HFMA introductory guide
Updated January 2023

NHS finance

Supported by

ONE NHS FINANCE

Published by the Healthcare Financial Management Association (HFMA)

HFMA House, 4 Broad Plain, Bristol, BS2 0JP

This guide was produced under the direction of the HFMA's Policy and Research Committee. The editors were Colin Forsyth, HFMA assistant technical editor and Sarah Bence, HFMA technical editor.

Cover design and typesetting was undertaken by Epigram Communications & Design Ltd.

The NHS is always changing and developing – this edition reflects the structures and processes in place in January 2023. We are keen to obtain feedback on ways in which the content, style and layout can be improved to better meet the needs of its users. Please forward your comments to policy@hfma.org.uk or the address above.

ISBN 978-1-910127-03-2

Foreword

Welcome to edition 14.1 of the HFMA's Introductory guide to NHS finance. We are grateful for the support of One NHS Finance in enabling this guide to be made available to everyone, free of charge.

This version follows the original structure, first introduced in 2013, but has been updated to reflect policy and organisational changes that have taken place since then and continue to take place at this time of considerable change for the NHS. In particular, it sets out the responsibilities and accountabilities of each of the key players in the NHS and explains what their role is in relation to NHS finance, following the enactment of the *Health and Care Act 2022*.

As with earlier editions, each chapter has been written with the help of practitioners and has been reviewed by experts in the relevant field. The main body of the guide focuses on the policy and organisational framework for the NHS in England, with separate chapters dedicated to Northern Ireland, Wales and Scotland identifying the specific circumstances that apply to the provision of healthcare services in the devolved nations.

As always, the guide is designed to give readers a solid grounding in – and practical understanding of – all key aspects of NHS finance and will provide contextual background that helps explain how the NHS has developed over the years. As well as appealing to its traditional audience (which ranges from executive and non-executive directors, governors and managers to clinicians, accounts assistants and budget holders), the guide is an excellent reference source for anyone embarking on a career in NHS finance. The guide will also provide a comprehensive introduction for anyone who is thinking of undertaking the HFMA's online learning programme and/ or qualification in healthcare business and finance.

The intention is that the guide is written in simple, straightforward and accessible language with references throughout so that readers can delve into subjects in more detail if they wish. Bullet point listings of key learning points are included and there is also a glossary in an appendix.

The HFMA is committed to improving the awareness of finance and financial management across the NHS and beyond and we trust that this guide will further this objective. Above all we hope that you will find it useful, informative and that it is a 'good read'.

If you have any comments, the HFMA team would like to hear from you – please email: policy@hfma.org.uk

Acknowledgements

The Introductory guide to NHS finance is developed under the direction of the HFMA's Policy and Research Committee and with the help of a wide range of practitioners, all of whom give their time and expertise free of charge. The HFMA is extremely grateful to everyone who has been involved in the guide's production. The main contributors to this edition are:

Mo Amin	Mark Bakewell	Phil Bradley
Nicci Briggs	Izhar Chaudhary	Sarah Day
Paul Dillon-Robinson	Maureen Edwards	John Evans
Emma Knowles	Ceri Lewis	Clare Liddy
Richard Mellor	Catherine Mitchell	Ian Moston
Lee Outhwaite	Debbie Paterson	Lisa Robertson
Lee Rowlands	Karl Simkins	Paul Sheldon
Adrian Snarr	Sheila Stenson	Robert White
Terry Whittle	Keith Wood	

Editorial work was carried out by Colin Forsyth and Sarah Bence (HFMA).

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HFMA introductory guide to NHS finance

Chapter 1: Introduction

Chapter 1. Introduction

1.1 About the guide

For more than thirty years, the *Introductory guide to NHS finance* has provided an easy to read, accessible overview of the workings and language of NHS finance for the benefit of practitioners and observers. The guide is produced by the Healthcare Financial Management Association (HFMA), a charity established over 70 years ago to support those working within the NHS finance function. By improving financial literacy both within and outside NHS finance, the HFMA hopes it can inform and improve the debate on healthcare finance issues.

The guide has been developed to provide a self-contained source of advice and guidance for readers from an array of backgrounds. There are many aspects of NHS finance that are unique to the service, and a language laden with jargon, abbreviations and acronyms has developed that can appear impenetrable to many outsiders or newcomers. Indeed, as the terminology develops with each set of reforms, even the most experienced NHS finance professionals can find themselves in unfamiliar territory.

The guide aims to provide advice to all levels of finance staff from finance directors (who often use it as an aide memoir to more recent changes) to governors and lay members; non-executive and executive directors (who may not be finance specialists but still have shared corporate responsibility for understanding and managing the financial position); clinicians; budget holders; service managers; accounts assistants and those who need an understanding of NHS finance for academic study purposes.

Over the years the guide has grown in size as it tries to provide an overview of both the current finance regime along with a sense of how the approach has developed over the years. Nevertheless, it remains (as its title suggests) an introductory guide that gives a reasonably straightforward but comprehensive description of NHS structures and processes.

1.2 Approach and format

Until 2022, the introductory guide was only available as a paperback book; now however, the guide is available online. It continues to follow the approach readers will be familiar with – namely that each chapter treats its topic in a largely self-contained way. Cross-references are included where they are helpful, and sources of further information and learning from the HFMA are listed at the end of each chapter.

This version of the guide is being published at a time of significant change for the NHS, across all four nations. In England, the *Health and Care Act 2022* is changing the shape of the NHS. In Northern Ireland, the development of a new integrated care system signals a new way of planning and managing health and social care services for the nation. Wales is in the process of establishing a national executive function that will strengthen national leadership and support the continuing transformation of services. Scotland is looking to introduce a National care service (NCS), working alongside the NHS in Scotland, to allow more effective service provision and facilitate greater integration and partnership working. By publishing online, the guide can be updated more frequently to recognise these changes, so that it will remain relevant and continue to provide timely information for those who need to refer to it through organisational and structural changes.

The bulk of the guide concentrates on the financial arrangements for the NHS in England with separate chapters dedicated to Northern Ireland, Wales and Scotland. These chapters identify the key issues and differences for those health systems.

The guide ends with a glossary of terms and abbreviations.

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.

HFMA introductory guide to NHS finance

Chapter 2: Background and context – how we got to where we are today

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Overview

This chapter looks back over the past few decades to chart the development of the NHS so that we can see how we have reached where we are in 2023. It also looks briefly at the origins of the NHS and its guiding principles.

2.1 The introduction of the NHS

The NHS was established by the NHS Act 1946. This Act specified that, it was `*the duty of the Minister ... to promote the establishment in England and Wales of a comprehensive Health Service designed to secure the improvement of the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness'*. The services provided to meet these aims were to be free of charge, based on clinical need, not the ability to pay. The NHS was launched, and the first patients treated on 5 July 1948.

Underpinning principles of the NHS

Although there have been many structural and policy developments since 1948, the underlying principles have not changed. These are that NHS services are:

- available to everyone
- free at the point of need (or use)
- based on clinical need, not the ability to pay.

All of the major political parties remain committed to these core principles.

Other enduring characteristics of the NHS are that:

- it is funded through taxation
- it manages within overall resource limits determined by the government each year
- finite resources have to be matched with what can seem like unlimited demand for health services with tough choices over priorities needed as a result
- there is an expectation that 'efficiency savings' can be made, often as a result of structural or technical developments
- there is intense political, public and media interest in, and scrutiny of, the NHS.

The NHS is also Europe's largest employer with over 1.8 million employees across the UK in 2022. However, although it is usually referred to as if it were a single organisation, it actually comprises a wide range of different bodies with specific responsibilities. We will be looking at many of these within this guide.

2.2 Key policy developments that have shaped the NHS since the 1980s (and continue to have an impact)

The internal market, 1980s

In the late 1980s it was decided that the NHS should be reconfigured to operate a 'quasi-market', known as the internal market, with many treatments commissioned on a 'cost and volume' or 'extra contractual referral' basis. A key feature of this approach was the separation of the provision of hospital and community services from the commissioning or purchasing function – the so-called 'purchaser/provider split'. Hospitals were encouraged to apply for self-governing trust status, creating organisations quite separate from the health authorities from which they were devolved. To achieve trust status, and formally separate from the health authorities, provider organisations had to follow an application process that assessed viability and robustness.

There was also an optional scheme to give general practitioners (GPs) the ability to hold budgets for the purchase of hospital services for their patients (known as GP fund holding). At the same time, trusts were encouraged to invest in and develop services and to compete with each other to win patient service contracts with purchasers.

The new NHS, 1997

In 1997, the white paper *The New NHS*[1] set out a programme for reform of the NHS. These proposals became law with the 1999 Health Act[2] (since superseded by the NHS Act 2006[3] and the Health and Social Care Act 2012[4]). The focus shifted away from the underlying competitive nature of the internal market to a more collaborative model, where NHS organisations worked together, and with local authorities, to re-focus healthcare on the patient. These changes in policy sought to ensure the seamless delivery of services.

Key changes were an end to GP fund holding and the introduction of new organisations for primary care. GP representation and engagement within the commissioning process was initially through health authority sub-committees. GPs would inform the commissioning process through these sub-committees, and as these arrangements became more established, GP groups were able to apply for trust status. This created bodies independent from the health authority and managing increasingly significant portions of former health authority budgets. Boundaries were encouraged to coincide where possible with local authority borders to simplify the integration of health and social care.

The 1999 Health Act established the Commission for Health Improvement. This was succeeded by the Commission for Healthcare Audit and Inspection, then by the Healthcare Commission and now the Care Quality Commission. The 1999 Health Act also established the National Institute for Health and Clinical Excellence or NICE – now the National Institute for Health and Care Excellence.

There was also a renewed emphasis on cutting management costs – a challenging objective given the increase in the number of NHS organisations, and the greater involvement of management at a local level.

The 'shared services initiative' was one element of this objective. The intention was to consolidate some administrative and back-office functions – for example, invoice processing or payroll services under a shared service partner. The sharing of services, rather than having many small local teams, would then lead to greater efficiencies, drive effectiveness, bring in greater consistency of reporting and lower costs in providing these management functions. In addition, the intention was to 'free-up'

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[1] UK Government, *The new NHS*, December 1997
[2] UK Government, *Health Act 1999*, June 1999
[3] UK Government, *National Health Service Act 2006*, November 2006
[4] UK Government, *Health and Social Care Act 2012,* March 2012

local teams to allow greater focus on areas such as financial advice and support, with less local management time spent on the transactional aspects (invoices, pay records) of financial services.

National shared service centre pilots were established, run as a joint venture between the Department of Health and Steria known as NHS Shared Business Services (NHS SBS). As the NHS structures have evolved, so have shared services and there are now several shared business services centres around the country.

The purchaser/provider split created by the internal market was retained. Initially health authorities remained and continued to purchase healthcare using service and financial framework agreements. These health authorities were then abolished but the division between commissioning and provision continued with primary care trusts (PCTs) taking over responsibility for commissioning hospital services. At their inception, many PCTs also had a provider role in relation to community services.

The 1997 white paper also heralded a move towards longer planning time frames, promising the replacement of annual contract negotiations with three-year resource announcements.

The NHS was encouraged to form partnerships with both private and public sector partners, including local authority social services. The 1999 Health Act also broadened the scope for pooling of health and social services budgets. Partnership working with the private sector was formalised in a 'concordat' agreement, which highlighted scope for joint working in elective, critical and intermediate care. New independently run diagnosis and treatment centres or independent sector treatment centres (ISTCs) were established, extending the role of the private sector in providing services to the NHS.

The NHS plan: a plan for investment, a plan for reform, 2000

In July 2000 the NHS plan[5] was presented to Parliament. The plan consisted of a vision of the NHS first outlined in the 1997 white paper – modernised, structurally reformed, efficient and properly funded. Much of the document was dedicated to identifying new targets and milestones on wide ranging issues (from waiting lists to implementation of electronic patient records) and measures that needed to be taken to facilitate the achievement of those targets.

Further developments in 2002

In April 2002 a further tranche of changes came into effect. At the end of March 2002, the 95 health authorities in England were abolished and replaced by 28 strategic health authorities (SHAs). At the same time the eight regional offices were replaced by four directorates of health and social care which were themselves dissolved in 2003. The changes, first outlined in April 2001 in the policy paper *Shifting the balance of power*[6], were designed to transfer management resource and control closer to the locality, and hence to the patient.

The establishment of PCTs was also completed in 2002 – a key change here was the fact that PCTs were allowed to expand primary care services beyond those traditionally provided by GPs. This prompted a growth in ‘GPs with special interests’ and in services provided in the community by PCTs where previously they had been delivered in an acute hospital setting.

Many of the monitoring and planning processes were devolved from the old regional offices to the new SHAs, while commissioning functions were transferred to PCTs.

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[5] Department of Health, *The NHS plan: a plan for investment, a plan for reform*, July 2000
[6] Department of Health, *Shifting the balance of power*, July 2001

Payment by results

A key element of the Labour Government's modernisation plans involved reforming the financial framework and the way funding flowed around the NHS. The proposal for bringing about this change was set out in 2002 in *Delivering the NHS improvement plan*[7] and introduced a system of payment by results (PbR). This was designed to ensure that money flowed with patients.

The main driver behind this initiative was patient choice – by introducing nationally-set standard prices for treatments, the need for local negotiation on price was removed and instead the focus was shifted to quality and responsiveness, the things that are important to the patient. The combination of patient choice and PbR was expected to drive an increase in healthcare capacity and deliver shorter patient waiting times.

Both patient choice and PbR were phased in over a period of years. Key milestones in the development of patient choice included:

- providing patients waiting for elective surgery for over six months with the choice of an alternative provider (summer 2004)
- patients requiring a routine elective referral offered a choice of four or five providers (including one private sector provider) at the point of referral (usually at their GP) by the end of December 2005
- patients needing to see a specialist able to choose to go to any hospital in England, including many private and independent sector hospitals (from April 2008).

The first steps to introduce the PbR financial framework were taken in 2003/04. Chapter 19 looks in more detail at changes in the way that NHS services are reimbursed.

NHS foundation trusts

NHS foundation trusts (FTs) 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*[8], consolidated in the *NHS Act 2006*. They were introduced to help implement the Labour Government's 10-year NHS plan. By creating a new form of NHS trust that had greater freedoms and more extensive powers, it was hoped that services would improve more quickly.

Initially, applications for foundation status were restricted to those trusts deemed as having the highest level of performance ('three-star' trusts as assessed by the Commission for Health Improvement), with the first wave of FTs coming into being in April 2004. Since then, there has been a steady growth in the number of FTs although the pace slowed as organisations struggled to demonstrate their long-term financial viability in the light of difficult economic circumstances, and increased expectations in relation to efficiency. The application process for FT status has also changed with an increased focus on clinical quality in the light of high-profile governance failures, such as that at Mid-Staffordshire NHS Foundation Trust.

At the outset, the regulation regime for FTs was different to that of NHS trusts, and Monitor[9] was established in 2004, specifically to regulate NHS FTs. However, it has since been 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 (further details are provided in chapters 8, 9 and 12).

