts to £26bn.

**Income tax**

The biggest element of government tax receipts, income tax was expected to benefit from a rise in employment. But successive rises in the personal allowance threshold are expected to cost an extra £3.9bn by 2015/16.

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**Defence**

According to the latest figures (2010), the UK is the fourth highest spender in cash terms on defence in the world behind the United States, China and France. But after fierce criticism of the £33bn review, the government has protected spending on defence by promising to raise overall expenditure in this area to a constant target of 0.7% of GDP.

**Education**

The capital budget of £2.7bn in 2010-11 was due to bottom out at £2.3bn in 2013-14 before being restored. About £6bn will be made available after April to create new school places, and to carry out maintenance and repair work to existing school buildings. General spending will rise behind inflation.

**Transport**

The Treasury will funnel a smidgen more cash into major transport projects, and it will also use a new, souped-up version of the private finance initiative to try to attract private sector cash. But we can still expect drastic fare rises over the coming years, as the coalition shifts the burden of funding the transport network from the taxpayer to the passenger.

**Public order & safety**

The Home Office and Ministry of Defence are struggling to implement some of the steepest cuts in Whitehall. Reductions in the police force combined with privatisations are key areas for savings. The Home Office is due a review.

**Health**

A backstairs privatisation of the health service has eaten into hospital and GP budgets, which will make a small, below-inflation rise in spending this year difficult to manage. Below-inflation rises are expected to continue as the NHS gets by on £104bn in 2012-13, rising to £114bn in 2014/15.

**Industry, agriculture & employment**

The Department for Business, Innovation and Skills is expected to cut 1.5% from its spending over four years.

**Housing & environment**

House building has fallen to a record low. Not since the 1920s has the UK built as few homes. Nevertheless, it is an area targeted for cuts. Environmental policy is likely to suffer as green subsidies are rolled back.

**Debt interest**

Although the national debt has ballooned to more than 70% of GDP, the UK is considered a safe haven by foreign lenders, which has kept interest rates low. That said, the UK must raise billions of pounds of new debt just to maintain spending.

**Personal social services**

A Cinderella area of spending, it covers home help to social work and is a chief target for cuts. An ageing population is expected to put extra strain on budgets.

**Social protection including tax credits**

The welfare bill is one of the chief drains on the public purse after wide-ranging cuts last year. Higher rate taxpayers have already lost their child benefit.

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**Text:** Philip Inman Economics Correspondent

**Graphics:** Guardian Graphics, Obvious. The Treasury
### Table 1: English NHS spending from 2009/10 to 2015/16, real terms in 2014/15 prices (£bn)

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</thead>
<tbody>
<tr>
<td>Total DEL, in cash terms (£bn)</td>
<td>98.42</td>
<td>100.42</td>
<td>102.84</td>
<td>105.22</td>
<td>109.72</td>
<td>113.30</td>
<td>116.36</td>
</tr>
<tr>
<td>Total DEL, excluding depreciation, in real terms (£bn)</td>
<td>108.84</td>
<td>108.06</td>
<td>108.72</td>
<td>109.41</td>
<td>112.03</td>
<td>113.30</td>
<td>114.75</td>
</tr>
<tr>
<td>Annual change in Total DEL spending, excluding depreciation, in real terms</td>
<td>-0.7%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>2.4%</td>
<td>1.1%</td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>Total DEL, excluding depreciation, per head, in real terms (£)</td>
<td>2,085</td>
<td>2,053</td>
<td>2,047</td>
<td>2,045</td>
<td>2,081</td>
<td>2,089</td>
<td>2,101</td>
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<tr>
<td>Annual change in Total DEL expenditure per head, in real terms</td>
<td>-1.6%</td>
<td>-0.3%</td>
<td>-0.1%</td>
<td>1.7%</td>
<td>0.4%</td>
<td>0.6%</td>
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</tbody>
</table>

**Source:** Public Sector Expenditure Analyses 2014 (HM Treasury); 2014 Autumn Statement (HM Treasury). Spending per head based on author’s calculation using Office for National Statistics population estimates and correspondence with HM Treasury as of 13/01/2014.
Figure 1: Public spending on health in the UK, in real terms and as a percentage of gross domestic product (GDP) (2014/15 prices)


Note: GDP deflators for 1949/50 to 1954/55 were estimated by using the GDP deflators available for the calendar years 1949 to 1954, calculating the yearly change in GDP deflator for these years and applying them to the fiscal years.
Figure 1: Total health spending as a percentage of GDP for the EU-15 countries, 2000 and 2012


* Data for Portugal are current rather than total spending. Data for Belgium exclude investments.
Figure 2: Public spending on health as a percentage of GDP for the EU-15 countries, 2000 and 2012


* Data for Portugal are current rather than total spending. Data for Belgium exclude investments.
At 17.6% of GDP in 2010, US health spending is one and a half as much as any other country, and nearly twice the OECD average.

Total health expenditure as a share of GDP, 2010 (or nearest year)

1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Total expenditure excluding investments.
Information on data for Israel: [http://dx.doi.org/10.1787/888932315602](http://dx.doi.org/10.1787/888932315602).

