HFMA introductory guide to NHS finance

Chapter 7: 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 20. The chapter also refers to the new ways in which care is being organised.

7.1 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 NHS talking therapies programme[96], but this is not as common.

Secondary care is often 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 several specialties.

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

7.2 What is tertiary care?

Tertiary care describes more specialised services usually provided in larger or teaching hospitals - for example, cardiac surgery. These services are usually 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.

7.3 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*[97]. Providers must be licensed[98] by NHS England and registered with the Care Quality Commission (CQC).

The provision of secondary and tertiary services is regulated by 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*[99] . Regulated activities include treatment of disease, disorder, 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*[100].

[96] NHS England, *NHS Talking Therapies for anxiety and depression*, December 2023
[97] NHS England, *NHS standard contract*, 2023
[98] NHS England, *NHS Provider Licence*, March 2023
[99] UK Government, *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*
[100] UK Government, *The Care Quality Commission (Registration) Regulations 2009*

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

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

7.4 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. They provide four main types 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 for people with mental ill-health or learning disabilities are provided in both inpatient 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[101] provides acute services at Harrogate District Hospital, community services in Leeds and North Yorkshire, as well as children's services in the wider North East. In other areas, both primary and secondary care services are provided by the same NHS trust - for example, the Royal Wolverhampton NHS Trust provides primary care services across nine practices in Wolverhampton.

7.5 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[102]. 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[103].

All NHS providers must have regard to the *NHS constitution*[104], 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:

- principles and values that guide the NHS
- 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.

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[101] Harrogate and District NHS Foundation Trust, *Hospital and community*, October 2023
[102] Section 25 of the NHS Act 2006 for NHS Trusts, and section 30 for NHS foundation trusts
[103] Section 1 of the NHS Act 2006
[104] Department of Health and Social Care, *NHS constitution for England*, August 2023

7.6 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, integrated care boards (ICBs), local authorities and other NHS trusts. NHS England and ICBs use the standard NHS contract when commissioning services
- specific funding from NHS England 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 (funding can be from various organisations including private industry, charities and research councils)
- charges made for 'hosted services' used by other NHS bodies - for example, pathology services, internal audit consortia
- charges to staff, visitors or patients for services provided - for example, catering and car parking
- charges for the provision of healthcare to overseas visitors 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 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). In 2021/22, total revenue income for NHS providers totalled £112.6bn[105].

NHS foundation trusts also have the power to enter 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 £41m in 2022/23[106]. Healthcare UK, part of the Department of Health and Social Care (DHSC) and the Department for International Trade, helps UK healthcare providers to do more business overseas.

Others have UK based subsidiaries - for example, QE Facilities[107], 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.

[105] Department of Health and Social Care, *Annual report and accounts 2021-22,* January 2023
[106] Moorfields Eye Hospital NHS Foundation Trust, *Annual Report and Accounts 2022/23*, June 2023
[107] NHS QE Facilities, *Estates and facilities*, December 2023

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 non-current assets or property, plant and equipment. This is funded from several sources:

- internally generated cash from depreciation/ amortisation and retained surpluses and proceeds from the sale of non-current assets (further details are included in chapter 14)
- financing from the DHSC, including public dividend capital
- leases
- donations and grants.

The capital expenditure rules for NHS foundation trusts are subtly different from NHS trusts. Further detail is provided in chapter 14.

7.7 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. However, there are distinctions between NHS trusts and foundation trusts 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[108] 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 that 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*[109].

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.

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 can be appointed as full voting members. Although the medical and nursing professions must be represented at board level, this can be via the chief executive if they have a medical or nursing background. Board meetings must be open to the public.

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

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
- 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 2022, there were 69 NHS trusts[110] – this number is expected to reduce only when an NHS trust is acquired by an NHS foundation trust.

NHS trusts – accountabilities

An NHS trust's chief executive is the accountable officer. This is a statutory role and means that they are accountable to the DHSC's accounting officer (via NHS England's accounting officer) and ultimately to Parliament (see chapter 10 for more about the role of the accountable officer). As well as this formal accountability line, NHS 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 10).

7.8 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[111]. 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 2022, there were 144 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. This follows the public inquiry into serious care failures at Mid Staffordshire NHS Foundation Trust (the Francis Report). It was recognised that all NHS providers face similar challenges, and in practice, there is now little difference between the regulation and oversight of NHS trusts and NHS foundation trusts (see chapters 9, 10 and 11).

NHS foundation trusts – structure

Members and the council of governors

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

[110] NHS England, *Consolidated NHS provider annual report and accounts 2021/22,* January 2023
[111] UK Parliament, Health and Social Care (Community Health and Standards) Act 2003

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. It 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.

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 the qualifications, competence, skills, experience and ability to properly perform the functions of a director[112]. 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 that provides the formal accountability link from the NHS foundation trust to Parliament. The accounting officer's duties are set out in a memorandum that states that 'accounting officers are responsible to Parliament for the resources under their control'[113].

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 9).

7.9 Non-NHS provider organisations

NHS services can be provided by private and third sector organisations, as long as they are licensed by NHS England and registered with the CQC. In 2021/22 £17 billion was spent by NHS England on healthcare from non-NHS providers, 9% of DHSC's total revenue expenditure limit[114].

Private sector providers

Unlike many countries within the Organisation for Economic Co-operation and Development (OECD), the UK has a relatively small private health insurance sector, accounting for just 2.8% of health expenditure in 2019[115]. However, private sector organisations are used by the NHS to boost capacity

[112] NHS England, *Code of governance for NHS provider trusts*, February 2023
[113] Monitor, *NHS foundation trust accounting officer memorandum*, August 2015
[114] Department of Health and Social Care, *Annual report and accounts 2021-22,* January 2023
[115] Organisation for Economic Co-operation and Development, *Private health insurance spending*, March 2022

and provide some specialist services. For example, the Priory Group provides a range of mental health services to the NHS. Of the group's total income of £712 million in 2022, £443 million came from NHS organisations[116].

