HFMA introductory guide to NHS finance

Chapter 8: NHS finance – the role of secondary and tertiary care providers

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Overview

This chapter looks at the main providers of secondary and tertiary care in the NHS with a focus on their roles, responsibilities, financing, and governance. To remind yourself of where providers fit into the NHS structure, look back at the diagram on page 13. The chapter also refers to the new ways in which care is being organised.

8.1 What is secondary care?

Secondary care is healthcare that is usually accessed via a referral from a primary care practitioner, usually a GP. Alternatively, it is accessed through emergency pathways, commonly via the emergency department. It is possible for patients to self-refer through some routes, for example, the improving access to psychological therapies (IAPT) programme, but this is not as common.

Often secondary care is thought of as being provided in a hospital setting, for example, acute clinical services at a district general or more specialist hospital. However, it is also provided in the community via a range of services such as district nursing, physiotherapy, and community clinics for a number of specialties, for example.

Secondary care includes both mental and physical healthcare services for those with both acute and long-term conditions. Mental health services cover both inpatients and community provision.

8.2 What is tertiary care?

Tertiary care is more specialised services usually provided in larger or teaching hospitals – for example, cardiac surgery. Often these services are accessed by a referral from one consultant to another. However, in larger hospitals that provide tertiary care services themselves, referral can take place directly on admission.

8.3 Who provides secondary and tertiary services?

Secondary and tertiary services can be commissioned from any service provider that meets the requirements set out in the NHS standard contract[90].

The provision of secondary and tertiary services is regulated by the Care Quality Commission (the CQC) – the list of regulated activities is set out in Schedule 1 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[91] . Regulated activities include treatment of disease, disorder, or injury, surgical procedures, and personal care. Any organisation in England that provides these activities must register with the CQC under the *Care Quality Commission (Registration) Regulations 2009*[92].

Service providers include NHS organisations, private sector healthcare providers (for example, Virgincare and BUPA), voluntary or charitable sector providers and social enterprise organisations (some of which are former NHS community service providers).

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[90] NHS, *NHS standard contract*, updated 2022
[91] UK Government, *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,* 2014
[92] UK Government, *The Care Quality Commission (Registration) Regulations 2009,* 2009

This chapter's primary focus is on NHS organisations and in particular community, mental health, acute and ambulance service providers. However, we will also look briefly at the part played by social enterprise organisations.

8.4 NHS trusts and NHS foundation trusts

All NHS providers in England are statutory bodies that are either an NHS trust or an NHS foundation trust – there are four main areas of healthcare service:

- acute services are usually provided in hospitals such as medical, surgical and maternity services.
- community services are delivered in patients' homes or community settings such as nursing homes, clinics, community hospitals, minor injury units, walk-in centres and mobile units.
- mental health services are for people with mental health problems/ illnesses or learning disabilities. Mental health services are provided both in in-patient settings and in the community.
- ambulance services provide emergency access to healthcare and patient transport services.

Some organisations provide more than one of these services, for example Harrogate and District NHS Foundation Trust provides acute services in Harrogate District Hospital as well as community services in Leeds and North Yorkshire and children's services in the wider North East. In other areas, both primary and secondary care services are provided, for example, The Royal Wolverhampton NHS Trust employs GPs to provide primary care services to the population of Wolverhampton.

8.5 What NHS provider bodies do - roles and responsibilities

In statute, both NHS trusts and NHS foundation trusts are established to provide goods or services for the purposes of the health service in England[93]. The health service is intended to secure improvement in the

- physical and mental health of the people of England
- prevention, diagnosis or treatment of physical and mental health illness[94].

They are all required to have regard to the NHS Constitution[95], provide high-quality healthcare and spend their money efficiently. They must also decide how the services they deliver will develop and improve.

The NHS Constitution sets out the:

- rights to which patients, public and staff are entitled
- pledges which the NHS is committed to achieve
- responsibilities that the public, patients, and staff owe to one another.