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[7] Department of Health, *Delivering the NHS improvement plan*, April 2002
[8] UK Government, *Health and Social Care (Community Health and Standards) Act 2003*, November 2003
[9] Monitor, *About Monitor: an introduction to our role,* August 2013

Commissioning a patient-led NHS, 2005

Following a consultation process in 2005, a reconfiguration of SHAs, PCTs and ambulance trusts was launched by the Department of Health with a significant reduction in their overall numbers. The aim was to reduce management overheads and generate cost savings that could be re-invested in the provision of healthcare.

The reduction in PCT numbers was consistent with the simplification of the commissioning process inherent in the patient choice and PbR initiatives. Increasingly patients were able to select their preferred healthcare provider, thereby refocusing the commissioning role on assessing overall supply levels, negotiating provider standards and managing demand.

SHAs also reduced from 28 to 10 to reflect the geographical span of the government offices for the regions, and so make working with other public sector partners easier.

The merger of ambulance trusts was designed to achieve purchasing and management economies of scale and to allow them to develop greater resilience than was possible with smaller scale operations.

The Darzi review – *High quality care for all*, 2008

In July 2007, the government asked the then health minister Lord Darzi to carry out a wide-ranging review of the NHS. An interim report was issued in October 2007 and recommended several changes to the provision of healthcare services within the primary and secondary care sectors, including the development of 'poly-clinics' where appropriate – a primary healthcare equivalent of the 'one-stop shop'. The final report – *High Quality Care for All*[10] – was issued in June 2008 (in time for the 60th anniversary of the NHS on 5 July 2008) and set out a vision of an NHS that 'gives patients and the public more information and choice, works in partnership and has quality of care at its heart'.

The NHS constitution, 2010

In January 2010, the first ever NHS constitution[11] came into effect. All NHS bodies, along with private and third sector organisations that provide NHS services, are required by law to take account of the Constitution in their decisions and actions.

Equity and excellence: liberating the NHS, 2010 and the Health and Social Care Act 2012

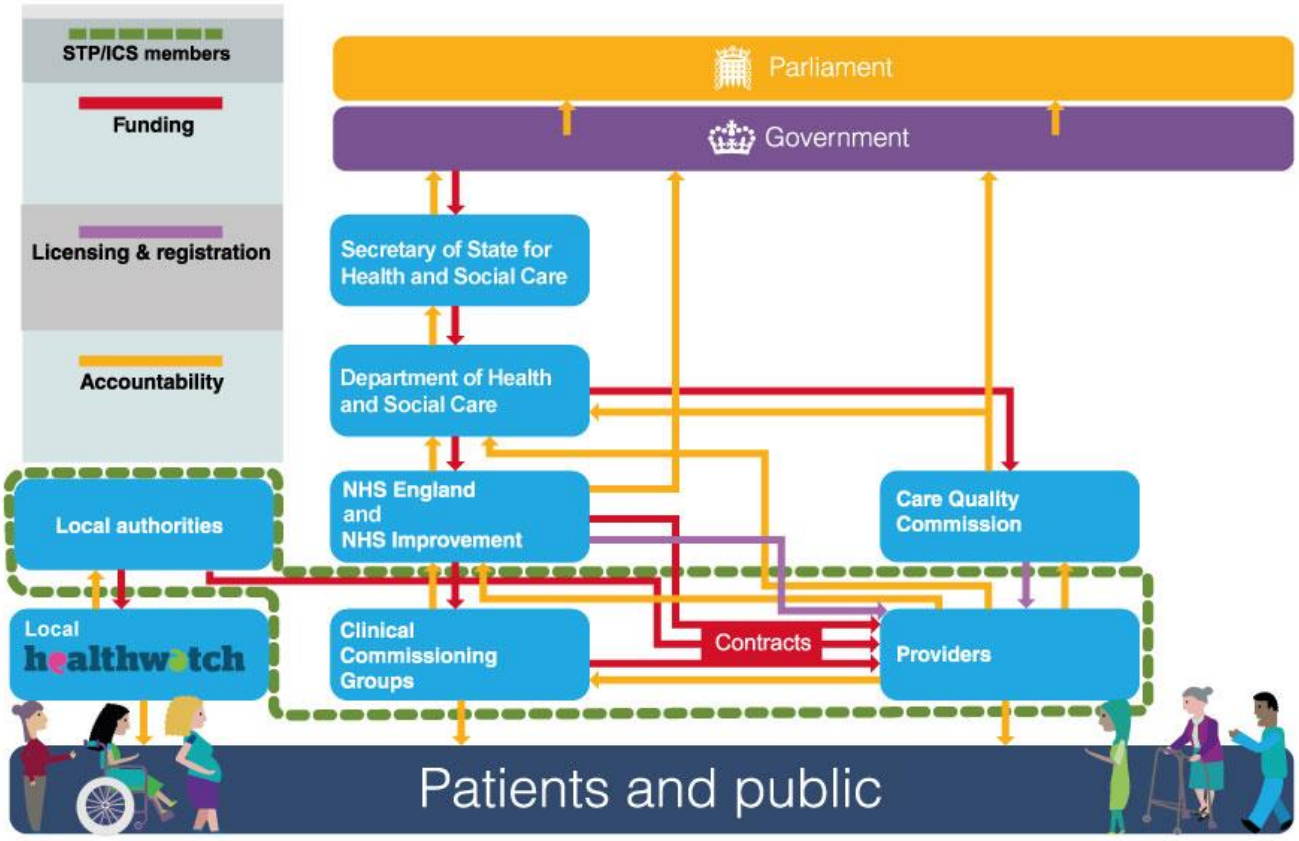
In July 2010, following the formation of the Coalition Government, the then Secretary of State for Health issued a series of consultation papers that signalled far-reaching changes for the NHS in England. These proposals (amended in places) were enacted in the Health and Social Care Act 2012 resulting in a new structure and approach for the NHS from April 2013.

2.3 The NHS structure 2012 to 2022

The structure introduced by the 2012 Act is shown in the diagram below and came into effect in April 2013. In April 2016, NHS Improvement (NHSI) was established as an integrated management structure enabling Monitor and the NHS Trust Development Authority (NHS TDA) to work together closely, particularly in supporting all NHS healthcare providers (foundation and non-foundation NHS trusts). In 2019, NHS England and NHS Improvement came together to form a single management organisation but remained legally separate.

[10] Department of Health, *High quality care for all*, June 2008
[11] Department of Health, *The NHS Constitution for England*, March 2012 (updated January 2021)

NHS structure 2012 - 2022



The key changes introduced by the 2012 Act were:

- abolishing SHAs and PCTs from April 2013
- introducing NHS England to:
  - authorise clinical commissioning groups (CCGs)
  - allocate funding to them
  - commission some specialist services itself
- handing the majority of NHS commissioning to CCGs that were authorised by (and accountable to) NHS England
- extending Monitor's role to that of sector regulator for the health and social care sectors with responsibility for licensing healthcare providers, setting and regulating prices and (with NHS England) ensuring continuity of services
- strengthening the role of the Care Quality Commission (CQC)
- setting up the NHS Trust Development Authority within the, then, Department of Health to oversee NHS trusts
- allowing commissioners to pay quality increments and impose contractual penalties
- giving FTs greater freedom on income, governance, and mergers
- handing responsibility for public health to local authorities with Public Health England set up within the Department of Health. Public Health England has since been abolished, replaced

by the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities from 1 October 2021

- setting up 'health and wellbeing boards' in every upper tier local authority (at county council level) to 'join up commissioning across the NHS, social care, public health and other services … directly related to health and wellbeing'
- developing local HealthWatch organisations from existing local involvement networks to ensure that the views of patients, carers and the public are considered
- setting up HealthWatch England as an independent committee within the CQC to support and lead local HealthWatch bodies.

However, ways of working have evolved since 2012. The remainder of this chapter covers the key strategic changes, culminating in the publication of a white paper in February 2021 to reform the NHS.

Five year forward view

In October 2014, the *Five year forward view*[12] was published. This set out the transformational changes needed by the NHS in order to meet the anticipated £30bn funding gap by 2020/21, arising from the difference between existing funding and that needed to meet expected demand. It set out the reasons for transformational change and the way that change may be achieved. The report stated that action was needed on four fronts:

- tackling the root causes of ill health, including obesity and drinking too much alcohol
- giving patients more control over their care
- breaking down barriers between GPs and hospitals, health and social care and physical and mental health
- introducing new models of care as well as investing in workforce, innovation, and technology.

The new models of care (in addition to those already operating in the NHS) outlined in the *Five year forward view* drew on international experiences and included:

- multispecialty community providers (MCPs)
- primary and acute care systems (PACs)
- urgent and emergency care networks
- viable smaller hospitals
- specialised care
- modern maternity services
- enhanced health in care homes.

The new care models were expected to provide better networks of care with increased out of hospital care and services better integrated around the patient. In January 2015, NHS England invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme. During that year, 50 vanguard sites were chosen to develop the various models, with the intention that they could be replicated elsewhere.

In December 2015, the financial position of the NHS had deteriorated and *Delivering the forward view: NHS planning guidance 2016/17 – 2020/21*[13] was published. This introduced the concept of sustainability and transformation plans (STPs) which were geographically based, five-year strategic

[12] NHS England, *The five year forward view*, October 2014
[13] NHS England, *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21*, December 2015

plans. This was the first time that a single set of planning guidance was made available to the whole NHS. It was produced by all the Department's arm's length bodies (ALBs), (NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission, Health Education England, National Institute for Health and Care Excellence and Public Health England).

In early 2016, all NHS bodies (working with local authorities and the third sector) identified 44 STP areas which covered the whole of England. Initially, these areas were called 'transformation footprints' but they are generally referred to as STPs. These footprints were determined locally based on natural communities, patient flows and existing working relationships. Some NHS bodies and local authorities were members of more than one STP. The rest of 2016 was spent working together to develop plans that addressed the STP key themes: collaboration (including integration of services), population health and wellbeing, quality, sustainability, workforce, facilities (IT and estates), and financial health.

As plans progressed, the requirement to close the gap in NHS finances and reduce deficits became more prominent. The STP model recognised that effective management of finances requires a system wide approach, one that looks at better ways of working together to provide the best quality health and social care in the most appropriate place, and within the resources available.

In March 2017, the *Next steps on the NHS five year forward view*[14] was published and STPs became sustainability and transformation partnerships. The proposal was that STPs would evolve into accountable care systems (ACS) which would work as a locally integrated health system.

In February 2018, *Refreshing NHS plans for 2018/19*[15] replaced the term ACS with integrated care system (ICS) in which commissioners and NHS providers, working with GP networks, local authorities and other partners, agree to take shared responsibility for operating their collective resources for the benefit of their local populations. This document also set out the ambition that all GP practices should be part of a primary care network (PCN) to achieve 'complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19'.

Implementing the five year forward view in mental health[16]

Following the publication of the *Five year forward view*, the chief executive of NHS England commissioned an independent review of mental health services. Led by the chief executive of MIND, the Mental Health Taskforce published its final report in February 2016[17]. It set out a view of the state of mental health services in England, a long-term view of improvements needed along with a series of recommendations for NHS organisations, the Department's arm's length bodies (ALBs), the government and other partners involved in the commissioning and provision of mental health services. The report concluded that £1bn of additional investment in mental health services was needed by 2020/21. As a consequence, the mental health investment standard (MHIS) was established which required CCGs to increase spending on mental health in line with their overall increase in allocation each year.

NHS long term plan

In July 2018, the NHS celebrated its 70th birthday. To coincide with this, the then prime minister announced a long-term funding settlement for the NHS, outside of the normal spending review cycle. An additional £20bn was committed by 2023. However, this funding came with the condition that the NHS must develop a 10-year plan to improve efficiency and address five key areas:

- putting the patient at the heart of how care is organised

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[14] NHS, *Next steps on the NHS five year forward view,* March 2017
[15] NHS, *Refreshing NHS plans for 2018/19,* February 2018
[16] NHS, *Implementing the five year forward view in mental health,* July 2016
[17] Mental Health Taskforce, *The five year forward view for mental health*, February 2016

- a workforce empowered to deliver the NHS of the future
- harnessing the power of innovation
- a focus on prevention, not just cure
- true parity of care between mental and physical health.

In January 2019, the *NHS long term plan*[18] was published. The plan aimed to make the NHS fit for the future and to get the most value for patients out of every pound of taxpayers' investment. The plan set out a range of aims – making sure everyone gets the best start in life, delivering world class care for major health problems and supporting people to age well. The plan provided a framework for local systems to develop plans, based on principles of collaboration and co-design, with the objective of ICSs covering the whole country by April 2021. At that time, it was expected that there would be one CCG for each ICS.

In June 2019, the *NHS long term plan implementation framework*[19] was published, setting out the requirements on STPs and ICSs when creating their five-year strategic plans. System plans were to be aggregated into a national implementation plan and were expected to adhere to the following principles:

- the implementation of commitments in the NHS long-term plan that have clinical implications, should be clinically led
- local communities should have meaningful input into the local plan
- workforce planning should be realistic
- plans should include how local systems and organisations would meet the five financial tests set out in the NHS long-term plan, including setting out capital investment priorities
- all commitments in the NHS long-term plan must be delivered and national access standards must be met
- implementation of the NHS long-term plan should be phased, based on local need
- health inequalities and unwarranted variation must be reduced
- local systems should consider how to prevent ill health as well as treat it
- plans should be developed in conjunction with local authorities.

2.4 Developments due to the Covid-19 pandemic

On 11 March 2020, the World Health Organisation declared that Covid-19 was a pandemic, meaning that it had spread worldwide. The NHS rapidly responded to the anticipated demand for Covid-19 care and increased intensive care beds by suspending all elective care and moving to telephone and digital consultations to limit contact. For NHS finance, the normal payment and contracting regime was paused, and all providers received monthly block payments, based upon income received between April and December 2019, the most up to date information available at that time. Capital was made available to purchase equipment and repurpose wards and other facilities to treat Covid-19 patients. During the first wave of the pandemic these capital costs were approved retrospectively to allow changes to be made at speed.

The pandemic caused significant transformation in the delivery of healthcare with one of the most significant changes being the rapid uptake of telephone and digital consultations. This has meant that one of the key ambitions of the NHS long term plan is being met sooner than anticipated. However, there has been an adverse impact on routine treatments with a large increase in waiting lists and a

[18] NHS, *The NHS long term plan*, January 2019
[19] NHS, *NHS long-term plan implementation framework*, June 2019

noticeable drop-in cancer care. The improvements set out for these areas in the NHS long term plan now need to address the change in starting point for many organisations.

Covid-19 demonstrated how organisations could work together to address a common goal when traditional financial barriers were removed, with many areas reporting improved relationships across health and social care. With the rollout of the Covid-19 vaccination programme, and as the impact of Covid-19 on NHS services reduces, the NHS intends to build upon the positive changes to working practices and inter organisational relationships, that the evolved during the pandemic.

Health inequalities

The NHS has been legally required to tackle health inequalities since the introduction of the *Health and Social Care Act 2012* but, the Covid-19 pandemic has dramatically increased the focus on health inequalities. The unequal impact of the pandemic across different sectors of society has highlighted existing inequalities and potentially created new ones. This was recognised in the 2021/22 planning guidance which required NHS bodies to specifically address health inequalities in elective recovery plans and accelerate preventative programmes for groups at the greatest risk of poor health outcomes. This is an ongoing requirement for the NHS.