Source: OECD Health Data 2012.
Reforms
Framework for the reforms

Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve (transactional reforms)

More choice and a much stronger voice for patients (demand-side reforms)

Better care Better patient experience Better value for money

More diverse providers, with more freedom to innovate and improve services (supply-side reforms)

A framework of system management, regulation and decision making which guarantees safety and quality, fairness, equity and value for money (system management, or ‘structural’ reforms)

Note: Adapted from NHS Health reform in England: update and commissioning framework, 2006
The new NHS: how providers are regulated and commissioned

**Contract with**

- Providers of NHS services
  - Private providers
  - Voluntary sector
  - GPs
  - Governors
  - Foundation trusts
  - NHS trusts

**Care Quality Commission**
Independent regulator for quality

**Monitor**
The financial regulator of foundation trusts

**NHS Trust Development Authority (NHS TDA)**
Responsible for overseeing the performance management and governance of NHS trusts

**NHS Improvement**
- Brings together Monitor and the NHS TDA, along with: NHS England’s Patient Safety Team; the Advancing Change Team; NHS Interim Management and Support’s two Intensive Support Teams; and the National Reporting and Learning System
- Oversees foundation trusts, NHS trusts and independent providers
- Supports providers and local health systems to improve
- Holds providers and boards to account and, where necessary, intervenes
The new NHS: how the money flows

Parliament
£120.4 billion

Health Education England
£5.0 billion

Department of Health
£106.8 billion

Regulators: 
NHS Improvement, 
Care Quality Commission

NHS England and regional teams (4)

£2.1 billion 
Sustainability and Transformation Fund

Local authorities (152)
£3.4 billion

Better Care Fund
£1.1 billion*

Clinical commissioning groups (209)

£71.9 billion

Public health

Community services

Mental health

Hospital services

Primary care

Specialised services

£3.4 billion

£12.8 billion

£15.7 billion

* Screening/immunisation programmes run by NHS England.

** In 2016/17 a total of 114 CCGs will have assumed full responsibility for the commissioning of primary medical care services under delegated commissioning arrangements. Nearly all CCGs are expected to have taken on delegated arrangements by 2017/18.
The new NHS: who can influence commissioning of services

Greater Manchester health and social care devolution arrangements**

** From 1 April 2016, leaders in Greater Manchester are taking greater control of the region’s health and social care budget. This includes taking on delegated responsibility for several commissioning budgets previously controlled by NHS England. Other areas are also pursuing ‘devolved’ arrangements.
WHY DOES FUNDING GO UP?

- **Politics** – main issue at elections
- **Population** increase & life expectancy
- **Demand** – emergency admissions up by 50% in 10 years
- Improving **access** to care – waiting times & 7 day
- Improvements in **technology** & drugs
IS THERE ENOUGH MONEY?

NHS is very complex

£10 billion extra funding announced; Sounds a lot but…

• Many parts of NHS in **deficit** already
• Money **phased** in over several years
• Real terms – but is **inflation** higher?
• **Cuts** elsewhere – e.g. Social Care, education, capital
• **Demands** on NHS increasing – 7 day working
5 Year Forward View
(and beyond?)
### Table 1: NHS England estimates of funding pressures facing the NHS in England by the end of the decade

<table>
<thead>
<tr>
<th>Annual productivity growth assumption</th>
<th>Funding requirement in 2020/21 above inflation</th>
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<tr>
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<td>£21bn</td>
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<tr>
<td>1.5%</td>
<td>£16bn</td>
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<tr>
<td>2.3%</td>
<td>£8bn</td>
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**Note:** NHS England's projections of total spending are in cash terms, allowing them to explore the impact of cost pressures (such as pay) separately to assumptions for GDP deflators. The budget for NHS England is then assumed to rise with inflation.
Table 1: Funding gap for the English NHS in 2020/21 under scenarios from NHS England's Five year forward view

<table>
<thead>
<tr>
<th>Productivity</th>
<th>Funding gap in 2020/21</th>
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<tbody>
<tr>
<td>0.0%</td>
<td>£30bn</td>
</tr>
<tr>
<td>0.8%</td>
<td>£21bn</td>
</tr>
<tr>
<td>1.5%</td>
<td>£16bn</td>
</tr>
<tr>
<td>2.0% - 3.0%</td>
<td>£8bn</td>
</tr>
</tbody>
</table>

**Note**: NHS England’s projections of total spending are in cash terms, allowing them to explore the impact of cost pressures (such as pay) separately to assumptions for GDP deflators. The budget for NHS England is then assumed to rise with inflation.
Figure 3: Funding pressures on English NHS in 2030/31 (2014/15 prices)

Tea & Coffee Break
Introduction to NHS England Finance

Adrian Perry, Head of Finance
CCG Financial Assurance and Performance
South (South East)

September 2016
Contents

National

Local – What do we do?

Outlook

Questions!
National
NHS England Mandate

• Published each year by the DH
  “To make sure the taxpayer has a say in how this money is spent, the Government provides direction and ambitions for the NHS through a document called ‘the Mandate’.”

• Accompanied by Financial Directions
• Financial directions set out Revenue resource limits, Capital resource limits and certain expenditure controls which NHS England must adhere to
• NHS England Group reports to treasury (through DH) in line with the different limits set out in the directions
IFRS Reporting

- NHS England Entities report and are monitored on International Financial Reporting Basis (IFRS)
- IFRS Interpreted for HM Government by Treasury’s Financial Reporting Manual (FReM)
- DH manual for accounts sets out further guidance for NHS bodies
- Statutory accounts are prepared on IFRS basis for all entities (CCGs, NHS England Parent and NHS England Group)
- CCG performance against financial duties measured on IFRS basis
Resource - £ billions

- NHS England  £101
  - Direct commissioning  £12
  - Specialised Commissioning  £15
  - Programme/Running Costs  £1

- CCGs  £73
Headlines from 15/16

NHS England delivered a small surplus of £599m above plan (0.005%!)

- £16m deficit from CCGs
- Direct Commissioning surplus of £195m
- Specialised overspend of £112m
- Other underspends of £532m largely centrally driven and one-offs

DH overall?