[93] For NHS trusts, this is section 25 of the *NHS Act 2006* and for NHS foundation trusts, it is section 30 of the same Act
[94] Section 1 of the *NHS Act 2006*
[95] Department of Health and Social Care, *NHS constitution for England*, updated January 2021

8.6 How NHS provider bodies are financed

Revenue financing

NHS providers receive revenue income (to meet the costs of their day-to-day running) from several sources including:

- contractual income for services commissioned by NHS England and NHS Improvement, clinical commissioning groups (CCGs), local authorities and other NHS trusts. NHS England and NHS Improvement and CCGs use the standard NHS contract when commissioning services.
- specific funding to those trusts providing nursing, medical and non-medical staff education and training services (generally based on the number of people in training).
- allocations/ grant funding where trusts are undertaking research and development.
- charges made for 'hosted services', for example, internal audit consortia.
- charges to staff, visitors or patients for services provided, for example, catering, car parking.
- charges for the provision of healthcare to overseas and private patients
- grants from other Government bodies or charitable organisations.
- the NHS injury cost recovery scheme – this allows the NHS to reclaim the cost of treating injured patients in all cases where personal injury compensation is paid.
- a limited number of NHS providers have Ministry of Defence (MOD) hospital units. Where this is the case, the organisation will have two additional contracts: one for training military medical personnel and one for treating military patients.

The levels of income received from these sources will vary between different types of trust – for example, community trusts are unlikely to have income relating to injury costs (unless they run minor injury units).

NHS foundation trusts also have the power to enter into other commercial ventures, such as through subsidiary companies providing support services.

Some NHS foundation trusts have commercial arrangements overseas, for example, Moorfields Eye Hospital NHS Foundation Trust has operated an eye hospital in Dubai since 2006. Private patients in London and Dubai generated income of £31m in 2019/20. Healthcare UK, part of the Department of Health and Social Care and the Department for International Trade helps UK healthcare providers to do more business overseas.

Others have UK based subsidiaries, for example, QE Facilities, a wholly owned subsidiary of Gateshead Health NHS Foundation Trust, provides estates and facilities management services, procurement services, training, transport, and consultancy services to the NHS foundation trust as well as other NHS and public sector bodies.

Capital financing

Capital expenditure is the money spent on assets that are expected to be used for more than a year, often referred to as property, plant and equipment. This is funded from a number of funding sources:

- internally generated cash from depreciation and retained surpluses and proceeds from the sale of non-current assets

- borrowing, usually from the Department of Health and Social Care, including public dividend capital for NHS foundation trusts
- leases
- donations and grants.

The capital expenditure rules for NHS foundation trusts are subtly different from NHS trusts. If you would like to find out more about capital funding (including borrowing limits), see chapter 15.

8.7 Constitution, structure and accountabilities

The roles and responsibilities of all NHS provider bodies are very similar, and a patient is unlikely to notice any differences between them. However, there are important distinctions in their constitution, structure, and accountabilities. These are outlined below.

NHS trusts – constitution

NHS trusts were formed from 1991 onwards under the *NHS and Community Care Act 1990*[96] to provide secondary healthcare services. The most common type is an acute hospital trust but as we have seen, there are also mental health, community and ambulance trusts as well as some combined trusts who operate across more than one sector. Some trusts operate regional or national centres of more specialised care, while others are classed as teaching hospitals as they train healthcare professionals and work closely with universities.

NHS trusts – structure

All NHS trusts have a board of directors whose constitution is set out in primary legislation under *The NHS Trusts (Membership and Procedure) Regulations 1990*[97].

Each NHS trust board can have a maximum of seven executive and seven non-executive members with the chair as an extra non-executive director (NED) to ensure that they are in the majority. The non-executive directors are appointed by NHS England and NHS Improvement, as part of the functions of the NHS Trust Development Authority that it carries out.

Within the board's executive directors, each trust must have:

- a chief officer (the chief executive who is also the 'accountable officer' – see below)
- a chief finance officer or finance director
- a medical or dental practitioner, and
- a registered nurse or midwife (except in the case of ambulance trusts).

Other executive directors attend board meetings in addition to the chief executive and chief finance officer and can be appointed as full voting members. In addition, although the medical and nursing professions must be represented at board level, this can be via the chief executive if she or he has a medical or nursing background. Board meetings must be open to the public.

An NHS trust board is collectively responsible for promoting the success of the organisation by directing and supervising its affairs. This involves:

- setting the organisation's values and standards and ensuring that its obligations to patients, the local community and the Secretary of State are understood and met

[96] UK Government, *National Health Service and Community Care Act 1990,* 1990
[97] UK Government, *The National Health Service Trusts (Membership and Procedure) Regulations 1990,* 1990

- providing active leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed
- setting the organisation's strategic aims
- ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives
- reviewing management performance.