2.5 Health and Care Act 2022

The *Health and Care Act 2022*[20] received Royal Assent on 28 April 2022. The Act built on the DHSC's legislative proposals for the NHS published on 11 February 2021, in the *Integration and innovation: working together to improve health and social care for all* white paper[21]. The proposals were developed from the *NHS long term plan* and the subsequent *NHS's recommendations to Government and Parliament for an NHS bill*[22].

Key provisions in the Act came into force from 1 July 2022. From this date, integrated care boards (ICBs) were established, and clinical commissioning groups (CCGs) abolished. The functions, staff, assets and liabilities of CCGs transferred to ICBs. There is a greater emphasis on collaboration, with the ICB becoming the statutory commissioning body within an ICS.

The ICB, as a partnership of NHS bodies within the local system, is responsible for:

- developing a plan to meet the health needs of their population
- developing a capital plan for NHS providers within their geography
- securing the provision of health services to meet the needs of the system population.

The creation of ICBs also allows NHS England to set financial allocations and other financial objectives at a system level. There is a statutory duty for all NHS bodies to meet the system financial objectives and deliver financial balance. NHS providers within the ICS retain their current structures, governance, and organisational financial statutory duties but there is a new duty to compel providers to have regard to the system financial objectives.

The *Health and Care Act 2022* also established integrated care partnerships (ICPs). This partnership brings together health, social care and public health as well as other bodies as appropriate, to develop a plan to address the wider health and care needs of the system. This plan will inform decision-making by the NHS organisations within an ICS and local authorities. The new structure (simplified) is set out in the diagram below.

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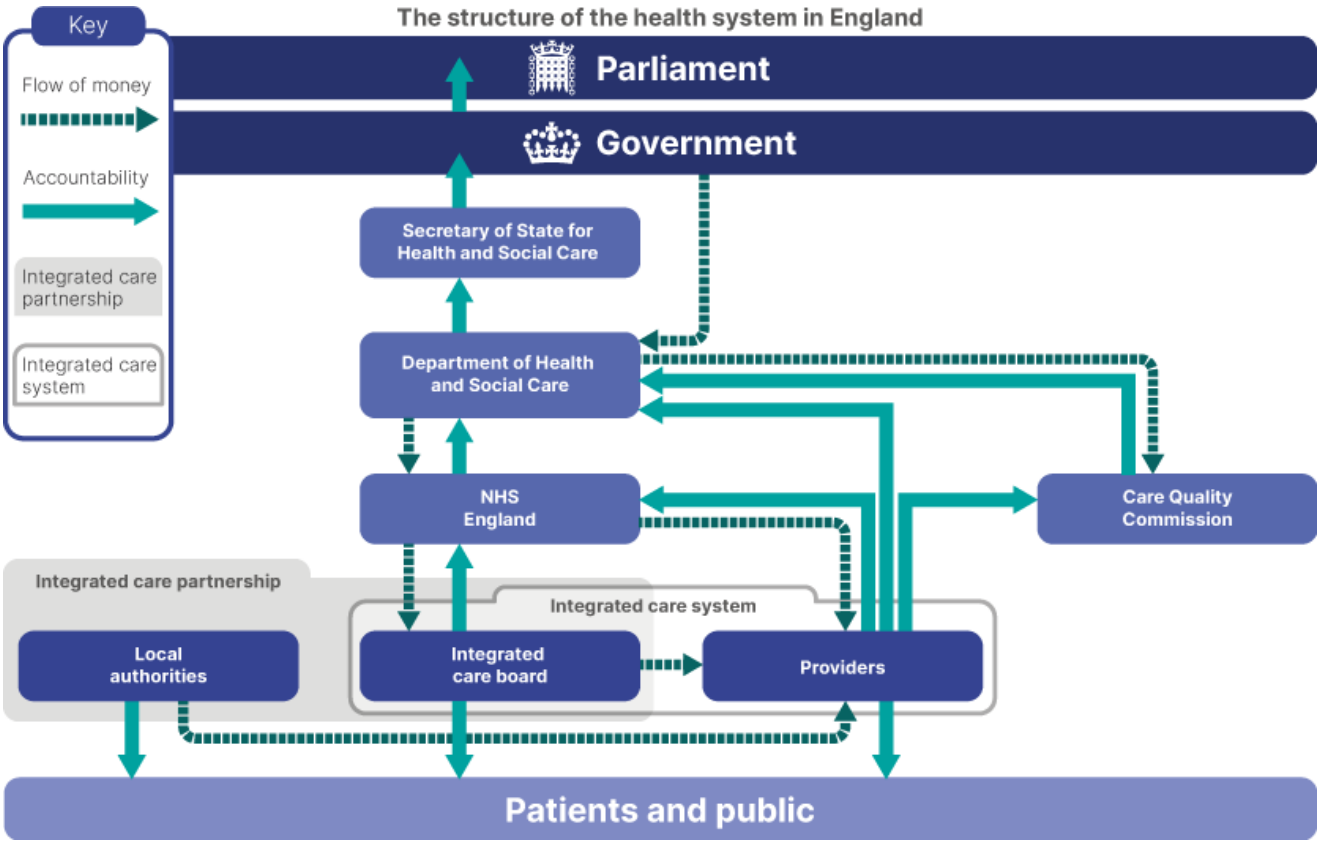
[20] UK Parliament, *Health and Care Act 2022*, April 2022
[21] Department of Health and Social Care, *Integration and innovation: working together to improve health and social care for all*, February 2021
[22] NHS England and NHS Improvement, *The NHS's recommendations to Government and Parliament for an NHS Bill*, September 2019

The current NHS structure



The white paper stated that the new legislation was not intended to address all the challenges faced by the health and social care system, and that further reforms would be needed. These broader changes include proposals to reform social care, the future design of the public health system and modernising the *Mental Health Act*.

The *Health and Care Act 2022* not only built on the NHS long term plan but is also designed to accelerate the positive changes in the health and care system that have come about through the pandemic. However, legislation is just one part of the change and much relies on having the right workforce, good leadership and getting the incentives and financial flows right. A supporting implementation programme will be developed for these areas, and it is expected that the reforms outlined in the white paper will begin to be implemented in 2022.

Since 2019, NHS England and NHS Improvement (made up of Monitor and the NHS Trust Development Authority (NHS TDA)) worked as a single organisation. However, the underlying statute did not allow them to fully collaborate. The Act transferred the powers of Monitor and NHS TDA to NHS England and abolished the previous organisations.

2.6 Other plans and white papers

Build back better

On 7 September 2021, the Prime Minister announced a new plan for health and care, with an additional £36bn to be spent over the next three years. *Build back better: our plan for health and social care*[23] set out intentions for healthcare and adult social care, supported by a new health and social care levy to raise the necessary funds through taxation.

The plan for healthcare focused on three main aspects: tackling the elective backlog, putting the NHS on a sustainable footing, and focusing on prevention. £5.4bn will be invested in adult social care over the next three years to fund social care payment reforms. From October 2023, a new £86,000 cap will be introduced to limit the amount that anyone in England will need to pay for personal care over their lifetime.

The plan also set out the intention to develop integration further than that set out in the *Health and Care Act 2022*. A national plan will support and enable integration between health and social care, to ensure that people experience well-coordinated care.

Additional funding through a health and social care levy was initially introduced from April 2022 as a 1.25 percentage point increase on national insurance contributions, but this approach was reversed in the September 2022 "mini-budget". However, HM Treasury confirmed that the additional funding requirement arising from the Build back better plan would still be met.

People at the heart of care

People at the heart of care: adult social care reform[24] sets out a 10-year vision for adult social care describing how previously announced funding will be used to reform adult social care, including developing the workforce, supporting digital transformation, and improving integration with housing.

The 10-year vision builds on the principles of personalised care, to drive user-led social care and give people choice, control, and independence. The vision applies this principle to those who draw on care and support, and their families and unpaid carers. It is recognised that early support is better than reactive intervention, helping people to retain or regain their skills and independence and preventing needs from developing.

The white paper sets out several 'I' statements to describe what adult social care should allow and enable, from the perspective of the person in receipt of services, or their family. It is expected that, to deliver this, the government, NHS, local authorities, care providers, voluntary and community groups and wider public sector, will work closely together to provide a range of support. This support will include home adaptations, better processes for direct payments, use of technology, improved co-design of care, promoting participation in work, and promotion of healthier choices and interventions.

To support improvements in the quality of care delivered, the 10-year vision aims to put social care on a par with the NHS, in terms of public perception of value and quality. The importance of data is acknowledged with an aim to give easy access to timely digitised information.

Fairness and accessibility also feature within the vision, building on recent announcements around capping the cost of care and ensuring that self-funders pay the same rates for care as local authorities. Improved information, advice and transparency is expected to make it easier to navigate the care system.

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[23] UK Government, *Build back better: our plan for health and social care*, September 2021
[24] Department of Health and Social Care, *People at the heart of care: adult social care reform*, December 2021

Joining up care for people, places and populations

Joining up care for people, places and populations[25] sets out a vision to join up planning, commissioning, and delivery across health and adult social care. Children's social care is excluded from the paper. The white paper sets out several areas where improvements can be made, building on existing policies and plans in many cases. There is a strong focus on integrated working at a 'place level'[26] as it is thought that that is the scale at which joint action is most effective. It states that *'the truly radical possibilities in this agenda are much more likely to be identified and realised by local organisations than through central prescription.'*

The white paper states that clear accountability is required at a place level so that all partners know where delivery and financial responsibility lies. An illustrative place board model is described, and, by spring 2023, all places are expected to adopt an equivalent model. It is expected that this governance model will provide:

- clarity of decision-making around service reconfigurations
- risk management
- agreement of outcomes
- resolution of disagreements between partners
- identify a single person who is accountable for the delivery of the shared plan.

It is expected that any arrangements will build upon existing structures and processes such as health and wellbeing boards and better care fund arrangements. A place board will not be required where an integrated care system (ICS) is made up of a single place.

The white paper recognises that a good financial framework can support integrated approaches to delivering health and care. It cites two main mechanisms for doing this – pooled and aligned budgets, where pooled budgets represent a formal agreement to align and share resources. Further detail on pooled and aligned budgets are included in *6.6 Local strategic partnerships*, but in summary:

Pooled budgets -The pooling of budgets involves partner organisations formally combining funds into a single budget, to be spent on agreed projects for designated services.

Aligned budgets -Aligned budgets can be either an informal or formal arrangement whereby partners align resources to meet agreed aims but have separate accountability for the respective funding streams.

It is expected that the use of pooled and aligned budgets will increase, although existing mechanisms such as the better care fund[27] will be kept under review as progress accelerates.

2.7 Comprehensive spending reviews and budgets

In terms of overall funding levels, the Labour Government made a commitment in 1997 to increase NHS funding to a level that would bring the UK's health spending in line with the average for the rest of Europe. The first step toward this target was taken in the 2000 budget, with a further significant increase in 2001. However, it was the 2002 budget that gave the first indication of the substantial and long-term increases required if that promise was to be delivered. Funding for these increases was achieved by the introduction of employer and employee national insurance surcharges at a rate of

[25] Department of Health and Social Care, *Joining up care for people, places and populations*, February 2022
[26] Place: a geographic area that is defined locally, but often covers 250,000-500,000 people - for example, at borough or county level.
[27] NHS England, *Better Care Fund*, August 2022

1%, and from the release of funds from other sources, enabled by the government's comprehensive spending review (CSR). The CSR process is designed to assess critically the spending of government departments in the light of changing priorities.

Successive budgets maintained the commitment to longer-term funding increases. However, the 2007 CSR process led to more modest increases for the three-year period from 2008/09 compared with the preceding period, averaging 3.9% growth in real terms, compared with 7.5% for the previous CSR period.

The impact of the economic downturn following the banking crisis in 2008 led to warnings about the future funding of the NHS.

In preparation for tighter times ahead, efficiency savings targets steadily moved upwards. To help achieve these targets and in line with a renewed emphasis on quality, the Department of Health expected NHS organisations to meet the 'quality, innovation, productivity and prevention (QIPP) challenge'. In practice, this meant organisations had to follow 'lean management principles' of avoiding duplication, preventing errors that then need to be corrected, and stopping ineffective practices. Inevitably this involved a focus on reducing back-office functions and (from a finance perspective) re-ignited the debate about the relative advantages and disadvantages of shared services.

The spending review in November 2015 focused on the need to reduce the public sector borrowing requirement while investing in key services notably the NHS in order to support the delivery of the Five Year Forward View. The health budget was increased by £10bn per annum by 2020 over and above that for 2014/15, taking the projected NHS budget to £119.6bn (see chapter 10 for more about the financing of the NHS).

In 2018, the then prime minister announced a long-term funding settlement for the NHS, outside of the normal spending review cycle. An additional £20bn was committed by 2023.

The 2020 spending review only set out plans for the 12 months from April 2021, due to the disruption caused by Covid-19 to public spending and the uncertainty in long term planning. However, the review set out that the NHS in England would get an extra £6.3bn to help meet the government's commitment to get the NHS budget to £148.5bn by 2023-24. The devolved nations received a corresponding uplift to funding based upon the Barnett formula which determines how money is allocated across the United Kingdom. Discussions continue regarding the appropriateness of the formula with arguments that a more needs-based formula should be applied. Details of the formula, and discussions concerning its application, were outlined in a 2021 House of Commons briefing paper *The Barnett formula*[28] .

The autumn budget and spending review in 2021[29] established a three-year budget for the Department of Health and Social Care, representing a 4.1% increase over the 2022 – 2025 period for the department. The spending review also set out capital funding for the next three years.

The 2022 autumn statement[30] provided further funding across the spending review period. The Department of Health and Social Care's 2022/23 planned spend of £168.2bn, is expected to increase to £180.4bn in 2024/25.

[28] House of Commons Library, The Barnett formula, May 2021
[29] HM Treasury, *Autumn budget and spending review 2021,* October 2021
[30] HM Treasury, *Autumn statement 2022*, November 2022

Key learning points

- Despite continual policy and legislative change, the underpinning principles of the NHS remain as they were in 1948: NHS services are available to everyone; free at the point of need (or use); and based on clinical need, not the ability to pay.
- NHS funding decisions usually form part of the wider comprehensive spending review process.
- Since the publication of the *Five year forward view* in 2014, the NHS has been working towards a more collaborative, integrated structure. This is now enshrined in legislation.
- The Health and Care Act 2022 puts integrated care systems onto a legal footing.

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.

HFMA introductory guide to NHS finance

Chapter 3: NHS finance - the role of the centre

Chapter 3. NHS finance – the role of the centre

The role of government, ministers, and the Department of Health and Social Care (including its ALBs)

Overview

This chapter focuses on the role of the 'centre' in relation to NHS finance and governance. The chapter covers:

- **Parliament**
- **government ministers**
- **the Department of Health and Social Care and its associated arm's length bodies (ALBs).**

For each element, the chapter looks at its status, accountabilities, roles and financing. To remind yourself of the overall structure of the NHS and where 'the centre' fits, look back at the diagram on page 21.