- Provider Overspends
Contents

Local – What do we do?
Clinical Commissioning Groups across the South of England
(Jan 2015)
South Overview – some facts

• Registered population of 14.7m people (25.6% of NHSE total)

• 50 CCGs, with programme allocations of £16.4bn (24.5% of NHSE total)

• Specialised commissioning funding of £3.2bn (23.9% of NHSE total)
• Primary care funding of £3.0bn (24% of NHSE total)

• 56 NHS providers (amongst many other non-NHS providers)
  • 35 FTs, 21 Trusts
  • 36 Acute, 12 Mental Health, 5 Community, 3 Ambulance

• NHS England currently employs 1,035 people across the South, with 78 in finance functions
NHSE South East - What we do

Corporate and Running Costs

Direct Commissioning

CCG Assurance & Performance

Other Stuff
Direct Commissioning

The South East Local Office has a Direct Commissioning budget of

£1.1bn

For comparison, Barts Health £1.3bn, East Kent Hospitals £0.5bn

What could £1.1bn buy?
... the new Wembley Stadium
... 30 Wayne Rooneys
...One thousand Madonna concerts
(performing in your living room)
Direct Commissioning

What does £1.1bn buy?

602 GP Practices
779 Dental Surgeries
893 Pharmacists
Services into 14 prisons, IRC & Secure Children’s Homes and Training Centres
Screening Programmes
Immunisation Programmes
Direct Commissioning

- Primary Care £845.6m (79%)
- Public Health £97.6m
- Secondary Dental £69.4m
- Health & Justice £52.3m
- Dental £226.1m
- Pharmacy £53.0m
- General Practice £505.4m
- Ophthalmic £16.0m
- Public Health £97.6m
- Other £9.3m
- Surplus £13.2m
Direct Commissioning

Primary Care, Public Health, Secondary Dental and Health & Justice.

The team ensures that processes are in place to enable us to deliver our financial plans through Budget setting and monthly reporting.

The quality of the information we provide is dependent on the information we receive, so we work closely with contract managers & CSU

Working with Capita to ensure GP payments are accurate & timely
CCG Assurance & Performance

A bit of background information …

In South East we have 20 CCG’s, 40% of the South total and nearly 10% of the national total.

Q: How much funding goes to CCG’s in South East?
A: £5.7 billion in total in 2015-16 which is 8% of the national allocation for CCG’s.
The split per CCG is shown below (in £m's).

Q: What do our 20 CCG’s spend the money on?
A: £5.6bn on commissioning healthcare and £0.1bn on running costs.
CCG Assurance & Performance

What we do …

• We assure the CCG’s **Finance & Activity plans** for the upcoming financial year(s) and assess consistency with Strategic Plans

• We **monitor performance against plans** on a monthly basis, producing internal and external reports that RAG rate against a number of key indicators

• We provide financial information and opinion to support the **CCG Assurance** process

• We work with CCGs to ensure **reporting in ISFE/non-ISFE returns** is representative of their position

• We review **Financial Recovery Plans** for robustness, and monitor and challenge progress being made against them

• We work alongside regional and national colleagues to ensure the **delivery and accuracy of in-year reporting**

• We **provide guidance and support** to CCG’s on financial issues, encouraging **collaborative working**

• We assist the Central Team in the delivery of the **Annual Accounts** by reviewing CCG submissions
Other Roles in Finance

**CCG Critical Friend**
- GPIT
- Property Services
- Technical finance issues
- Translating guidance

**Primary Care**
- PMS contract payments
- Advice and assistance with CQRS
- Link with PCS
- Capital

**Costing of Services**
- Direct commissioning
- Running costs
- Reorganisations

**Ad hoc returns**
- Co-commissioning
- RTT
- Programme budgeting

**SBS/ISFE**
- ISFE training
- Workflow issues
Contents

Outlook
5YFV - Longer-term strategic view

Health expenditure projections to 20/21

Source: NHS England modelling
The efficiency challenge

A taxonomy of savings

Effectiveness – get the best outcome per £ spent
- Optimise system to maximise effectiveness, address variation
- Prevention
- Patient and clinician engagement and behaviours
- Deliver care in best model/setting/channel

Efficiency – get the most from inputs
- Across acute, mental health, community and primary care:
  - Workforce productivity/staff mix
  - Procurement
  - Drug use optimisation
  - Estates & back office
  - System overheads
  - External income

Economy – get the best priced inputs
- Pay restraint
- Agency costs
- Procurement prices
- Drug prices

Allocative efficiency

Technical efficiency
Sustainability & Transformation Fund – 3 aims

Stabilise finances

Drive performance

Ensure STP collaboration

Conditionality

- Delivery of control totals
- Carter efficiency targets

- Performance trajectory targets
- Revisions to sanctions framework

- Shared ownership and sign off of plan
What are we trying to achieve?

Focus on delivering long-term transformational change in line with FYFV

Embed national vision and priorities (including the £22bn) in credible locally owned plans

Provide “entry route” for strategic transformation funds

Create balanced provider landscape and eliminate CCG deficits sustainably

Shared ownership of plans and delivery between providers and commissioners across appropriate geographies
What are the key building blocks?

- Balance between liberated strategic thinking and rigorous long-term modelling
- Multi-year allocations, tariff indicators and standard assumptions
- Local programming of key efficiency programmes, e.g. RightCare
- Whole health economy risk management
- Focus geographies
  - “Transformation Areas”
  - Success Regime
  - Devolution
- Value-based business cases for investment
  - Transformation fund
  - High resource growth areas and geographies
- Balance between focus on 44 “strategic footprints” and 500+ organisations accountable for delivery
ANY QUESTIONS?
Lunch Break
HFMA Kent Surrey Sussex Branch
Introduction to NHS Finance
NHS Governance, Regulation & Audit
Content

Regulation in the NHS

Principles of Good Governance

NHS Audit & Assurance

• Audit Committee
• External Audit
• Internal Audit

Some other important aspects of NHS Governance

• Governance across Partnerships
• Clinical Audit
• Counter Fraud
Introduction to NHS Finance
NHS Regulation
It’s out of control
Fears that GPs are too busy to manage Clinical Commissioning Groups have been realised. A recent review by one of the big 4 accounting firms criticised poor governance for the failing profession and prescribing anomalies have been highlighted in a recent report.