The policy that all NHS trusts will transition to foundation status has not officially been reversed but no NHS trusts have been authorised as NHS foundation trusts since 1 May 2016, when Mersey Care NHS Trust and Wirral Community NHS Trust achieved foundation status. At the end of March 2021, there were 71 NHS trusts[98] – this number is expected to reduce only when an NHS trust is acquired by an NHS foundation trust.

NHS trusts – accountabilities

In terms of accountability, an NHS trust's chief executive is the accountable officer. This is a statutory role and means that he or she is accountable to the Department of Health and Social Care's accounting officer (via NHS England and NHS Improvement's accounting officer) and ultimately to Parliament (see chapter 13 for more about the role of the accountable officer). As well as this formal accountability line, trusts are accountable to their patients and to the commissioners of their services (via contracts). In addition, there is a system of independent inspection and regulation by external organisations such as the CQC (see chapters 9 and 12).

8.8 NHS foundation trusts

NHS foundation trusts – constitution

NHS foundation trusts were created as new legal entities in the form of public benefit corporations by the *Health and Social Care (Community Health and Standards) Act 2003*[99]. In practice this means that every NHS foundation trust has a duty to consult and involve a council of governors (comprising staff, patients, members of the public and other key stakeholders) in strategic planning.

The first NHS foundation trusts were authorised in 2004. On 31 March 2021, there were 145 licensed NHS foundation trusts. Originally, NHS foundation trusts were regulated through a light touch oversight regime. However, since 2015/16, the level of regulation has increased so, in practice, there is little difference between the regulation and oversight of NHS trusts and NHS foundation trusts (see chapters 9 and 12).

NHS foundation trusts – structure

Council of governors and members

NHS foundation trusts have members that are drawn from the local community and provide a link between the trust and its patients, service users and stakeholders. NHS foundation trust members fall into one of the three categories - the public, patients, and staff. When applying to be a member of an NHS foundation trust, an individual applicant can also confirm an interest in becoming a governor. The council of governors is elected by the members, from each of its constituencies, as well as those who are appointed from stakeholder organisations, and is required to hold the NHS foundation trust to account and to represent the interests of the members of the trust, as well as the interests of the public.

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[98] NHS England and NHS Improvement, *Consolidated NHS provider annual report and accounts 2020/21,* January 2022
[99] UK Government, Health *and Social Care (Community Health and Standards) Act 2003,* 2003

The board of directors

Every NHS foundation trust must have a board of directors that consists of a non-executive chair, executive directors and non-executive directors (NEDs). The non-executive directors, including the chair, must be in the majority.

The executive directors must include the chief executive, who is the accounting officer (see below), a finance director, a registered medical practitioner or a registered dentist and a registered nurse or a registered midwife. Additional executive directors can be appointed as full voting members of the board, so long as the non-executives remain in the majority.

NEDs should have experience or skills that help the board function well[100]. NEDs are appointed by the council of governors based on recommendations made by a nominations committee.

The board of directors is collectively responsible for every decision it takes regardless of individual directors' skills or status. In particular, the board of directors must set the NHS foundation trust's strategic aims (taking account of the views of the council of governors) and is responsible for ensuring compliance with the NHS foundation trust's terms of authorisation, its constitution, mandatory guidance, relevant statutory requirements, and contractual obligations. Meetings of the board of directors must be open to the public, although sensitive discussions can be held in private.

NHS foundation trusts – accountabilities

The NHS foundation trust's chief executive is also the accounting officer. This is a statutory role originally set out in the 2003 Act which provides the formal accountability link from the NHS foundation trust to Parliament. The accounting officer's duties are set out in a memorandum issued by NHS Improvement that states that 'accounting officers are responsible to Parliament for the resources under their control'.

As well as the formal accountability line from the accounting officer, NHS foundation trusts (like other trusts) are accountable to both their patients and to the commissioners of their services (via contracts). In addition, there is a system of independent inspection and regulation by organisations such as the CQC (see chapter 12).

8.9 Social enterprise organisations (SEOs)

What they are – constitution, structure and accountabilities

SEOs are not-for-profit service providers that operate in a range of areas. Where they provide healthcare services, they are accountable to the organisation commissioning that healthcare from them. They are run for the benefit of the community and any financial surplus made is reinvested into patient services, staff, and local communities.

In terms of regulation and accountability, SEOs are not part of the NHS – instead, they are stand-alone businesses. Any SEO that wishes to provide services to NHS patients must therefore be registered with the CQC and licensed by NHS England and NHS Improvement.