3.1 Parliament

What it is – status and accountabilities

Parliament is the United Kingdom's highest legislative body and sits at the top of the accountability tree. In relation to the NHS, Parliament holds the Secretary of State for Health and Social Care to account for the functioning and use of resources of the Department of Health and Social Care (DHSC) and the NHS.

Parliament approves the estimates for spending and supplementary estimates. This is the bedrock of regularity, that is, ensuring that taxpayers' money is spent wisely and well, and for the purposes intended.

The devolved nations of Northern Ireland, Wales and Scotland

Parliament has devolved responsibility for some functions to the legislatures of the devolved nations, including the provision of healthcare services. Chapters 21 (Northern Ireland), 22 (Wales) and 23 (Scotland) explore the legislative and accountability arrangements for each nation.

What the UK Parliament does – roles and responsibilities

The main functions of the UK Parliament, where powers have not been devolved, can be described as to provide:

- checks on and challenges to the work of government
- making and changing laws
- debating the import issues of the day
- checking and approving government spending.

As part of this process, the House of Commons (and the House of Lords) appoint select committees. House of Commons select committees have a duty to check and report on the work of government departments, in particular on spending, policies and administration.

The Health and Social Care Select Committee (a Commons select committee) has a maximum of 11 members and the quorum for any formal proceedings is three. As the members of the committee are appointed by the House they remain on the committee until the next dissolution of Parliament, unless discharged. The members of this committee are appointed by the House of Commons and its constitution and powers are set out in *House of Commons Standing Order No.152*[31].

As well as holding the Secretary of State to account, the cross-party House of Commons Health and Social Care Select Committee examines the expenditure, administration and policy of the DHSC and its associated bodies.

The chair of the committee is a backbench MP (i.e., not a government minister) elected by MPs at the beginning of each parliament. The chair has considerable influence over the focus and working practices of the committee.

Within its remit, the committee has complete discretion to decide which areas to investigate and has the power to require the submission of written evidence and documents, and to send for and examine witnesses. The committee's oral evidence sessions are usually open to the public and are often televised. Deliberative meetings of the committee, where there are full and free discussions of issues and courses of action, are held in private.

When an inquiry ends, a report is agreed by the committee and then published by Her Majesty's Stationery Office. The report is usually published in two volumes: the findings of the committee and the background (memoranda and oral) evidence. The government is committed to responding to such reports within two months of publication.

The committee is supported in its work by a team of staff and by part-time specialists, usually academics or experts from professions relevant to its inquiries.

Two other Parliamentary committees can scrutinise the DHSC and the NHS:

- the Public Accounts Committee (PAC)
- the Public Administration and Constitutional Affairs Committee (PACAC).

The PAC keeps a check on all public expenditure including money spent on health. Its remit takes it far wider than a view on the annual accounts, with the results of National Audit Office value for money studies usually being considered. In these instances, the PAC takes evidence, usually questioning accounting officers, chief executives and director generals from relevant organisations (such as the DHSC and NHS England), before publishing its own report and making recommendations.

The PACAC examines the reports of the Parliamentary and Health Service Ombudsmen. It considers matters relating to the quality and standards of civil service administration and constitutional issues.

Other select committees, and the House of Lords, may from time-to-time conduct inquiries into government policies that impact upon the DHSC.

[31] House of Commons, *Standing orders 2002,* October 2001

3.2 Secretary of State for Health and Social Care

What the role is – status and accountabilities

The Secretary of State for Health and Social Care is a Cabinet minister with responsibility for the 'work of the Department of Health and Social Care, including:

- overall financial control and oversight of NHS delivery and performance
- oversight of social care policy.'[32]

The Secretary of State is accountable to Parliament for the provision of a comprehensive health and care service in England.

What the Secretary of State does – roles and responsibilities

The NHS was established under the *National Health Service Act 1946*. This and other subsequent Acts of Parliament relating to the NHS set out the duty of the Secretary of State to provide a comprehensive health and care service in England.

The Secretary of State is politically accountable for the NHS and for the resources allocated to the health and social care system.

They are also responsible for:

- oversight of all NHS delivery and performance
- system design
- the legislative framework
- overall strategic direction
- mental health
- championing patient safety.

The *Health and Care Act 2022*[33] sets out some changes to the responsibilities of the Secretary of State; most notably it provides a new power for them to intervene in local service reconfigurations.

3.3 Health ministers

What they are – status and accountabilities

The Secretary of State is supported by a team of health ministers who are appointed by the government. These ministers are either MPs elected by the public or members of the House of Lords. They are accountable to the Secretary of State.

What ministers do – roles and responsibilities

Health ministers each have individual responsibility for different aspects of the DHSC's work. The portfolios attached to the ministerial posts often change, depending on the priorities at that point in time and the personal interests of the individuals. For the latest information on ministerial portfolios see the DHSC's website[34].

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[32] UK Government, *Secretary of State for Health and Social Care*, 2022
[33] UK Parliament, *Health and Care Act 2022*, April 2022
[34] UK Government, *Department of Health and Social Care*, 2022

3.4 The Department of Health and Social Care

What it is – status and accountabilities

The Department of Health and Social Care (DHSC) is the Department of State responsible for the NHS, public health and adult social care in England. The DHSC is accountable, via its principal accounting officer (the permanent secretary), to Parliament 'for safeguarding the public funds' allocated to it[35].

The DHSC supports the Secretary of State and ministers in carrying out their ministerial responsibilities including:

- accounting to Parliament and the public for the way money is spent and what is achieved with it
- answering Parliamentary questions and dealing with other Parliamentary business such as debates and enquiries
- responding to communications from the public and MPs
- communicating with the public.

There is a departmental board chaired by the Secretary of State that includes non-executives from outside government. This board provides advice and support to ministers, and the principal accounting officer, across all the DHSC's responsibilities. An audit and risk assurance committee reports into the board, with the department being subject to external audit by the National Audit Office. The board scrutinises reports on performance and challenges the DHSC on how well it is achieving its objectives'[36].

What the Department of Health and Social Care does – roles and responsibilities

The Department of Health and Social Care's (DHSC) overarching purpose is to help people live more independent, healthier lives for longer. It works closely with its partners in the health and care system, its arm's length bodies (ALBs), agencies, local authorities, across government, and with both patients and the public to achieve this aim. The governmental website[37] identifies the DHSC's responsibilities as being:

- supporting and advising ministers: to help them shape and deliver policy that delivers the government's objectives
- setting direction: anticipating the future and leading debates so that global and domestic health is protected and improved
- accountability: making sure the department and its ALBs deliver agreed plans and commitments
- acting as guardians of the health and care framework: making sure the legislative, financial, administrative and policy frameworks are fit for purpose and work together
- troubleshooting: in the last resort, taking the action needed to resolve crucial and complex issues.

The DHSC's outcome delivery plan[38] lists five priority outcomes that are shared with its ALBs and partner organisations. The outcome delivery plan (ODP) replaced the pre Covid-19 single department plan.

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[35] Department of Health and Social Care, *Accounting Officer System Statement*, July 2018
[36] *Accounting Officer System Statement* (as above).
[37] Department of Health and Social Care, *About us,* August 2022
[38] Department of Health and Social Care, *DHSC outcome delivery plan*, July 2021

Outcome delivery plan priority outcomes

The Department of Health and Social Care supports ministers in leading the nation's health and social care and helping people live more independent, healthier lives for longer by:

- protecting the public's health through the health and social care system's response to Covid-19
- improving healthcare outcomes by providing high-quality and sustainable care at the right time in the right place and by improving infrastructure and transforming technology. Supporting the NHS to deliver high-quality, safe and sustainable hospital care and secure the right workforce
- improving healthcare outcomes through a well-supported workforce
- improving, protecting and levelling up the nation's health, including reducing health disparities
- improving social care outcomes through an affordable, high-quality and sustainable adult social care system.

Performance against the short-term objectives and long-term ambitions in the OPD and its predecessor single department plan is set out in the DHSC's annual report and accounts[39].

Linked to these responsibilities and objectives, the DHSC has several key roles including:

- providing leadership for the NHS, adult social care and public health services (including - for example, health promotion, health protection against infectious diseases, the safety of medicines and ethical issues) and setting the strategic framework within which they operate
- developing policy and legislation relating to the NHS, adult social care and public health
- supporting the delivery of improvements in the health and adult social care system via performance monitoring and evaluation; managerial and professional leadership of external groups; building capacity and capability and ensuring value for money
- leading on the integration of health and wellbeing into wider government policy
- allocating the funding received from the Treasury
- setting healthcare standards, targets and outcome measures – there are separate outcomes frameworks for the NHS, public health and adult social care
- agreeing the mandate with NHS England based on these outcomes frameworks
- reviewing the performance of its arm's length bodies (see below) and intervening (by direction) if necessary
- managing performance against its statutory responsibilities and holding the NHS to account – this includes ensuring that the NHS lives within its allocated resources and achieves required efficiency savings.

These roles are translated into several specific 'deliverables' for the NHS by NHS England which is responsible for the day-to-day operational management of the NHS and operates at arm's length from the DHSC (see chapter 4).

[39] UK Government, *DHSC annual report and accounts: 2020 to 2021*, January 2022

How the Department of Health and Social Care is financed

Parliament, through HM Treasury, usually sets the DHSC's budget for a five-year period in a budgetary exercise known as the spending review, that takes place across government. The DHSC submits evidence to the Treasury setting out its proposals for expenditure plans covering the five-year period. These plans are then discussed and challenged over several months before being finalised. The outcome of the most recent spending review was released in September 2021 and covers the years 2022/23 to 2024/25, a three-year budget on this occasion. More information about the spending review process is included in chapter 2.

Once the Treasury has set the overall budget total, the DHSC determines how this should be allocated. Most of the funding is allocated to NHS England, but some is retained in central budgets - for example, for 2021/22 the total revenue budget for the DHSC was £169.1bn of which £139.1bn was allocated to NHS England[40]. The DHSC's funding also finances its associated ALBs (see below).

Once resources have been allocated, the DHSC has an on-going responsibility to ensure that the NHS lives within them, and that its objectives are achieved as efficiently as possible. This includes monitoring performance against national targets.

3.5 Arm's length bodies

What they are – status and accountabilities

Arm's length bodies (ALBs) are stand-alone national organisations sponsored by the DHSC to undertake activities to help deliver its agenda. They range in size but tend to have boards, employ staff and publish accounts. There are three types of ALB.

Types of ALB

Executive agencies – these are part of the DHSC (and are accountable to it) but have greater operational independence than a division or section of the DHSC.

Special health authorities – these are independent bodies created by order under section 28 of the *NHS Act 2006* and subject to direction by the Secretary of State for Health and Social Care.

Executive non-departmental public bodies (NDPBs) – these are established by primary legislation and have their own statutory functions. Their relationship with the DHSC is defined in legislation and some have greater independence than others.

Regardless of their status, every ALB has a framework agreement that sets out its relationship with the DHSC – in particular, these agreements cover:

- lines of accountability
- working arrangements
- core financial requirements
- relationships with other ALBs and organisations in the system
- how the ALB is held to account for delivering its objectives and outcomes and for the use of public money.

[40] HM Treasury, *Budget 2021*, March 2021

Each ALB must also submit a business plan to the DHSC for approval each year indicating how its objectives will be achieved and forecasting its financial performance. Every ALB must lay its annual report and accounts before Parliament.

The DHSC has a duty to keep the performance of ALBs under review and the Secretary of State can intervene in the event of 'significant failure'.

What ALBs do – roles and responsibilities

ALBs can be categorised by function as follows.

Regulatory – ALBs that hold the health and social care system to account:

- NHS England (NDPB)
- Care Quality Commission (CQC) (NDPB)
- Medicines and Healthcare Products Regulatory Agency (executive agency)
- Human Fertilisation and Embryology Authority (NDPB)
- Human Tissue Authority (NDPB).

Public welfare – ALBs that focus primarily on safety and the protection of public and patients:

- UK Health Security Agency (UKHSA) (executive agency)
- Health Research Authority (NDPB).

Standards – ALBs that focus primarily on establishing national standards and best practice:

- National Institute for Health and Care Excellence (NICE) (NDPB).

Central services to the NHS – ALBs that provide cost-effective services and focused expertise across the health and social care system:

- NHS Blood and Transplant (special health authority)
- NHS Business Services Authority (special health authority)
- NHS Counter Fraud Authority (special health authority)
- NHS Resolution (special health authority).

We will look more closely at the role of NHS England in chapter four. Some of the other ALBs that have a particular bearing on NHS finance and governance are considered later in this chapter.

How ALBs are financed

ALBs are financed primarily out of the settlement received by the Department of Health and Social Care (as 'grant in aid') although some levy fees for services provided - for example, the CQC charges a registration fee. Others are financed largely via charges to users of their services - for example, in the case of NHS Blood and Transplant, hospitals (both NHS and private) pay for each unit of blood supplied.

Wholly or partially owned companies

There are also some bodies that are either wholly or partially owned by the DHSC, and so fall within the DHSC group. These include:

- Supply Chain Coordination Ltd (SCCL) – set up in 2018, NHS Supply Chain is an NHS body and manages the sourcing, delivery and supply of healthcare products, services and food for NHS trusts and healthcare organisations across England and Wales
- NHS Property Services Ltd – set up in 2012 to take over the residual estate left by strategic health authorities and primary care trusts after their abolition by the *Health and Social Care Act 2012*
- Community Health Partnerships (CHP) – established in 2001, the CHP's purpose is to provide high quality health and social care facilities that meet local needs.

Annual accounts

ALBs produce accounts in a format prescribed by the DHSC under the group accounting manual, and will, in almost all circumstances, be consolidated into the DHSC's annual report and accounts. The published accounts include a full schedule of the ALBs and subsidiary bodies[41].

3.6 Office for health improvement and disparities (OHID)

What it is – status and accountabilities

Up until October 2021, it was Public Health England (PHE) that provided national leadership for public health: protecting the public's health, improving the public's health and improving population health.

From October 2021, the Office for Health Improvement and Disparities (OHID)[42], incorporated most of PHE's functions that directly support development and delivery of national health improvement policy. OHID priorities include the following areas: health disparities, prevention, access to services, partnerships across relevant bodies and innovation in health improvement.

What OHID does – roles and responsibilities

OHID has the following key areas of responsibility:

- national health improvement, prevention of poor health, and tackling health disparities
- regional public health
- public health analysis
- public health advice on nursing, midwifery and allied health professionals.

3.7 UK Health Security Agency

What it is – status and accountabilities

In August 2020, following the outbreak of the Covid-19 pandemic, the then Secretary of State for Health and Social Care announced the establishment of the National Institute for Health Protection (NIHP), bringing together health protection elements of Public Health England with the NHS Test and Trace service and the Joint Biosecurity Centre's intelligence and analytical capability[43]. Subsequently the new organisation was named as the UK Health Security Agency (UKHSA), and it became fully

[41] Department of Health and Social Care, *Annual Report and Accounts, 2020-21, Annex E*, 31, January 2022
[42] Department of Health and Social Care, *Office for health improvement and disparities, About us,* 2022
[43] Department of Health and Social Care, *The future of public health: the NIHP and other public health functions*, September 2020

operational in October 2021[44]. It was established to help ensure that the UK can respond quickly and at greater scale to deal with pandemics and future threats.