Caring
Referral process has been criticised as “harsh” by patient groups. CCGs are being blamed for the lack of resources within the NHS.

GP Systems failing patients
GP computer systems are failing to warn doctors about dangerous prescriptions that could be putting patients’ lives at risk, new research claimed today.

CCG paid for services it did not receive
A CCG has paid for services at a local hospital that were not provided. A recent audit has identified overpayments made for services commissioned from an acute provider. Poor data quality and information systems caused the failure…
Regulation in the NHS

The key regulators and standard setters for NHS bodies:

- **Standards of Care**
  - Care Quality Commission (CQC)
  - National Institute for Health and Clinical Excellence (NICE)
- **Operational/Financial Performance**
  - Providers: NHS Improvement (previously NHS Trust Development Agency and Monitor)
  - Commissioners: NHS England

- **Over-arching everything are**
  - Department of Health (National Health Policy)
  - HM Treasury (Financial matters. e.g. Approval of major capital spend)
The NHS has to comply with lots and lots of other regulations and standards....

- **Other NHS specific**
  - National agencies - such as NHS Protect (for Counter Fraud and Security Management), Medicine & Healthcare products Regulatory Agency, Health & Social Care Information Centre, Public Health England, Health Education England
  - Not strictly regulators - but issue professional guidance: British Medical Association, Royal College of Nursing

- **Plus all the “usual” regulators**
  - Health & Safety Executive, Information Commissioner’s Office, HMRC etc
NHS Improvement

FORMERLY - MONITOR + TRUST DEVELOPMENT AUTHORITY

- **Regulate** Providers – license NHS providers and monitor performance

- **Ensure problems** at providers are solved
  - by management, or
  - use powers to intervene. e.g. Put provider into ‘special measures’ and appoint Improvement Director

- **Support** national change programmes – provide leadership/expertise
Care Quality Commission

• Independent **Regulator** of healthcare service quality

• **Inspects** quality of services - under 5 key “domains”, are they:
  • Safe?
  • Effective?
  • Caring?
  • Responsive to people’s needs?
  • Well led?

• **Reports** in public – Rates services as:
  • Outstanding
  • Good
  • Requires Improvement
  • Inadequate

• Requires action plans to **improve**
National Institute for Health & Clinical Excellence

Promotes consistent standards and aims to avoid “Postcode Lottery”

Responsible for provision of guidelines in four areas:

1. Medicines & treatments
   • Assessment of new drugs and treatments as they become available

2. Clinical practice
   • Issues evidence based guidelines on how particular conditions should be treated

3. Health Promotion
   • Guidance on how public health and social care services can best support people

4. Social Care
   • Information services for those managing and providing health and social care
Introduction to NHS Finance
Principles of Good Governance
Why/What is Good governance?

- Leads to:
  - good management
  - good performance
  - good stewardship of public money
  - good public engagement and, ultimately,
  - good outcomes.

- Builds public and stakeholder confidence that healthcare is in good hands.
- Describes the ways in which organisations conduct themselves to ensure they carry out their duties successfully and to the standards expected of them.
- Concerned with accountability and responsibilities, and describes how an organisation is directed and controlled.
- Underpinned by Nolan Principles...
In short, “governance” is:

“the way an organisation is directed and controlled”

In the NHS, governance arrangements need to ensure bodies are:

• Accountable (to the public and government) for:
  • commissioning/delivering essential healthcare services properly, and
  • spending public money wisely
Integrated Governance

- Corporate governance – including strategic risk management;
- Financial governance;
- Clinical governance;
- Information governance; and
- Research governance.
Key Governance Tools

- Constitution
- All strategies, policies, procedures (SOs, SFIs etc)
- Standards of Business Conduct
- Assurance Framework and Risk Management arrangements
- Company Secretary role
- Committee structure and Terms of Reference
  - Audit Committee
- Reporting structures
- Controls to manage Conflicts of Interest
- 3 Lines of Defence (bit more on this later!)
Introduction to NHS Finance
Audit & Assurance in the NHS
“Internal Controls”:

- Processes/mechanisms put in place by management to help accomplish specific goals or objectives
- Examples include: policies, authorisation limits, separation of duties, physical security, supervision, reconciliations etc.

“Assurance”:

- “Evidence”, “the avoidance of doubt” or “difference between guessing and knowing”
- Independent, external assurances include reports/opinions from - auditors, inspectors, legal experts etc.
- Internal assurances encompass regular and ad-hoc reports such as management accounts/KPI progress reports - from execs, line management or compliance teams
Three Lines of Defence Model

Definition:

1. Management control is the first line of defence in risk management,
2. the various risk control and compliance oversight functions established by management are the second line of defence,
3. and independent assurance is the third.”

Institute of Internal Auditors (IIA) Position Paper
Sources of Assurance

‘Three Lines of Defence’

FIRST
Arrangements to ensure objectives are being met and risks managed

SECOND
Corporate oversight and compliance functions

THIRD
Objective assurance that the system is working, supported by the audit committee

Internal Controls
Management And Oversight
Checking Testing
Audit Committees

The Board/Governing Body will delegate to an Audit Committee the detailed scrutiny of assurances regarding:

• Accounting systems and financial reporting;
• Preparation of accounts & supporting materials (e.g. Annual Report);
• Operation of wider internal controls;
• Identification and management of risk; and
• Content and operation of the Assurance Framework.
Audit Committee’s Key Functions

Sub-Committee of the Board/Governing Body

Membership - non-executive and [majority] independent

Prime function is to provide Board with assurance

Assurance over what.....?