Third sector providers

The third sector describes a range of organisations that are neither public nor private sector – for example, voluntary and community organisations, charities and social enterprises. They are 'not for profit' organisations that are independent of government, value-driven, and reinvest surpluses in pursuit of their goals. A range of these organisations provide NHS services; we will look at the specific case of social enterprise organisations (SEOs) next.

Social enterprise providers

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).

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) programme that removed provider activities from primary care trusts[117], 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 test that shows the company will benefit the community it was set up to serve. Any surpluses made must be reinvested for the good of the community. CICs are granted their status by the Office of the Regulator of Community Interest Companies[118] and registered with Companies House.

7.10 Collaborative working

Integrated care systems

After many years of local development, integrated care systems (ICSs) were put on a statutory footing by the Health and Care Act 2022[119]. This created 42 ICSs across England, each consisting of and integrated care board (ICB) – the lead statutory NHS organisation responsible for commissioning NHS services, and an integrated care partnership (ICP) – a statutory committee of the ICB, partner local authorities and other local representatives responsible for developing an integrated care strategy.

Under the Act, providers must have regard to the system financial objectives and have a duty to collaborate across the health and care system. This requires 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.

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[116] Companies House, *Priory Group Limited, Annual report and consolidated financial statements for the year ended 31 December 2022,* September 2023
[117] The Department of Health's TCS programme was completed on 31 March 2011. Most services transferred to NHS trusts, but some were set up as community interest companies.
[118] *Office of the Regulator of Community Interest Companies*,2023
[119] UK Government, Health and Care Act 2022

See chapter 4 for more information about integrated care systems.

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more NHS trusts or foundation trusts working across multiple places to realise the benefits of working at scale. In August 2021 NHS England issued *Working together at scale: guidance on provider collaboratives*[120]. The guidance indicated that provider collaboratives should:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience - for example, by providing mutual aid
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Since April 2022 trusts providing acute or mental health services have been expected to be part of at least one provider collaborative. Other providers should be part of a collaborative where this would benefit patients. Collaboratives are expected to be a key part of service transformation, enabling shared ownership of objectives and plans. Governance arrangements for the collaborative are subject to local determination. ICBs may contract with a provider collaborative via a lead provider or with each individual party within the collaborative.

For example, the Black Country provider collaborative[121] is a collaboration between four large acute hospitals with a vision of creating 'one healthcare system, across multiple sites, working in partnership to provide better, faster and safer care to the population of the Black Country and beyond.' It is working towards this via three work programmes: clinical improvement, corporate improvement and system improvement.

The concept of collaboration between NHS providers is not new – for example, mental health collaboratives have existed for some years for specialised services. In November 2022 the NHS Confederation and NHS Providers conducted a survey to evaluate the evolution of provider collaboratives[122]. Key findings from the survey were:

- many collaboratives are still in early stages of development, with 70% focusing on governance arrangements, leadership models and decision-making processes
- despite this, collaboratives are already working to improve quality, strengthen community services, tackle backlogs and improve efficiency
- relationship building is a key priority
- collaboratives vary by sector and maturity, and the permissive approach to their development should be preserved
- to succeed, collaboratives need time, staffing, resources and leadership: current operational and financial pressures mean support will be needed to realise the benefits of collaboration.

Place-based partnerships

While provider collaboratives focus on scale and mutual aid across multiple places or systems, collaboration is also important at a more local level. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities and alongside communities, typically with

[120] NHS England, *Working together at scale: guidance on provider collaboratives,* August 2021
[121] Black Country Provider Collaborative, *About us, 2023*
[122] NHS Confederation and NHS Providers, *The evolution of provider collaboration,* March 2023

the involvement of voluntary, community and SEOs. They focus on delivering tangible local service changes and engaging directly with communities, often to shape the delivery of community services, social and primary care. These partnerships are often coterminous with local authorities – for example, Nottingham and Nottinghamshire Integrated Care System has established four place-based partnerships, one for each local authority[123].

National policy for place-based partnerships was issued jointly by NHS England and the Local Government Association in September 2021[124]. The guidance is permissive in terms of the structure and governance of place-based partnerships, but identifies several potential activities:

- health and care strategy and planning at place
- service planning
- service delivery and transformation
- population health management
- connect support in the community
- promote health and wellbeing
- align management support.

Collaborative culture

We have seen that the Health and Care Act 2022 established a legislative duty for all NHS organisations to collaborate and we have examined the structures and systems in place to enable this.

Legislation is just one part of the change and much relies on having trust, constructive relationships, the right workforce, good leadership and getting incentives and financial flows right. It is not possible to rely only on legislation to enable effective collaboration and co-ordination of local services. This requires changes to behaviours, attitudes and relationships, particularly as NHS provider organisations have effectively been encouraged to compete against one another in the past. Financial frameworks and governance arrangements can support this, but it will take time and effort to embed the required cultural changes.

Key learning points

- Secondary healthcare is provided by NHS bodies and non-NHS bodies. They must all be licensed by NHS England and registered with the Care Quality Commission (CQC).
- 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.
- Secondary care providers are expected to collaborate and coordinate with bodies that deliver health and social care at a local level.

[123] Nottingham and Nottinghamshire ICS, *Care in my area*, 2023
[124] NHS England and Local government Association, *Thriving places,* September 2021

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 online learning courses that are available. The directory of resources can be found here.