The UKHSA is an executive agency of the Department of Health and Social Care and is therefore accountable to the DHSC.

What the UKHSA does – roles and responsibilities

The UKHSA is responsible for planning, preventing and responding to external health threats, and providing intellectual, scientific and operational leadership at national and local level.

The responsibilities of the UKHSA include:

- the health protection functions previously the responsibility of Public Health England
- planning and executing the response to external health threats such as pandemics
- the Joint Biosecurity Centre
- NHS Test and Trace.

3.8 Health Education England

What it is – status and accountabilities

Health Education England (HEE)[45] was originally established by the 2012 Act as a special health authority within the Department of Health and Social Care. In April 2015 it became a NDPB. It has 2,250 members of staff. In April 2023 it will become part of NHS England as a standalone directorate.

What HEE does – roles and responsibilities

HEE provides national leadership and oversight on strategic planning and development of the health and public health workforce and allocates education and training resources. In other words, HEE ensures that the healthcare workforce has the right skills and is available in the right numbers.

HEE has the following key functions:

- providing national leadership on workforce planning and development, ensuring the security of supply of the professionally qualified clinical workforce
- promoting high quality education and training, responsive to the needs of patients and local communities
- allocating and accounting for NHS and public health education and training resources and the outcomes achieved[46].

[44] UK Health Security Agency, About us, 2021
[45] Health Education England, *About,* 2022
[46] Department of Health and Social Care, *Framework Agreement between the Department of Health and Social Care and Health Education England: 2018 – 2021*, July 2019

3.9 NHS Digital

What it is – status and accountabilities

NHS Digital[47] is the trading name for the Health and Social Care Information Centre (HSCIC). HSCIC was created as a special health authority in 2005 and changed to a NDPB in April 2013. It was rebranded as NHS Digital in 2016. On 1 February NHS Digital will become part of NHS England as a standalone directorate.

What NHS Digital does – roles and responsibilities

NHS Digital is responsible for the information, data and IT systems for commissioners, analysts and clinicians in health and social care in England. It has the following key functions:

- collect and disseminate data, to maximise the accessibility, quality and utility of health and care data
- run live services, both citizen-facing such as the NHS app, and systems such as the electronic prescribing service
- develop new products, services and enablers
- support the UK response to Covid-19, through delivery of the digital services for test and trace and vaccinations.

3.10 Care Quality Commission (CQC)

What it is – constitution, structure and accountabilities

The Care Quality Commission[48] began operating on 1 April 2009 as the independent regulator of health and adult social care in England. It is an executive non-departmental public body and was established to regulate fundamental standards of quality and safety, which were first set out in the *Health and Social Care Act 2008*.

Although it is formally an ALB of the Department of Health and Social Care, the CQC is independent of central government and directly accountable to Parliament[49]. However (as with all ALBs), the CQC has a framework agreement with the Department of Health and Social Care that sets out its relationship and lines of accountability. It also publishes a strategic plan that forms the basis of regular meetings with the Department.

What it does – roles and responsibilities

The CQC was given a range of legal powers and duties as part of the Health and Social Care 2008 Act, these include:

CQC powers and duties

- registering providers of healthcare and social care to ensure that they are meeting the essential standards of quality and safety
- monitoring how providers comply with the standards by gathering information and inspecting them when the CQC think it is needed

[47] NHS Digital, *About NHS Digital,* 2022
[48] Care Quality Commission, *About us,* 2022
[49] Care Act 2014

- using enforcement powers, such as fines and public warnings and closing down services, if services drop below the essential standards and, particularly, if the CQC think that people's rights or safety are at risk
- acting to protect patients whose rights are restricted under the Mental Health Act
- promoting improvement in services by conducting regular reviews of how well those who arrange and provide services locally are performing
- carrying out special reviews of particular types of services and pathways of care, or investigations on areas where the CQC has concerns about quality and safety
- seeking the views of people who use services and involving them in the CQC's work
- telling people about the quality of their local care services to help providers and commissioners of services to learn from each other about what works best, where improvement is needed, and help to shape national policy.

As a result of the Health and Social Care Act 2012, the CQC gained additional responsibilities including the establishment of HealthWatch England.

HealthWatch England

HealthWatch England is a national body established to enable the views of people who use NHS and social care services to influence national policy, advice, and guidance. It is constituted as a statutory committee of the CQC and its chairperson is a CQC non-executive director. Its role is to provide leadership, guidance and support to local HealthWatch organisations (see chapter 8) and advise the Secretary of State, NHS England, and local authorities. HealthWatch England is funded as part of the Department of Health and Social Care's grant in aid to the CQC and must make an annual report to Parliament.

The Care Act 2014 required the non-executive members of the CQC to appoint executive members to be the Chief Inspector of Hospitals, the Chief Inspector of Adult Social Care and the Chief Inspector of General Practice.

The CQC's strategy from 2021[50] sets out ambitions under four themes:

- people and communities - regulation that is driven by people's needs and experiences, focusing on what is important to people and communities when they access, use and move between services
- smarter regulation - smarter, more dynamic and flexible regulation that provides up-to-date and high-quality information and ratings, easier ways of working with the CQC and a more proportionate response
- safety through learning - regulating for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives
- accelerating improvement - enabling health and care services and local systems to access support to help improve the quality of care where it's needed most.

How the CQC is financed

The CQC is funded through fee income from providers registered with CQC.

[50] Care Quality Commission, *A new strategy for the changing world of health and social care - CQC's strategy from 2021*, April 2022

Key learning points

- The Secretary of State is accountable to Parliament for the provision of the comprehensive health and care service in England.
- The Secretary of State is supported by a team of health ministers who are appointed by the Government. These ministers are either MPs elected by the public or members of the House of Lords. They are accountable to the Secretary of State.
- The Department of Health and Social Care (DHSC) is the Department of State responsible for the NHS, public health and adult social care in England.
- Arm's length bodies (ALBs) are stand-alone national organisations sponsored by the Department of Health and Social Care to undertake activities to help deliver its agenda.
- Examples of ALBs include NHS England, Care Quality Commission, and the UK Health Security Agency.

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.

HFMA introductory guide to NHS finance

Chapter 4: NHS finance – the role of NHS England

Chapter 4. NHS finance – the role of NHS England

Overview

This chapter looks at what NHS England is, how it is structured and the role it plays in relation to NHS finance and governance. To remind yourself of where NHS England fits into the NHS structure, look back at the diagram on page 21.

4.1 What is NHS England?

Initial establishment and legacy arrangements

In constitutional terms, NHS England is an executive non-departmental body working at arm's length from the Department of Health and Social Care (DHSC) (i.e., it is a Department of Health and Social Care arm's length body or ALB).

In 2023 it is planned that both NHS Digital (from January 2023) and Health Education England (from April 2023) will become part of NHS England as standalone directorates.

In its current statutory form NHS England was established by the *Health and Care Act 2022*, merging NHS Improvement and the previous version of NHS England.

The legacy NHS England[51] oversaw the commissioning side of the NHS and was originally set up under section 9 of the *Health and Social Care Act 2012*[52]. It became fully operational on 1 April 2013 and until March 2013 was called the NHS Commissioning Board.

NHS Improvement oversaw the provider side of the NHS. NHS Improvement came into being on 1 April 2016, bringing together two separate arm's length bodies – Monitor (holding responsibility for foundation trusts) and the NHS Trust Development Authority (being responsible for NHS trusts). NHS Improvement was not a separate legal entity; it had an integrated management structure to allow Monitor and the NHS TDA to work more closely together.

From 1 April 2019, NHS England and NHS Improvement came together to form a single organisation, although remained legally separate. They had a single joint leadership structure and effectively operated as a single body.

Accountability and working arrangements

NHS England is accountable to the Secretary of State for Health and Social Care and the DHSC for meeting its legal duties and fulfilling its mandate. In formal terms, the line of accountability runs from NHS England's accountable officer (the chief executive, as designated in the 2012 Act) to the DHSC's accountable officer (the permanent secretary) to the Secretary of State and Parliament.

The mandate[53] is a multi-year document published, and updated, by the Secretary of State. It sets out the objectives that NHS England is expected to deliver in the forthcoming year along with its financial allocation. As set out in the *Health and Social Care Act 2012*, NHS England publishes a

[51] NHS England, *About us,* 2022
[52] UK Government, *Health and Social Care Act 2012,* 2012
[53] Department of Health and Social Care, *The Government's 2021-22 mandate to NHS England and NHS Improvement*, March 2021

business plan prior to the beginning of the financial year to set out how it intends to exercise its functions in that year and each of the next two financial years. An annual report is published showing how it performed. Previously, the mandate was updated annually but this was changed in the *Health and Care Act 2022* which replaces the requirement to have a new mandate each year with a new requirement to always have a mandate in place. This is to allow more flexibility to set longer term objectives and to amend the mandate to reflect changing strategic needs without having to wait for the annual cycle.

As with all ALBs, there is also a 'framework agreement' that sets out the working relationship and lines of accountability between the DHSC and NHS England along with financial requirements and relationships with other organisations (see chapter 3 for more about ALBs).

From 2019/20, in line with the *NHS long term plan* and ever closer joint working between the organisations, the NHS England mandate and NHS Improvement remit letter were combined into a single accountability framework, with a single *NHS mandate 2022 to 2023*[54], being published in March 2022.

NHS England is accountable to the DHSC for staying within its allocated resources (the 'commissioning revenue limit' allocated to it by the DHSC) as well as delivering a wide range of improvements to healthcare through several 'outcomes frameworks'. NHS England is also responsible for the functioning of the entire commissioning system and the associated budget and for reporting the consolidated financial position of itself and integrated care boards (ICBs).

4.2 What NHS England does – roles and responsibilities

Comprehensive health service

Alongside the Secretary of State, NHS England has an overriding statutory responsibility for promoting a comprehensive health service that will 'secure improvements in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical and mental illness'[55]. As well as general duties - for example, having regard to the *NHS constitution*; exercising its functions economically, efficiently and effectively; securing continuous improvement and promoting innovation, NHS England has several specific statutory duties relating to:

- establishing and holding ICBs to account
- commissioning of services - for example, NHS England must commission directly those services specified in regulations – see below
- partnership working/co-operation - for example, a duty to co-operate with the DHSC, the Care Quality Commission (CQC) and the National Institute for Health and Care Excellence (NICE); meeting safeguarding duties for children and vulnerable groups
- emergencies – to ensure that it and ICBs are properly prepared and resilient. In the event of a major incident, NHS England assumes responsibility for coordinating the input of all healthcare organisations
- finance – to manage overall expenditure on commissioning and general management, t and produce accounts that include the consolidated accounts of all ICBs. This is facilitated by the mandated use of a single financial ledger system called the integrated single financial environment (ISFE) that is designed to ensure consistency of reporting and simplify consolidation.

NHS England allocates funding to ICBs and holds them to account for the management of these public funds. It is also responsible for managing financial risk across ICBs.

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[54] Department of health and Social Care, *NHS mandate 2022 to 2023*, March 22, updated June 2022
[55] NHS England's legal duties and powers are set out in sections 9 and 23 and schedule A1 of the 2012 Act.

As mentioned above, NHS England commissions some services itself (referred to as 'direct commissioning') – specifically:

- primary care services provided by GPs (this is delegated to ICBs - see chapter 6 for more details), dentists, opticians, community pharmacists
- specialised services[56] – in 2020/21 these accounted for £19.3bn of the annual NHS budget. Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. Specialised services are not available in every local hospital because they must be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, that is planned and arranged locally, specialised services are planned nationally and regionally by NHS England. A good example is transplant surgery.
- offender healthcare (including high security psychiatric facilities)
- some services for members of the armed forces.

These services are commissioned by the relevant regional team using common 'single operating models' and reporting to a single board within NHS England. These models have been designed to ensure that all patients are offered consistent, accessible, high-quality services across the country.

In addition, although local authorities are responsible for commissioning some public health services, many of which are delivered by NHS providers, NHS England has a direct commissioning responsibility for some preventive public health services. These are commissioned through a model developed with stakeholders and include:

- the national immunisation programmes
- the national screening programmes
- public health services for offenders in custody
- sexual assault referral centres
- child health information systems.

In 2020/21 NHS England's direct commissioning activities accounted for £27.2bn[57].

NHS England is also required to carry out several other roles, including those set out below:

- setting commissioning guidelines
- allocating funding for the purchase of healthcare to ICBs
- developing model care pathways
- establishing model contracts for ICBs to use when commissioning services
- supporting ICBs as they develop their skills and capacity including promoting good practice
- determining the structure of future payment systems
- promoting and extending choice
- the roll-out of personalised care (see chapter 5 for more details)
- championing patient and carer involvement
- overseeing the cancer drugs fund.

The *2019/20 accountability framework* set out deliverables against two overarching objectives – ensuring the effective delivery of the NHS long term plan and supporting government in managing

[56] NHS England, *Specialised services,* 2017
[57] NHS England, *2020/21 annual report (page 186)*, 2022

the efforts of EU exit on health and care. Within these objectives, NHS England was required to lay the foundations to implement the NHS long term plan, including the development of integrated care systems (ICSs); achieve financial balance; maintain and improve performance; improve the quality and safety of services.

Regulation of health and social care

NHS England is the sector regulator for health and social care. NHS England promotes high quality health and care for all. It will support NHS organisations to work in partnership to deliver better outcomes for patients and communities, with the best possible value for taxpayers and to continuously improve.[58]

NHS England has responsibility for licensing all providers of NHS-funded care in England, including independent providers, under the duty of protecting and promoting the interest of NHS patients. In extreme circumstances, if licence conditions are breached, there is the power to remove directors and governors, as well as revoking the provider's licence to operate. Regulation of providers is carried out in co-operation with CQC who also register providers against safety and quality criteria.

There is more detail about the regulatory role of NHS England in chapter 12.

Commissioning support units

NHS England also hosts several commissioning support units (CSUs). CSUs provide both transactional and transformational support and services to many ICBs, helping them to deliver their commissioning role. This may be in the form of business support functions such as finance and human resources; providing data analysis and storage; developing the health needs assessment or handling media enquiries.

Arrangements between CSUs and ICBs are covered by service level agreements (SLAs) that set out the expectations and requirements of each party.

Each CSU is led by a managing director and operates with a governing body (but not a legal board). As they are part of NHS England, all hosted CSUs fall within NHS England's own governance arrangements.

Each CSU operates under an agreed NHS England operating framework. The operating framework includes the powers delegated by NHS England and reflects any additional conditions under which the CSU must operate. CSUs are required to break even with any profits reinvested into the business.

Regional teams

NHS England has seven regional teams. The regions act as the local offices of NHS England with functions that include commissioning some primary care and specialised services. There are seven regions – East of England, London, Midlands, North East and Yorkshire, North West, South East and South West. The regional teams are responsible for the quality, financial and operational performance of the NHS organisations in their region. Their core functions are focused on:

- healthcare commissioning and delivery across their geographies
- professional leadership on finance, nursing, medical staff
- specialised commissioning
- patients and information

[58] NHS England, *What we do,* 2022

- human resources
- organisational development
- assurance and delivery.