“the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities (both clinical and non-clinical)”

Source: HFMA NHS Audit Committee Handbook - AC Model Terms of Reference
Audit Committee Scope

In particular, adequacy and effectiveness of:

• All risk and control related disclosure statements (in particular Governance Statement)
• Underlying assurance processes, effectiveness of the management of principal risk
• Policies for ensuring compliance with regulatory & legal requirements and related reporting and self-certifications
• Policies and procedures related to fraud and corruption

Source: HFMA NHS Audit Committee Handbook - AC Model Terms of Reference
Audit Committee - Key Responsibilities

- Governance, Risk & Control
- Financial Reporting
- Internal Audit
- External Audit
- Other Assurance
- Counter Fraud
- Management
- Board Reporting
External Audit

• Always carried out by external, independent, firms
• Firms are regulated and authorised
• Following demise of the Audit Commission, from 2016 all NHS bodies must now appoint their own external auditors
• Report any material mis-statements to the Audit Committee
• Can also report directly to the Department of Health under certain conditions if serious issues.
Key role/responsibilities of external audit relate to:

- checking end of year accounts
- reviewing quality accounts and testing a sample of indicators
- responsibility to report if the content of Annual Governance Statement is inconsistent with results of their audit work
- give a conclusion about “Value For Money” aspects of the organisation
Internal Audit

• Is a management resource, established to be independent of operations
  • Has a right of access to all information/records
  • Can report direct to Audit Committee Chair if necessary
• May be delivered by an internal team, but usually outsourced to specialist firms or shared-services
• Is accountable to independent Audit Committee
• Must comply with Public Sector Internal Audit Standards
Internal Audit

- Internal Audit work plans cover all areas
  - CQC compliance, to computer security through Estates, HR and Finance
- Annual Plan within a long-term (typically 3 year) Strategic Plan
- Risk based, with topics drawn from the organisation’s Board Assurance Framework and Risk Management processes.
- Internal audit reports usually contain
  - An opinion level for the area
  - Graded recommendations in respect of any issues (control failures or weaknesses)
- At end of the year results are summarised into an overall “Head of Internal Audit Opinion”
  - Informs the organisation’s Annual Governance Statement.
Introduction to NHS Finance
Some other important aspects of NHS Governance
NHS Trusts/CCGs work with multiple partners:

- Across CCGs, through collaborations and lead commissioner arrangements
- Other Provider bodies – NHS, Private and ‘third sector’
- Local shared and hosted services
- National/regional back office/shared services – CSUs, SBS
- Local authorities - social services/Better Care Fund
- Others e.g. University Medical Schools, NHS Property Co, NHS England
Governance across Partnership Organisations

Main governance processes covered are:

- Contracts, partnership arrangements, and service level agreements;
- Governance arrangements over formal partnerships/pooled budgets, including audit, processes for managing risk and concerns arising;
- Monitoring outcomes/performance information metrics (KPIs);
- Additional scrutiny by Health & Wellbeing Boards.
Health & Wellbeing Boards

• Hosted by Local Authorities
• Aim to integrate Health & Local Authority services
• Joint planning to tackle inequalities
• Social conditions are a key cause of poor health
• Joint Strategic Needs Assessment
Clinical Audit

• Not the same as Internal/External Audit!
• Focus is on improving clinical processes and learning lessons.
• Studies are clinician-led – usually with central support and co-ordination by an internal Clinical Audit team.
• Clinical Audit plans cover national mandated audits, plus local topics developed by clinicians and the NHS organisation.
• Plans usually reported to, and monitored by Quality Committee.
Fraud in the NHS....

Woman walks off the street to land a job as an NHS nurse for five years - treating hundreds with no qualifications

Michael Waterfield, prosecuting, said that when the Nursing and Midwifery Council discovered the mistake it "wrote to the defendant and said she should not practice but she didn't reply nor tell the hospital."

She worked there until February 2007 and claimed £86,700 gross.

Moonlighting nurse rapped

ISLEWORTH: Woman pocketed £20k

AN ISLEWORTH nurse who moonlighted for an employment agency while being signed off sick from her NHS job has been found guilty.

Yvonne Quiteriano, 51, of Osterley Road, was sentenced at Isleworth Crown Court on Friday, January 13, after fraudulently pocketing more than £20,000 in sick and agency pay.

Quiteriano had been a cancer specialist for the Imperial College Healthcare NHS Trust when she stopped work because of an injured leg in March 2009.

But within days she was on the books of a temp agency in an effort to make in extra cash, which she did until April 2010.

Howard Tobias, prosecuting, said: "She had signed off work in March 2009 from her employer at the Imperial College NHS Trust and had then gone on to work for an agency."

"At the same time as receiving money from the agency she failed to declare employment sickness payments.

FRAUD IS NOT A VICTIMLESS CRIME. IT DOES REAL HARM
Fraud in the UK

Recorded Fraud Offences 2013/14 = 211,279 (17% increase on 2012/2013)

Total cost of fraud in the UK per year has been estimated at:

£73 billion!

(Source: National Fraud Authority estimate in March 2012)

Of which Public Sector Fraud = £20.3 billion (including Benefits and Tenancy Fraud)

What about the NHS?

Estimates up to £3 billion annually!
Definition of Fraud

Fraud is a lie or deception. Trickery, in order to obtain goods, money or services to which you know you are not entitled. To avoid paying for something that you know you should pay for.