There is a range of SEO models operating in health and social care including mutual, co-operative or employee-owned organisations and community interest companies (CICs). CICs are set up specifically as organisations operating for the benefit of the community.

Many SEOs are single service providers, for example providing speech and language therapy or podiatry. However, around 40 were set up as a result of the 'transforming community services (TCS)'

[100] Monitor, *NHS foundation trusts: Code of Governance,* updated July 2014

programme that removed provider activities from primary care trusts[101], the commissioning bodies at that time. These tend to provide a full range of community services including district nursing, health visiting and school nursing. For example, CSH Surrey is co-owned by its employees and provides community nursing and therapy services.

For an SEO to be constituted as a CIC, it must pass a community interest test that shows the company will benefit the community it was set up to serve. An asset lock exists that means that any surpluses made must be reinvested for the good of the community. CICs are granted their status by the CIC Regulator and registered with Companies House. CIC accounts are submitted in line with Companies House timetables rather than those of the NHS.

For more information visit the CIC regulator's website: www.cicregulator.gov.uk

What SEOs do

SEOs are commissioned to provide services to NHS patients to meet local needs.

How SEOs are financed

SEOs are funded for NHS services through contracts with NHS commissioning bodies, usually CCGs. Some SEOs also provide services under contracts with local authorities. Others have formed subsidiary companies (such as charitable arms) to take advantage of tax opportunities and enable the receipt of charitable donations.

8.10 New models of care

Seen as one of the first steps for delivering the shared vision for the future of the NHS outlined in the *Five Year Forward View* (see chapter 2 for more details), the new care models programme supported the improvement and integration of NHS services through better networks of care, increased out of hospital care and services integrated around the patient. The vision was centred around several new care models that required existing providers to work in different ways often in new partnership arrangements.

50 vanguards were set up in 2015 as locally driven pilots for the new models of care that would then contribute to the development of care models that could be replicated across England. This was intended to be the first wave of a six-wave programme that would transform the healthcare system by 2020/21. However, subsequent waves were never developed and responsibility for new care models transferred into NHS England and NHS Improvement's system transformation group in 2018.

There has been some limited evaluation of the success of this programme, focusing mainly on the objective to reduce emergency admissions to hospital. There is some evidence that emergency admissions in vanguard areas grew more slowly than in non-vanguard areas[102] and that there was a small reduction in emergency admissions from care homes and the older population[103].

Since December 2015, a number of key documents have been published that propose to transform the NHS to working in an integrated fashion (see chapter 2). For NHS provider bodies as well as some non-NHS providers, this means that they are now part of integrated care systems (ICSs).

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[101] The Department of Health's national TCS programme was completed on 31 March 2011. The government required primary care trusts to transfer community care to other organisations. Most chose NHS trusts, but some were set up as community interest companies.
[102] NAO, *Developing new care models through NHS vanguards*, 2018
[103] National Institute for Health Research, *The vanguard programme to integrate health and social care achieved some of its aims but took time to show an effect*, November 2020

8.11 Integrated care systems

ICSs are non-statutory bodies but the *Health and Care Act 2022*[104] will formalise ICSs through the creation of statutory integrated care boards (ICBs) on 1 July 2022, which will replace CCGs.

Under the Act, NHS providers will retain their current financial statutory duties, structure, and governance. Their relationship with the CQC will remain unchanged. However, providers will have to have regard to the system financial objectives.

There will be a new duty to collaborate across the health and care system. This will require all health bodies to ensure that they pursue the three aims of:

- better health and wellbeing for everyone
- better quality of health services for all individuals
- sustainable use of NHS resources.

Providers will be expected to work together in collaboratives, with ICB boards able to delegate to provider collaboratives to determine how healthcare is best delivered to the local population. See chapter 5 for more information about integrated care systems.)

Key learning points

- Secondary healthcare is provided by NHS bodies and non-NHS bodies. They all have to be registered with the Care Quality Commission.
- There are two types of NHS provider body – NHS trusts and NHS foundation trusts.
- The differences between the two types of body mainly relate to their governance arrangements as they are now regulated using the same regime.
- The move to integrated healthcare is unlikely to impact on the structure of secondary care providers but they will be expected to collaborate and coordinate with bodies that deliver healthcare at a local level.

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects. It also highlights e-learning courses that are available. The directory of resources can be found here.

[104] UK Parliament, *Health and Care Bill*, July 2021 – the Act was not available to reference at time of publication