The regional teams also commission some primary care services, although ICBs commission GP services themselves (see chapter 6 for more details). Local professional networks (LPNs) are hosted by the regional teams and cover dentistry, pharmacy and eye health. They encourage service improvements for their local communities.

Clinical senates and strategic clinical networks

NHS England hosts 10 clinical senates across the country. Their role is to help ICBs, health and wellbeing boards and NHS England to make the best possible decisions about healthcare for the population they serve. Clinical senates are multi-professional forums and operate on a geographical basis, that are in general, aligned to the regional boundaries.

NHS England also hosts several strategic clinical networks. These networks bring together those who use, provide and commission services for complex patient pathways, in order to develop integrated, whole system approaches. The clinical networks focus on four main areas: cardiovascular; maternity, children and young people; mental health, dementia and neurological conditions; and cancer. However, regions can set up other clinical networks if there is local need.

4.3 How NHS England is financed

NHS England's budget is allocated to it by the DHSC. Most of this budget is then allocated to ICBs and used by them to commission services. For 2022/23 the total revenue budget allocated to NHS England to deliver the mandate is £151.8bn with £110.5bn allocated to ICBs including monies for running costs. NHS England's own central costs and reserves amount to around £12.7 bn (including historic continuing healthcare claims) and its specialised and other direct commissioning (excluding that carried out for public health) accounts for £30.5bn. See chapter 10 for more details.

NHS England also has a capital budget as part of the wider DHSC allocation. The total NHS England capital budget for 2022/23 is £7.9bn, all of which is allocated - via ICBs, to the provider sector. See chapter 15 for more detail on capital funding in the NHS.

These are initial allocations for revenue and capital allocations. They can change during the year depending on circumstances, and address issues - for example, further allocations were made in-year to address funding requirements for Covid-19 activity.

Key learning points

- NHS England has an overriding statutory responsibility for promoting a comprehensive health service that will 'secure improvements in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical and mental illness'.
- NHS England has seven regional teams. The regions act as the local offices of NHS England with functions that include commissioning some primary care and specialised services.
- NHS England's revenue budget is allocated to it by the Department of Health and Social Care. Most of this budget is then allocated to ICBs and used by them to commission services.
- NHS England's capital budget is allocated to it by the Department of Health and Social Care. All this budget is allocated, via ICBs, to the provider sector.

Additional HFMA resources

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HFMA introductory guide to NHS finance

Chapter 5: NHS finance – the role of integrated care systems

Chapter 5. NHS finance – the role of integrated care systems

Overview

This chapter looks at what integrated care systems (ICSs) are, how they are structured and their role. The *Health and Care Act 2022*[59] (the Act) was enacted on 1 July 2022 and brings the proposals set out in the white paper, *Integration and innovation: working together to improve health and social care for all*[60], into effect.

Current arrangements and expectations for ICSs will be reflected in this chapter. ICS arrangements are expected to be refined over time as greater system working develops.

Each ICS comprises:

- **an integrated care partnership (ICP): a formal committee of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS**
- **a statutory integrated care board (ICB) bringing the NHS together locally to improve population health and care, replacing clinical commissioning groups (CCGs).**

The Act established ICPs and ICBs across England. This was done at the same time as abolishing clinical commissioning groups (CCGs).

To remind yourself of the overall structure of the NHS and where ICSs fit, look back at the diagram on page 21.

5.1 What are ICSs?

ICSs bring together acute, community and mental health trusts, GPs, other primary care services, local authorities and other care providers including the voluntary, community and social enterprise (VCSE) sector. ICSs cover the whole of England and the principle of coterminosity, an ICS being coterminous with one or more upper tier local authority areas (county council or unitary body), has been applied, with a small number of exceptions[61].

The aim of ICSs is to 'improve the health of all residents, better support people living with multiple and long-term conditions, preventing illness, tackling variation in care and delivering seamless services while getting maximum impact for every pound'.[62]

ICSs represent a shift away from the former focus on competition towards a new model of collaboration. Building on sustainability and transformation partnerships (STPs) set up in 2016, an ICS is 'a new type of even closer collaboration. In an ICS, NHS organisations, in partnership with

[59] UK Parliament, *Health and Care Act 2022*, April 2022
[60] Department of Health and Social Care, *Integration and innovation: working together to improve health and social care for all*, February 2021
[61] Department of Health and Social Care, *Integrated care systems boundaries review: decision summary*, July 2021
[62] NHS England, *NHS achieves key Long Term Plan commitment to roll out integrated care systems across England*, March 2021

local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve'. [63]

As set out in the Act, the NHS statutory body for each ICS is the integrated care board (ICB). An integrated care partnership (ICP) has been established as a joint committee of every ICB with those local authorities that fall wholly or in part in the area covered by the ICB.

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated care boards (ICBs) have taken on the NHS commissioning functions of CCGs as well as some of NHS England's commissioning functions. ICBs are also accountable for NHS expenditure and performance within the system.

Integrated care partnerships (ICPs) bring together the ICBs, their partner local authorities and other locally determined representatives and are tasked with developing an integrated care strategy to address the health, social care and public health needs of their system, and being a forum to support partnership working.

5.2 ICS structure and responsibilities

Current arrangements

Prior to the *Health and Care Act 2022,* there was no statutory basis for ICSs. They were voluntary partnerships, that developed with varying priorities and arrangements to reflect different local geography, demography, health challenges and history of collaboration. The Act put these arrangements onto a statutory footing.

ICSs bring together local organisations in a pragmatic and practical way to deliver integration with the 'four core purposes of:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development'.[64]

As set out in *Next steps to building strong and effective integrated care systems across England*[65], to deliver the aim to provide a more integrated service 'will require all parts of our health and care system to work together as ICSs, involving:

[63] NHS England and NHS Improvement, *Integrated care systems*, January 2021
[64] NHS England and NHS Improvement, *2021/22 priorities and operational planning guidance: implementation guidance*, March 2021
[65] NHS England, *Integrating care: Next steps to building strong and effective integrated care systems across England*, January 2021

- stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care
- provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale
- developing strategic commissioning through systems with a focus on population health outcomes
- the use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.'

In delivering on the core ICS design principles of subsidiarity (performing only those tasks that cannot be performed at a more local level) and collaboration, NHS England has set out three key components within an ICS – system, place and neighbourhoods.

As detailed in *Designing integrated care systems in England*, 'there are three important levels at which decisions are made:

- **neighbourhoods** (populations circa 30,000 to 50,000 people) - served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through primary care networks (PCNs).
- **places** (populations circa 250,000 to 500,000 people) - served by a set of health and care providers in a town or district, connecting PCNs to broader services including those provided by local councils, community hospitals or voluntary organisations.
- **systems** (populations circa 1 million to 3 million people) - in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.'[66]

In November 2022, the Secretary of State for Health and Social Care commissioned an independent review of ICSs. Focussed on helping local leaders to deliver improved health outcomes across England, the review is chaired by former health secretary Rt Hon Patricia Hewitt. Hewitt is currently chair of NHS Norfolk and Waveney Integrated Care Board[67].

Legislative changes

The Act put ICSs on a statutory footing, legislating for every part of the England to be covered by an ICB and ICP (together known as an ICS). As well as establishing ICSs on a statutory footing, other elements in the Act included formally merging NHS England and NHS Improvement; and making changes to procurement and competition rules relating to health services. The Act does not cover wider reforms of the social care and public health systems.

The Act and explanatory notes, alongside the white paper and *Integrated care systems: design framework*[68] sets out how the NHS will operate within a statutory ICS. This includes areas of consistent national requirements for all ICSs, as well as where local determination of approach can be applied. Several guidance documents were published[69] ahead of the Act's commencement to cover areas such as governance, provider collaboratives and engagement, as well as a due diligence checklist to support the transition from CCGs to ICBs.

There are two forms of integration that are underpinned by the legislation: integration within the NHS to remove some of the barriers to collaboration; and greater collaboration between the NHS and local

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[66] NHS England and NHS Improvement, *Designing integrated care systems in England*, June 2019
[67] Department of Health and Social Care, *Independent review of integrated care systems*, November 2022
[68] NHS England and NHS Improvement, *Integrated care systems: design framework*, June 2021
[69] NHS England and NHS Improvement, *FutureNHS Collaboration Platform – ICS guidance workspace* (login to the FutureNHS site is required)

government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people

There is also a clear recognition that place-based partnerships and provider collaboratives will be important elements of an ICS structure. Neither of these are statutory bodies, but instead are constructs of existing organisations.

Integrated care board (ICB)

The ICB's function is to arrange for the 'provision of services for the purpose of the health service in England'. This means commissioning health services, including primary care services, for the area that the ICB covers unless those services are commissioned by NHS England. NHS England will be able to delegate some of its functions to ICBs.

All ICBs have a duty to exercise their functions effectively, efficiently and economically. The general duties of an ICB include improving the quality of services, reducing inequalities, promoting patient involvement and patient choice, promoting innovation, research, education and training.

Property, rights and liabilities transferred from CCGs to ICBs or NHS England on 1 July 2022 in accordance with a transfer scheme. The scheme transferred everything either to a single ICB where the areas both bodies cover were the same or to one or more ICBs where the areas did not coincide. Staff transferred in accordance with TUPE regulations. ICBs can employ staff and determine their remuneration and terms and conditions.

However, an ICB is not simply a larger CCG and is expected to work differently in practice – its governance model reflects the need for integration and collaboration across the system. It can exercise its functions through place-based committees (while remaining accountable for them) and it is also directly accountable for NHS spend and performance within the system.

Each ICB is governed by a constitution. Each ICB board consists of:

- a chair – appointed by NHS England with the approval of the Secretary of State for Health and Social Care
- a chief executive – appointed by the chair with the approval of NHS England
- at least three other members – referred to as ordinary members. Ordinary members must include:
    - one member jointly nominated by the NHS providers that provide services in the ICB's area
    - one member jointly nominated by those who provide primary medical services in the ICB's area
    - one member jointly nominated by the local authorities whose areas coincide with, or include all or part of, the ICB's area.

At the start of each year, the ICB and its partner NHS trusts and NHS foundation trusts, must prepare a forward plan setting out how they propose to exercise their functions in the next five years and a plan setting out their planned capital resource use. Both plans must be shared with the ICP for the area, each health and wellbeing board established by a local authority that covers some or all of the ICB's area and NHS England. The forward plan must be subject to consultation with the people that the ICB is responsible for. *Guidance on developing the joint forward plan*[70] was published by NHS England in December 2022.

For some services that cover wide geographical areas, ICBs work together to develop shared plans. The supporting governance arrangements are co-designed between the relevant providers, ICBs and

[70] NHS England, *Guidance on developing the joint forward plan*, December 2022

NHS England regional teams. It is important for those working across integrated care system boundaries, such as ambulance providers, to agree their working relationships with the ICSs that they support, with a view to avoiding unnecessary variation of practice or duplication.

Integrated care partnership (ICP)

The ICP is a joint committee of the ICB with those local authorities that fall wholly or in part in the area covered by the ICB. The ICP is made up of:

- one member appointed by the ICB
- one member appointed by each of the responsible local authorities
- any other members appointed by the ICP.

As well as local NHS bodies and local authorities, members of the partnership can include the voluntary, community and social enterprise (VCSE) sector; statutory bodies with an interest in housing, justice or education; or members from health and wellbeing boards. The *ICS design framework* sets out the intention that there should be a broad representation of partners working to improve health and care in their communities.

The ICP must be given the local authorities' joint strategic needs assessment. The ICP will prepare an integrated care strategy that sets out how the assessed needs of the area are to be met by the exercise of the functions of the ICB, NHS England and local authorities. This strategy must consider the extent to which those needs could be met more effectively by making pooled budget arrangements under section 75 of the *NHS Act 2006*.

Place-based partnerships

The legislation creates an enabling framework for local partners to build on existing partnerships at place and system levels that align services and decision-making in the interests of local people. There will be no legislative provision about the arrangements at place, although there is the expectation that ICBs will establish place-based arrangements. There is no definition given for what place should be as this is down to local determination. For small ICSs, place could have the same geographic footprint as the ICS. However, it is important that places reflect meaningful communities and enable joined-up decision-making across the NHS, local authority and other partners. The ICB remains accountable for resources deployed at a place level. Several possible governance structures for place-based partnerships are set out within the *ICS design framework*.

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts working across multiple places to realise the benefits of mutual aid and working at scale. Since July 2022 trusts providing acute or mental health services needed to be part of at least one provider collaborative. 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.

Providers of NHS services play a key role in identifying the priorities for change and delivering the solutions for better outcomes for the population. It is expected that the contracts held by the providers of healthcare services will evolve to support longer-term, outcomes-based agreements, with less transactional monitoring.

Collaborative culture

As set out in the Act, all NHS bodies (NHS England, ICBs, NHS trusts and NHS foundation trusts) have a new statutory duty to 'have regard to wider effect of decisions'. When making decisions about the exercise of the body's functions, regard must be taken 'to all likely effects of the decision in relation to':

- the health and well-being of the people of England
- the quality of healthcare services provided to individuals in England
- efficient and sustainable use of resources.

As recognised in the white paper, legislation is just one part of the change and much relies on having trust, the right workforce, good leadership and getting the incentives and financial flows right. It is not possible to legislate for collaboration and co-ordination of local services. This requires changes to behaviours, attitudes and relationships. The financial framework and governance arrangements can support this, but it will take time and effort to embed the current cultural changes taking place.

One of the fundamental principles of an ICS is to use the power of partnership working to coalesce around the citizen to deliver health and social care. To improve population health, address inequalities, improve allocative efficiency, and help to support broader social and economic development, there will need to be real clarity on the relative and combined role of all partners on these agendas.

5.3 How ICSs are financed and regulated

Since 2021/22, allocations have been made at a system (or ICS) level. This was originally via a lead CCG, and combined both recurrent funding, and funds for non-recurrent areas such as Covid-19, elective activity recovery or financial recovery. This principle of system wide allocations helps ensure that funding is distributed to meet agreed priorities. Capital monies are also held at system level.

The ICS partner organisations worked together on planning (activity, workforce, financial) to identify how, as a system the national (and local) NHS priorities would be met.

With the passing of the 2022 Act, ICBs have a statutory duty to contain expenditure within the limits directed by NHS England, with a requirement to deliver system financial balance.

NHS England may make directions about ICBs' management or use of financial or other resources. NHS England may also set joint financial objectives for ICBs, and their partner NHS trusts and NHS foundation trusts. ICBs and partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that limits specified by a direction by NHS England are not exceeded.

ICBs, as statutory organisations, are held to account by the regional teams of NHS England for ensuring the discharge of their functions. System oversight[71][72] arrangements have been put in place for 2022/23 (see chapter 12 for further details).

Each ICB is required to prepare an annual report that will include disclosures specified in the Act, and annual accounts as directed by NHS England. These accounts will be audited by local auditors in accordance with the Local Audit and Accountability Act 2014.