- s2 Fraud by False Representation
- s3 Fraud by Failure to Disclose
- s4 Fraud by Abuse of Position
- s11 Obtaining Services Dishonestly
- Burden of Proof – Beyond All Reasonable Doubt
So who commits fraud against the NHS...?

Patients
- Wrongful claiming of fee exemption/travel expenses
- Altering FP10 prescriptions
- Using aliases to obtain controlled drugs/treatment
- Counterfeit coins and banknotes

Managers and staff
- Timesheet and payroll fraud
- Creation of bogus employees
- False purchase orders/invoices
- False sick/study/adoption leave

Professionals
- Altering prescriptions
- Claiming for work not undertaken
- Creating ghost patients
- Forged qualifications
- False references

Contractors and suppliers
- Submitting bogus invoices
- Price fixing
- Insider knowledge of tenders
- Bribery
A few common examples of fraud in the NHS

- Manipulation of prescription by patients
- Ghost patients on a CCG’s Continuing Healthcare database.
- Care Provider failing to notify CCG a patient has passed away - and continuing to submit invoices for care.
- Failure to declare Conflicts of Interests
- Supplier Invoicing Fraud – duplicate/inflated
- Staff working while on sick leave.
- Staff Expenses fraud – bogus trips/mileage claimed.
- Agency staff overclaiming - Timesheet fraud.

This is not an exhaustive list!
The UK Bribery Act 2010

A person commits an offence if they:

• Receive a Bribe from someone,
• They offer a Bribe to someone,
• They Bribe a foreign official,
• If the Board/Governing Body fail to take reasonable steps to prevent Bribery.
Examples of possible Bribery Offences in NHS

• Purchasing Officer/CHC placement team accept an inducement (tickets/travel) from a supplier/care provider to purchase goods or services on behalf of the Health Body.

• Finance Officer provides details of competitor pricing during a tender process in return for cash/holiday etc.

• Temporary Staffing team accept gifts from a Staff Agency to encourage use of that agency.

• Consultant/GP accepts all expenses paid training/conference in foreign locations (e.g. Philadelphia, Dubai) from pharmaceutical or medical device company.
How to protect yourself

DO
• Declare all gifts and hospitality over the limit set out in the Gifts and Hospitality Policy

DO NOT ACCEPT
• Backhanders, facilitation payments or favours to gain business

ASK YOURSELF
• How would this look if my actions were reported in the Local or National press....?
Quotes to help those new to NHS perhaps...

Challenge jargon and complexity: “If you can't explain it simply, you don't understand it well enough.”
Albert Einstein

Demand brevity: “This paper, by its very length, defends itself from ever being read.”
Winston Churchill

And finally, a good reason why we need checks and balances in large organisations!
“I try to buy stock in businesses that are so wonderful that an idiot can run them. Because sooner or later, one will.”
Warren Buffett
Any Questions?

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The content of this document is intended to give general information only. Its contents should not, therefore, be regarded as constituting specific advice, and should not be relied on as such. No specific action should be taken without seeking appropriate
Introduction to CCG Finance

Adrian Perry
Head of Finance, CCG Financial Assurance and Performance
NHS England South (South East)
Introduction

• What is a CCG?
• CCG Responsibilities
• CCG Improvement & Assurance
• Planning for the Future
What is a CCG?

- Membership bodies
- Led by an elected Governing Body
  - In practice the membership delegates functions to the CCG Governing Body
- Independent Statutory Bodies
- Accountable to the Secretary of State for Health through NHS England
CCGs – Statutory Body

- Governing Body
- Sub Committees:
  - Remuneration Committee
  - Audit Committee
  - Patient Safety & Quality Committee
  - **Primary Care Commissioning Committee**
CCGs - Commissioning

- Responsible for 2/3 of NHS England budget
  - c.£72 billion and increasing
- Responsible for the health of the entire CCG’s population
- Responsible for healthcare commissioning
  - Mental Health
  - Urgent & Emergency Care
  - Elective Hospital Services
  - Community & Primary Care
Clinicians being involved in prioritising, planning and decision making on behalf of the population
Financial Responsibilities

- Statutory Financial Targets
- Programme Budgets
- Running Costs
- Cash
- Distance from Target
CCG Improvement & Assessment

• Better Health:
  – How CCG contributes towards improving health and wellbeing.

• Better Care
  – Care Redesign, Performance of Constitutional Standards and Outcomes

• Sustainability
  – How CCG is remaining within financial balance and securing good value for patients and public

• Leadership
  – Quality of CCG leadership, plans and governance arrangements
  – How the CCG works with it’s partners
CCG Improvement & Assessment Framework

Improved Health
- Personalisation and Choice
- Health inequalities
- Clinical priority: Diabetes
- Child obesity
- Smoking
- Falls
- Anti-microbial resistance
- Carers

Better Health

Better Care
- Urgent and emergency care
- Primary medical care
- NHS Continuing Healthcare
- Elective access
- 7 day service
- Care ratings
- Clinical priorities:
  - Maternity
  - Dementia, Cancer,
  - Learning disabilities,
  - Mental health

Leadership
- Quality of Leadership
- Workforce engagement
- CCGs' local relationships
- Probity and corporate governance
- Sustainability and transformation plan

Sustainability
- Estates strategy
- Allocative efficiency
- New models of care
- Financial sustainability
- Paper-free at the point of care

Delivering the Five Year Forward View
Planning, STPs and the Future…

- Sustainability and Transformation Plans across a wider footprint
- System wide Income & Expenditure
- “Shared Fates” - Shared £ Targets
- Single Demand and Capacity Model
- Different Care Models/Organisational Structures:
  - Horizontal Care Structures
  - Accountable Care Organisations
  - Form following function?
Challenges

• Financial Sustainability (both CCG and STP wide)
• Performance Targets
• Increasing activity/complexity
• Better Care Fund and Joint Commissioning
Questions....
Tea & Coffee Break
Provider Organisations

Sheila Stenson
Deputy Director of Finance
Maidstone & Tunbridge Wells NHS Trust

Victoria French
Associate Director of Finance
Kent & Medway NHS & Social Care Partnership Trust
Contents

- What is a provider?
- How is a provider funded?
- What is the money spent on?
- How do providers manage their finances?
- Current challenge for provider sector
What is a provider?