There is more detail about allocations in chapter 6 and chapter 10 includes more information about how the NHS is financed.

[71] NHS England, *NHS oversight framework 2022/23*, June 2022
[72] NHS England. N*HS Oversight Framework,* July 2022

Key learning points

- The aim of ICSs is to 'improve the health of all residents, better support people living with multiple and long-term conditions, preventing illness, tackling variation in care and delivering seamless services while getting maximum impact for every pound'.
- The *Health and Care Act 2022* created integrated care boards (ICBs) and integrated care partnerships (ICPs), putting ICSs on a statutory footing.
- The ICB's function is to arrange for the 'provision of services for the purpose of the health service in England'. This means commissioning health services, including primary care services, for the area that the ICB covers.
- Property, rights and liabilities transferred from CCGs to ICBs on 1 July 2022.
- Provider collaboratives are partnership arrangements involving two or more trusts working across multiple places.
- ICBs must contain expenditure within the limits directed by NHS England.
- All NHS bodies (NHS England, ICBs, NHS trusts and NHS foundation trusts) have a new statutory duty to 'have regard to wider effect of decisions'.
- One of the fundamental principles of an ICS is to use the power of partnership working to coalesce around the citizen to deliver health and social care.

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, including a section dedicated to system working. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 6: NHS finance – the role of integrated care boards

Chapter 6. NHS finance – the role of integrated care boards

Overview

This chapter looks at what integrated care boards (ICBs) are, how they are structured and what they do with a focus on accountability, governance, and finance. To remind yourself of where ICBs sit in the NHS structure, look back at the diagram on page 21.

The *Health and Care Act 2022*[73] established statutory integrated care boards (ICBs) that took on the functions of clinical commissioning groups (CCGs) from 1 July 2022.

6.1 What are ICBs?

Constitution

Covering the whole of England, ICBs are statutory bodies created by the *Health and Care Act 2022*. They took on their statutory roles from 1 July 2022.

There are 42 ICBs. covering areas that are largely in line with either upper tier (county council), or unitary local authority boundaries.

Structure

Each ICB has a unitary board, responsible for ensuring that the organisation plays its role in achieving the four aims of integrated care systems – to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience, and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development.

As a minimum, the unitary board must have the following members:

- an independent non-executive chair who does not hold a role in another health and care organisation within the ICB area, and who is appointed by NHS England
- a minimum of two other independent non-executive members
- chief executive
- chief finance officer
- director of nursing
- medical director
- a minimum of three partner members to include one from NHS trusts and foundation trusts that provide services within the ICB area; one from general practice within the ICB area; and one from the local authority that holds statutory social care responsibility for the ICB area. Partner members are full members of the unitary board, bringing knowledge and a perspective from their sector. They are not acting as representatives for their sector.

The ICB must act in a way that is consistent with its statutory functions, both powers and duties, that include:

- having regard to and acting in a way that promotes the *NHS constitution*

[73] UK Parliament, *Health and Care Act 2022*, April 2022

- exercising its functions effectively, efficiently, and economically
- securing continuous improvement in the quality of healthcare services and outcomes
- duties in relation to children, including safeguarding
- duties in relation to adult safeguarding and carers
- duties in relation to equality, including the public sector equality duty
- compliance with information law
- meeting the provisions of the *Civil Contingencies Act 2004*[74].

Accountabilities

ICBs are accountable to NHS England for improving outcomes for patients and for getting the best possible value for money from the funding they receive, and to the public and patients. The formal accountability link is from the ICB's accountable officer (chief executive) to NHS England's accountable officer but from the public/ patient viewpoint the key document is the ICB's written constitution.

An ICB's constitution sets out how it will meet its responsibilities and describes its governing principles, rules, and procedures. This document is a statutory requirement and must be available to the public. As well as being a public document, the constitution must be adhered to by:

- the ICB's employees
- individuals working on behalf of the ICB
- anyone who is a member of the ICB's unitary board, or any committees/ sub-committees established by the unitary board.

An ICB's constitution must meet the requirements set out in the 2022 Act. ICBs must also adhere to the *Commissioning outcomes indicator set*[75] developed by the National Institute for Health and Care Excellence (NICE). This provides clear, comparative information about the quality of health services and associated health outcomes. NHS England will look at performance against the outcomes indicators and assess how well ICBs are meeting their financial duties.

NHS England uses the *NHS oversight framework*[76] to assess an ICB's overall performance. This annual assessment is required by law. The assessment covers a range of areas including how the ICB has contributed to the wider local strategic priorities of the integrated care system (ICS), how successfully it has performed its statutory functions, and how it has delivered against any other relevant guidance issued around the functions of an ICB. As ICBs are new statutory bodies, the approach will need to evolve and take into account the findings and recommendations of the independent review by the Rt Hon Patricia Hewitt[77]. While the review will focus on ICSs, it will also cover the NHS targets and priorities for which ICBs are accountable.

If an ICB is unable to fulfil its duties effectively or there is a significant risk of failure, NHS England has powers to intervene. In the most severe cases this will involve mandated intensive support through the recovery support programme. More information about regulation and oversight can be found in chapter 12.

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[74] NHS, *Integrated care board: model constitution template,* March 2022 [FutureNHS login required]
[75] NHS Digital, *CCG outcomes indicator set,* October 2020
[76] NHS, *NHS oversight framework,* June 2022
[77] Department of Health and Social Care, *Hewitt review: terms of reference*, December 2022

Decision-making within an ICB

ICBs have a scheme of reservation and delegation (SoRD) that sets out how and where decisions are taken. It specifies which functions are reserved to the board; which functions have been delegated to an individual or committee; and which functions have been delegated to another body or will be made jointly. ICBs are also expected to develop a functions and decisions map that is easily understood by the public.

Beyond 2022/23, it is anticipated that some statutory functions may be delegated to place based partnerships.

6.2 What ICBs do – roles and responsibilities

Functions of an ICB

ICBs bring partners together from across the local system, to work in a collaborative way. ICBs have several functions[78]:

- developing a plan to meet the health and healthcare needs of the population
- allocating resources to deliver the plan across the system
- establishing joint working arrangements with partners to embed collaboration
- establishing governance arrangements to support collective accountability between partner organisations
- arranging for the provision of health services in line with allocated resources
- leading system implementation of people priorities
- leading system wide action on data and digital
- using joined up data and digital capabilities to understand local priorities and track progress
- ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability
- driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money
- planning for, responding to, and leading recovery from incidents.

Commissioning

ICBs are responsible for commissioning most of the hospital and community NHS services for their local area (see section 4.2 for services commissioned by NHS England, and Chapter 16 - Commissioning, for more details), negotiating contracts with healthcare providers and monitoring their implementation.

Services commissioned directly by ICBs are:

- planned hospital care
- rehabilitative care
- maternity services

[78] NHS England and NHS Improvement, *FutureNHS Collaboration Platform – ICS guidance workspace* (login to the FutureNHS site is required)

- urgent and emergency services, including ambulance and out-of-hours services (ICBs must also commission these services for anyone in their area although for some patients the costs will subsequently be charged to the ICB that covers the GP practice with which they are registered)
- community health services
- mental health services
- learning disabilities services
- abortion services
- infertility services
- continuing healthcare.

Personalised care

ICBs also have a role in the implementation, promotion, and expansion of personalised care, which may include a personal health budget (PHB). A PHB is an amount of money used to support a person's health and wellbeing needs, planned and agreed between the person and their local NHS team. PHBs allow individual patients to decide how to use the money that they are entitled to, to deliver the care they need. By enabling individuals to undertake the commissioning role themselves, they have more choice and control in how their long-term healthcare needs and outcomes are met. Several groups of people have a legal right to a PHB[79] including patients eligible for continuing healthcare or children and young people's continuing care, and people eligible for section 117 after-care[80] through the *Mental Health Act 1983*.

Commissioning of primary care

ICBs hold delegated responsibility to commission services provided by GPs. From 1 July 2022, nine ICBs have delegated responsibility for one or more pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community). It is expected that all ICBs will take on this responsibility from 1 April 2023[81].

Delegated commissioning

Delegated commissioning allows ICBs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning and will require assurance that its statutory functions are being discharged effectively.

An ICB has a delegation agreement with NHS England that sets out the matters for which the ICB has decision-making responsibility.

It is important to note that NHS England retains its statutory responsibilities in relation to commissioning primary care even though an ICB is operating under full delegated responsibility.

ICBs are responsible for managing GP prescribing – they meet the costs of prescriptions written by their member practices but not the associated dispensing fees.

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[79] NHS England and NHS Improvement, *Guidance on the legal rights to have personal health budgets and personal wheelchair budgets,* December 2019
[80] UK Government, *Mental Health Act 1983,* 1983 (updated March 2022)
[81] NHS, *Delegation of NHS England's direct commissioning functions to integrated care boards*, May 2022

Specialised commissioning

At present, ICBs are not responsible for commissioning national or regional specialised services – these are commissioned by NHS England (see chapter 4). However, from April 2023, the commissioning of several specialised services will be delegated to ICBs where it has been deemed appropriate to do so.

ICB statutory duties

ICBs must also fulfil several other statutory duties that are grouped under six headings in the DHSC's guide *The functions of clinical commissioning groups*[82]: These functions have transferred to ICBs with further guidance anticipated to explicitly set these out for the new bodies[83].

General – including: the commissioning of NHS services for the local area; to co-operate with other NHS bodies; to have regard to the *NHS constitution* and guidance on commissioning issued by NHS England; to promote innovation in health service provision; to promote the involvement of patients.

Planning, agreeing, monitoring services – including: to contribute to the joint strategic needs assessment (JSNA) and joint local health and wellbeing strategy (JLHWS) and to have regard to them; to prepare and publish a commissioning plan before the start of each financial year that sets out how the ICB will secure improvements in services and outcomes, reduce inequalities, involve patients and fulfil its financial duties; to comply with regulations relating to best practice in procurement/ patient choice and anti-competitive conduct.

NHS England issues financial planning guidance each year that establishes the 'business rules' for the financial position. Although not a statutory duty, adherence to these rules informs the ICB's 'risk rating'.

Finance – including to ensure the annual budget, revenue and capital limits and running cost allowance are not exceeded; to provide financial information to NHS England to keep proper accounts and records; to use the prescribed banking service.

Governance – including to have a governing body and accountable officer; to have a published constitution; to publish an annual report; to maintain one or more publicly accessible registers of interest; to make arrangements for managing conflicts of interest.

Co-operation – including co-operation with local authorities for the wellbeing of children; support planning for carers; and support to local authorities and other relevant bodies where appropriate - for example, care assessments, working with justice services, and for some areas under mental Health Acts.

General duties applying to NHS or public bodies – including effectiveness, safeguarding, employment, Human Rights, equality, data protection and health and safety.

In relation to finance and governance notable powers include the ability to:

- enter partnership arrangements with local authorities - for example, pooled budgets and lead commissioning
- enter contracts to provide services
- act jointly with other ICBs, including pooling commissioning funds for lead/ joint commissioning

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[82] Department of Health and Social Care, *The functions of clinical commissioning groups,* June 2012
[83] NHS, *Interim guidance on the functions and governance of the integrated care board: statutory CCG functions to be conferred on ICBs,* June 2022 [FutureNHS login required]

- make direct payments to patients (subject to regulations)[84]
- enter externally financed development arrangements
- pay governing body members remuneration and travelling or other allowances.

Commissioning support units (CSUs)

Initially the 2012 Act gave all CCGs the option to obtain business support services – notably payroll, HR, finance, IT and communications services, from commissioning support units (CSUs) hosted by NHS England. Service level agreements (SLAs) set out what each party to the agreement expected and/or required. Initial SLAs were in place until October 2014. NHS England subsequently ran a national procurement process to make commissioning support services available to CCGs and other commissioners of health and social care. This resulted in the lead provider framework (LPF).

In 2018, the LPF was replaced by the health systems support framework (HSSF)[85] to support the development of population health management and integrated systems. This framework is available for use by any public sector body engaged in the management or support of the health, care, or wellbeing of the population across the United Kingdom. ICBs can still purchase services from CSUs through this framework, but the emphasis is on services to support integrated care and digital transformation, with providers listed from across the public and private sector.

6.3 How ICBs are financed

ICBs receive funding for commissioning NHS services from NHS England. The main allocation is based on a formula that supports the aim of improving health outcomes and reducing inequalities. It takes account of the number of people registered with each GP as well as the sparsity of the local population. From 2019/20, the allocation formula recognises[86] the improved data for community services which shows that a different distribution is needed for some services, and this has rolled forward to ICBs. In addition, improvements have been made for mental health, learning disabilities and health inequalities. Work has also been undertaken to review allocation levels against targets, recognising that some local systems have been over or underfunded through previous allocations. An adjustment is made to move ICBs towards their target allocation (known as convergence), in a sustainable way, usually over several years.

Part of an ICB's allocation must be put into a pooled budget with the relevant local authority designated as the better care fund (BCF)[87]. With ICBs required to work collaboratively with local authorities 'to make the most efficient and effective use of health and social care funding', the size and scale of pooled funds is set to increase over the coming years.

Within the ICB allocation is an identified amount for primary medical care. ICBs are required to support primary care networks with this allocation.

ICB running costs

ICBs also receive a separate allowance for their day-to-day management and administration costs, known as the running cost allowance, and it is based on the population served by each ICB's constituent practices adjusted to take account of the risk of inaccurate lists and unregistered people.

This allowance must cover all ICB management costs including the costs of commissioning support services. ICBs are free to decide how best to use this allowance to carry out commissioning support activities and may choose to undertake some, or all, of these roles themselves. They also have the flexibility to use the money to buy in the services needed - for example, data analysis and contract

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[84] See personalised care above
[85] NHS, *Health systems support framework*, 2021
[86] NHS, *Note on Clinical Commissioning Group (CCG) Allocations 2019/20-2023/24,* January 2019
[87] NHS England, *Better Care Fund,* Accessed August 2022

monitoring from external sources. As well as covering the costs directly associated with commissioning, the allowance covers the costs of the chief executive, chief finance officer, internal and external audit, and counter fraud services. CCGs were required to reduce their running costs by 20% by 2020/21 as part of a wider reduction in administrative costs by NHS England. CCGs could decide how to deliver this efficiency locally and allocations were reduced accordingly. This reduction has transferred to the relevant ICB.

Key learning points

- ICBs are statutory bodies created by the *Health and Care Act 2022* and cover the whole of England.
- ICBs are responsible for agreeing the care that patients registered with their constituent practices need, negotiating contracts with healthcare providers and monitoring their implementation. They commission most NHS services for their patients.
- ICBs are accountable to NHS England for improving outcomes to patients and for getting the best possible value for money from the funding they receive, and to the public and patients.
- ICBs receive funding for commissioning NHS services from NHS England. The main allocation is based on a formula that supports the aim of improving health outcomes and reducing inequalities. It takes account of the number of people registered with each GP as well as the sparsity of the local population.

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, including a section dedicated to commissioning that includes considerations for CCGs during the transition to ICBs. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 7: NHS finance – the role of primary care

Chapter 7. NHS finance – the role of primary care

Overview

This chapter looks at the main primary care services in the NHS with a focus on what they do and how they are financed. In terms of their position in the NHS structure, primary care services fall within the 'providers' box in the diagram on page 21.