- Primary, secondary, tertiary

Hospitals (acute)
- Mental Health Trust
- Ambulance Trust
- GPs
- Community Services
- Local Authority
- Dental Providers

Private providers (e.g. BUPA)

3rd sector (charities, social enterprises)
Contents

- What is a provider?
- How is a provider funded?
- What is the money spent on?
- How do providers manage their finances?
- Current challenge for provider sector
Your Thoughts?

Please take 5 minutes in groups to discuss the below:

*How do you think providers are funded?*

*What do you perceive the role of Finance to be in a provider setting?*
How is a provider funded?

Clinical commissioning groups (CCGs)

NHS England

Local authorities

Contract with

Providers of NHS services

Private providers

Voluntary sector

GPs

Foundation trusts

NHS trusts

Care Quality Commission
Independent regulator for quality

Monitor
The financial regulator of foundation trusts

NHS Trust Development Authority (NHS TDA)
Responsible for overseeing the performance management and governance of NHS trusts

NHS Improvement
- Brings together Monitor and the NHS TDA, along with: NHS England’s Patient Safety Team; the Advancing Change Team; NHS Interim Management and Support’s two Intensive Support Teams; and the National Reporting and Learning System
- Oversees foundation trusts, NHS trusts and independent providers
- Supports providers and local health systems to improve
- Holds providers and boards to account and, where necessary, intervenes

Source: The Kings Fund
Payment by Results (PbR) – an introduction

• Payment by Results (PbR) is the hospital payment system in England. Under PbR, commissioners pay providers a national tariff or price for the number and complexity of patients treated or seen.
• The currency, or unit of payment, for the admitted patient care tariff is the Healthcare Resource Group (HRG).
• HRGs are clinically meaningful groups of diagnoses and interventions that consume similar levels of NHS resources.
• Tariff prices have traditionally been based on the average cost of services using annually collected reference costs.
• The tariff is uplifted by a nationally determined market forces factor (MFF) which is unique to each trust (i.e. location in the country can affect the cost to provide a service)
Payment by Results (PbR) – the aims

PbR was introduced to:

• support patient choice by allowing the money to follow the patient to different types of provider

• reward efficiency and quality by allowing providers to retain the difference if they could provide the required standard of care at a lower cost than the national price

• reduce waiting times by paying providers for the volume of work done

• refocus discussions between commissioner and provider away from price and towards quality and innovation.

(Source: Department of Health)
Payment by Results (PbR) – an overview

**Treatment**
- Admitted Patient Care, Outpatients, A&E

**Coding**
- On discharge care is coded by clinical coders
- These codes, and other data including age and length of stay, are recorded on the Patient Administration System (PAS)

**Grouping**
- A currency is used to collate the interventions and diagnoses into common groupings so a tariff can be applied.
- The currency for admitted patient care is Healthcare Resource Group (HRG4)
- Data is submitted to the Secondary Users Service (SUS) which assigns the HRG based on the clinical codes

**Tariff**
- The tariff price depends on the HRG
- Tariff adjustments - long or short stays, best practice, uplifts, Market Forces Factor (MFF)
- Income = activity x price x MFF

**Payment**
- Commissioners (CCGs) and Providers (Trusts) agree an annual contract for activity which is paid in equal twelfths each month
- Commissioners and Providers use the reports from SUS to compare planned activity against actual. This could result in an additional payment to the Provider or a refund to the Commissioner each month
Payment by Results (PbR) – current position

- Review of national tariffs by Monitor commenced in 2013 and has proved challenging to agree a new approach
- Constant debate as to whether PbR is now fit for purpose
- NHS England and Monitor have published the 2016/17 National Tariff Payment System, which came into effect on 1 April 2016 and uses HRG4.
- This year’s national tariff aims to give providers of NHS services the space to restore financial balance and support providers and commissioners to make ambitious longer term plans for their local health economies.
Non PbR Income – an overview

• Providers receive income via non PbR for treating patients

• In most cases non PbR covers areas where a national tariff has not yet been agreed

• There will be a contract between the Commissioner and Provider for a set level of activity at an agreed (negotiated) price. This is then paid via a locally agreed tariff or a block payment.
Other Income

• A provider has other sources of income in addition to PbR and Non PbR that relate to non patient care activities

• This includes:
  • Education and training
  • Research and Development
  • CQUIN
  • Private patients
  • Overseas patients
  • Car Parking
  • Catering
Contents

- What is a provider?
- How is a provider funded?
- What is the money spent on?
- How do providers manage their finances?
- Current challenge for provider sector
How much is…?

Please take 5 minutes in groups to answer the following questions:

1. How much of a provider budget is staff salaries (in percentage terms)?
2. How much of a provider budget is drugs (in percentage terms)?
3. How much do the following items cost the NHS:
   – One nurse (for a year)
   – One consultant (for a year)
   – One hip replacement
   – One course of chemotherapy
   – Annual insurance premium for clinical negligence
What is the money spent on in a provider?

- Pay costs, 66%
- Other, 15%
- Clinical Supplies, 8%
- Drugs, 7%
- Depreciation, 4%
How many NHS Staff work in provider organisations?

• In 2015, across provider organisations the NHS employed:
  – 149,808 doctors
  – 314,966 qualified nursing staff and health visitors
  – 25,418 midwives
  – 23,066 GP practice nurses
  – 146,792 qualified scientific, therapeutic and technical staff
  – 18,862 qualified ambulance staff
  – 30,952 managers.
• 51.5% of NHS employees are professionally qualified clinical staff
• 26.6% provide support to clinical staff
• Between 2009 and 2015 the number of professionally qualified clinical staff within the NHS has risen by 3.9%.
Number of nurses employed in acute settings (excluding bank and agency staff)

Source: HSCIC. NHS workforce statistics, September 2015

Source: Health Foundation
Contents

- What is a provider?
- How is a provider funded?
- What is the money spent on?
- How do providers manage their finances?
- Current challenge for provider sector
Financial governance framework (1)

- Standing Financial Instructions (SFIs)
  - DEFINE
- Scheme of Delegation
  - DEFINE
- Business Case process
  - DEFINE
Financial governance framework (2)

• Annual Planning Cycle
  – Provider organisations are required to submit an annual plan to NHS Improvement each April
  – This annual plan should be based on annual budgets set for the organisation

• Budget Holder limits and authorisation

• Performance Meetings
  – DEFINE
Budget Holder Responsibilities

- Budget Holders are responsible, once budgets are set:
  - To contain expenditure within budget
  - To ensure that all expenditure attributed to the budget has been requisitioned and authorised by an appropriate, designated member of staff or the Budget Holder
  - To review budgetary information on a regular basis and undertake any corrective action that may be required to bring it in line with plan
  - To liaise with the Finance Directorate in the production of accurate reports and reliable forecasting
  - To ensure no capital expenditure is incurred against revenue budgets
  - To ensure that value for money is being obtained from expenditure incurred on individual budgets
External Monitoring and Reporting

• Providers submit monthly, quarterly and annual reporting to regulatory bodies.
• Previously the Continuity of Services Risk Rating (COSRR) scored providers on a scale of 1-4, with 1 being poor performance and 4 being exceptional performance based on two metrics - capital service capacity and liquidity.
• For 2016-17 the finance and use of resources assessment (developed with the Care Quality Commission) will be used to identify early signs of financial problems. It will bring a greater focus on efficiency using the recommendations of the Carter report. Four metrics will be implemented immediately:
  – Capital service capacity
  – Liquidity
  – Distance from control total or financial plan
  – EBITDA margin
• A further three will be introduced in shadow form in 2016/17:
  – Cost/weighted activity unit
  – Capital controls
  – Agency spend
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Historic Provider Performance

2012/13
- Number of trusts in deficit: 28 (11%)
- Number of trusts in surplus: 221 (89%)

2013/14
- Number of trusts in deficit: 66 (27%)
- Number of trusts in surplus: 183 (73%)

2014/15
- Number of trusts in deficit: 129 (52%)
- Number of trusts in surplus: 120 (48%)

Year to date deficit, Q3 2015/16
- Number of trusts in deficit: 61 (25%)
- Number of trusts in surplus: 179 (75%)

Note: number of trusts based on official count from TDA and Monitor, which includes mergers

Source: Health Foundation
Performance of the NHS provider sector year ended 31 March 2016, shows:

- overall the NHS provider sector reported a deficit of £2.45 billion, this is £461 million worse than planned
- 157 (65%) out of 240 providers reported a deficit: the majority of these were acute trusts
- providers paid £751 million in fines and readmission penalties to commissioners of which £253 million was re-invested in improving patients services
- the provider sector spent £3.64 billion on agency and contract staff: £1.4 billion more than planned
- providers made £2.9 billion of savings: £316 million less than planned
Future of the Provider Sector

• The NHS is facing a £21.6bn funding gap over the next five years.

• This is expected to be addressed through:
  – £6.7bn of national delivered savings from areas such as the 1% pay cap and reducing NHS England central budgets and admin costs
  – £1bn from non-NHS providers and CCG running cost reductions already delivered
  – £4.3bn from activity-related efficiencies, such as care redesign
  – £8.6bn from provider productivity – indicating a 2% annual efficiency requirement each year
  – £1bn from other commissioning efficiencies
2016-17 Provider Challenge

- Following the agreement of control totals in all but 19 providers and the implementation of the £1.8bn sustainability and transformation fund, the aggregate planned deficit stands at around £550m for 2016-17.
- There are three areas identified for improvement by the end of July:
  - pathology and back office consolidation
  - pay costs
  - unsustainable service consolidation.
Sustainability and Transformation Fund

• The NHS shared planning guidance 2016/17 – 2020/21 outlines a new approach to ensure that health and care services are planned by place rather than around individual organisations.

• Every health and care system needs to produce a sustainability and transformation plan (STP), showing how local services will work together to improve the quality of care, their population’s health and wellbeing and NHS finances.

• NHS organisations need to establish place-based ‘systems of care’, collaborating to address the challenges and improve the health of the populations they serve.

• There are 44 STP localities across the country, with first plans submitted in June 2016 and revised plans due for submission in September 2016.
Lord Carter Efficiencies

Operational Productivity & Performance

- Optimising Clinical Resources
- Optimising Non Clinical Resources
- Quality and Efficiency
  - Patient Pathway
- Model Hospital / Integrated Performance Network
- Engagement / Implementation
  - Productivity & Efficiency Plans 2020
  - Productivity & Efficiency Timetable 2020

- Procurement Transformation Programme
- Clinical Governance
- Integrated Performance Network
- Model Hospital
- Digital Information
- Estates & Facilities
- Corporate & Admin Functions
- Patient Recovery (Non Acute Setting)
- Collaboration & Co-Ordinator of Clinical Services
Any Questions?

Thank you
Close of Session

Thank you for coming!