7.1 What is primary care and who provides it?

Primary care is where people normally go when they first develop a health problem. Often this will be a GP but there are many other health professionals in this front-line team including nurses, health visitors, dentists, opticians and pharmacists.

In this chapter we are going to focus on providers of primary care services and look at prescribing (a significant cost to the NHS).

It is worth noting at the outset that, although they are an essential part of the NHS, most GPs, dentists, opticians and pharmacists are independent contractors or businesses. They are not usually NHS employees, although there are new delivery models developing in some parts of England, where NHS bodies are taking on the provision of primary care services - for example, The Royal Wolverhampton NHS Trust directly provides primary care services across eight GP practices[88].

7.2 Accountability

Primary care service providers are accountable to:

- the patients to whom they provide services
- NHS England and/ or the integrated care board (ICB) that agrees signed contracts with them for the services provided and outcomes achieved
- their own professional bodies
- the Care Quality Commission (CQC) for meeting fundamental standards of quality care i.e., the standards below which care must never fall.

7.3 What primary care providers do

Primary care providers play a central role in the community. All of us will have some contact with NHS primary care during our lives. General practitioners (GPs) or 'family doctors', pharmacists, dentists and opticians all provide health services to the public. They also act as a gateway to other services - for example, most referrals to secondary care in hospitals will come from a primary care practitioner, usually a GP.

Each primary care service is discussed in turn below.

7.4 General practice

General practice is funded to deliver care on a list-based system. This means that the funding received covers the primary care needs of their registered population across the spectrum of

[88] The Royal Wolverhampton NHS Trust, *The Royal Wolverhampton Trust Primary Care Network*, 2022

healthcare needs; from healthy individuals to people with multiple complex conditions. General practice services are split into three categories: essential, additional, and enhanced:

- essential services must be delivered and are covered by baseline funding. Essential services cover the care of a patient during an episode of illness, the general management of chronic disease and care of the terminally ill
- additional services are also covered by baseline funding, but practices can choose to opt out of one or more of these. If a practice chooses not to deliver an additional service, their baseline funding is reduced accordingly. Additional services cover areas such as contraceptive services, minor surgery or out of hours services
- enhanced services attract a payment on top of the baseline funding. Directed enhanced services (DES) cover areas such as childhood immunisations and health checks for people with learning disabilities and must be specifically commissioned by NHS England or an ICB. Local enhanced services (LES) are optional and are commissioned by individual ICBs depending upon local requirements.

General practice can hold a variety of contracts[89] and receive several different income streams.

General medical services (GMS)

The GMS contract is a national contract with a nationally specified payment rate per patient (referred to as global sum income; this is the baseline income for the GMS contract). The contract is held in perpetuity by the practice and is not with individual GPs. Payments for contracted services are made to the practice.

Personal medical services (PMS)

The PMS agreement is locally negotiated in place of a GMS arrangement and uses locally agreed prices. PMS contracts are held in perpetuity but are with the individuals in the practice and not the partnership. Commissioners can give six months' notice on the contract if necessary.

Alternative provider medical services (APMS)

An APMS contract allows services to be delivered by alternative providers, with locally agreed contracts and prices. This differs from GMS and PMS contracts as it is time limited.

Directed enhanced services (DES)

All contractor groups (GMS, PMS or APMS) are entitled to sign up to deliver directed enhanced services. These are nationally defined services that can include areas such as minor surgery; health checks for people with learning disabilities; and dealing with violent patients.

The primary care network (PCN) contract[90] is also a DES, enabling PCNs to be included within the main GP contract. PCNs are covered in more detail later in this chapter (section 7.6).

Local enhanced services (LES)/ local quality improvement schemes/ local commissioning schemes

ICBs may commission local schemes from general practice to meet the requirements of their population - for example, alcohol and substance misuse, cardiovascular checks, flu immunisation, minor injuries, smoking cessation programmes and student health.

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[89] NHS England, *GP contract*, 2022

[90] NHS England, *Network contract directed enhanced service*, 2022

Quality and outcomes framework (QOF)

The QOF framework rewards individual practices based upon the quality of care delivered to patients. The framework sets out a range of standards across three domains: clinical, public health and quality improvement. Points are awarded for achievement against indicators in each standard and practices receive a payment per point, based upon their number of registered patients. Many indicators previously included in QOF are now part of the investment and impact fund (IIF) to be delivered by primary care networks (PCNs; see section 7.6 below).

Participation in QOF is voluntary and some areas use local quality improvement schemes instead.

Statement of financial entitlements

All general practice contractors are governed by the statement of financial entitlements (SFE) that details the payment framework and methods. The current full statement of financial entitlements was published in 2013 and has been subsequently amended each year. It sets out the payments due for each element of the contract (global sum, quality and outcomes framework, directed enhanced services including those relating to primary care networks, and additional specific payments) and the conditions attached to them.

The global sum (baseline) payment per patient is revised quarterly and paid monthly. Total practice income is calculated by multiplying the global sum payment by the weighted list size. The weighting is obtained using the Carr-Hill formula that takes account of six indices:

- additional needs; mortality rates and long-term conditions
- number of nursing and residential homes
- list turnover
- rurality
- age and sex profile of the population
- market forces - for example, differing staff costs.

The total payment is then reduced by a nationally agreed percentage for any additional services that the practice has opted out of providing.

Reimbursements

The statement of financial entitlements[91] also sets out several areas where general practice may receive cost reimbursements.

Premises

GP premises payments under both GMS, PMS and APMS contracts, are covered by the GP premises directions. The NHS will reimburse practices for costs relating to rent, rates, clinical waste and, in some cases, assistance towards service charges. Practices that own their premises receive a notional rent payment.

Dispensing doctors

Patients who live in some rural areas can receive dispensing services from their GP practice (under specific conditions). GP practices that provide dispensing services for patients receive a fee for each item dispensed and can sign up to deliver the dispensary services quality scheme that attracts additional funding. Fees are in line with a nationally agreed scale.

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[91] Department of Health and Social Care, *NHS primary medical services directions,* 2022

Locum cover

Practices may receive a contribution towards locum costs to cover parental leave, suspension of a GP or sickness of a GP.

Care Quality Commission fees

All GP practices (GMS/ PMS/ APMS) are entitled to full reimbursement of Care Quality Commission (CQC) fees.

Out of hours services

Out of hours services are classified as an additional service, so GP practices can opt out of delivering them, with their baseline funding reduced accordingly. Given the pressures on a practice that providing this service can create - for example, at a small practice with few GPs, many practices have chosen not to provide an out of hours service.

ICBs are responsible for commissioning most out of hours services and ensuring there is access for their local population. This can be through the GP practice, or from an out of hours service provider. Some specialist out of hours services will be commissioned through NHS England.

The general practice forward view and the NHS long term plan

Published in 2016, the *General practice forward view*[92] (GPFV) sought to address the pressures general practice faced, particularly around workforce and increasing workload.

Subsequently, the *NHS operational planning and contracting guidance for 2017/19*[93] set out increased investment across several areas through a sustainability and transformation package totalling over £500 million. Funding was allocated to improve access to primary care and clinical commissioning groups (CCGs) were invited to bid for support from an estates and technology transformation fund.

In addition, increases in funding for additional roles and GP trainees came with a requirement to redesign care to ensure that services were sustainable and able to take advantage of changing technology.

The development of general practice through PCNs is set out in the *NHS long term plan*[94]. Several funding streams set out in the GPFV are included in the funding for PCNs.

Digital first primary care

Digital first primary care[95] is a programme that plans to move towards a new approach for GP practices, where patients can easily access the advice, support and treatment they need using digital and online tools, thus freeing up professional time for more complex patients. The NHS long term plan commits that every patient will have the right to be offered digital-first primary care by 2023/24.

The GP contract set out several requirements to move towards this right, giving all patients the right to online consultations by April 2020 and video consultations by April 2021. Building on GPFV funding, £15 million per year has been provided for three years, from 2020/21 to 2022/23, to support online consultations and the delivery of a digital first approach.

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92 NHS England, *General practice forward view,* April 2016
93 NHS England, *NHS operational planning and contracting guidance for 2017-19,* December 2017
94 NHS England, *NHS long term plan*, January 2019
95 NHS England, *Digital first primary care,* 2020

7.5 Primary care in integrated care systems

The *Health and Care Act 2022*[96] established integrated care systems (ICSs). Within an ICS, the integrated care board (ICB) is the NHS statutory body. The ICB holds responsibility for commissioning health services, including primary care services for the local population, apart from those directly commissioned by NHS England. The ICB has a board that includes a member nominated by those who provide primary medical services in the ICB's area, ensuring that the voice of primary care is included in decisions made to develop system level strategy and in resource allocation.

An ICS, as a partnership of health and care organisations, operates at three levels: system (population 1 million – 3 million people); place (population 250,000 – 500,000); neighbourhood (population 30,000 – 50,000). Primary care has a role to play at each level but is integral to the success of care delivered at a neighbourhood level. Care at a neighbourhood level is based on understanding the needs of the local population and delivering care as close to people's homes as possible. PCNs are central to this, expanding what is offered in GP practices and building multi-disciplinary teams that span organisational boundaries.

7.6 What is a primary care network?

The *NHS long term plan* introduced primary care networks (PCNs) to expand integrated community-based healthcare, building on previous voluntary working arrangements that were operating in some parts of England. All GP practices are expected to be part of a PCN, although participation is voluntary. A PCN is a group of general practices working together with a range of local providers – including across primary care, community services, social care and the voluntary sector, offering more personalised, coordinated care to their local populations.

PCNs are expected to work jointly with other organisations to deliver neighbourhood care, setting out these working arrangements in their network agreement.

Additional roles

Each PCN must have a named clinical director who must be a practicing clinician within that PCN.

To expand the primary care workforce, PCNs can recruit to other roles to meet the needs of their local populations. It is up to each PCN to decide the distribution of roles required. These roles are:

- social prescribing link worker (funded from 2019/20)
- clinical pharmacist (funded from 2019/20)
- physician associates (funded from 2020/21)
- first contact physiotherapists (funded from 2020/21)
- pharmacy technicians (funded from 2020/21)
- health and wellbeing coaches/ care co-ordinators (funded from 2020/21)
- occupational therapists/ dietitians / podiatrists (funded from 2020/21)
- first contact community paramedics (funded from 2021/22)
- mental health practitioners (funded from 2021/22)
- GP assistants (funded from winter 2022/23)
- digital and transformation lead (funded from winter 2022/23).

[96] UK Parliament, *Health and Care Act 2022*, April 2022

The *Update to the GP contract agreement 2020/21 – 2023/24*[97] and a subsequent letter to GP practices[98] set out the agenda for change band and maximum reimbursement amount available for each role.

Funding PCNs

Several different income streams fund the development and operation of PCNs. Each PCN has a nominated practice that receives the payments on behalf of the network.

PCNs receive an amount of core funding from ICB allocations per registered patient per year. Further funding is received from the ICB to fund the clinical director role (from the primary medical care allocations). In addition, each practice that participates in a PCN receives a participation payment from NHS England. This is paid directly to the practice.

As noted above, the PCN model allows each network to recruit several additional roles. PCNs can claim 100% reimbursement of the salary costs for these roles, through the additional roles reimbursement scheme (ARRS). The funding comes from the ICB's primary medical care allocation and is subject to a maximum amount per role. The arrangement is currently through to 2023/24, in line with the current period covered by NHS allocations.

Extended hours and extended access

Extended hours have become a PCN responsibility, and the funding associated with the extended hours directed enhanced service incorporated into the network contract DES.

The *General practice forward view* set out the intention to improve access to primary care, with 100% of the population able to access appointments outside of core hours. This extended access attracts a payment per patient, that transferred to PCNs from April 2021.

A nationally consistent offer combining extended hours and extended access requirements will be developed but, in the meantime, PCNs and ICBs are expected to work together to define local arrangements.

Investment and impact fund

The investment and impact fund (IIF) has been available to PCNs from 2020/21 and is available through the network contract directed enhanced services (DES). The fund operates in a similar way to QOF, rewarding achievement of PCN objectives through a points-based system. It is divided into three domains: prevention and tackling health inequalities; providing high quality care; a sustainable NHS. Indicators within the IIF may overlap with those set out in the QOF.

7.7 ICB commissioning of primary care

CCGs were able to take on greater responsibility for general practice commissioning in their areas from 2014/15[99]. This change was introduced to support the development of integrated out-of-hospital services, based around the needs of local people but only applied to general practice; dental, ophthalmic and pharmacy services remained the responsibility of NHS England. From July 2022, all ICBs have taken on delegated responsibility for commissioning primary care services from GPs. In addition, nine ICBs have also taken on delegated responsibility for one or more pharmaceutical

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97 NHS England and BMA, *Update to the GP contract agreement 2020/21 – 2023/24,* February 2020
98 NHS England, *Supporting general practice, primary care networks and their teams through winter and beyond*, September 2022
99 NHS England, *About primary care co-commissioning*, 2020

services, general ophthalmic services and dental services (primary, secondary and community). It is expected that all ICBs will take on this responsibility from 1 April 2023.

Delegated commissioning

Delegated commissioning allows ICBs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning and will require assurance that its statutory functions are being discharged effectively.

An ICB has a delegation agreement with NHS England that sets out the matters for which the ICB has decision-making responsibility.

7.8 Nationally commissioned primary care services

NHS England is currently responsible for commissioning dental, ophthalmic and community pharmacy services in most areas; ICBs do not commission the mandatory parts of these services. However, ICBs can be involved in discussions about the provision that is needed for their population. In addition, ICBs can commission some local enhanced services to meet the needs of their population.

7.9 Dental services

NHS England is responsible for commissioning all NHS dental services[100], including secondary dental care provided by hospitals. Dental contracts are negotiated locally, using national guidelines. Payments are governed by a statement of financial entitlements that covers reimbursement for services provided and employment related charges. The dental contracts pay dentists for a set number of units of dental activity (UDAs) or units of orthodontic activity (UOA), plus any additional services agreed with the commissioner.

Dentists can provide private dental services from their premises, but it must be clear to the patients whether their care is being provided under the NHS or privately.

There are three contract types for NHS dentistry used within primary care dentistry:

General dental services (GDS)

The GDS contractor provides mandatory services – the typical range of services that must be provided by all dentists, they may also provide advanced mandatory services such as orthodontics, domiciliary services and conscious sedation. GDS contracts are usually held in perpetuity.

Personal dental services (PDS)

PDS agreements are time limited with a defined and fixed expiry date. The typical range of services that must be provided within these contracts are advanced mandatory services inclusive of domiciliary services, orthodontic services and sedation services.

Personal dental services plus (PDS+)

Activity under these contracts is counted in units of dental activity alongside specific key performance indicators in respect of access and performance.

[100] NHS England, Dental commissioning, 2022

Patient charges

There are three standard charges for NHS dental treatment in England and Wales, that most people pay. There are exemptions from fees for patients who meet certain criteria - for example, for children aged under 18 or people in receipt of certain benefits.

7.10 Pharmacy services

There are three levels of pharmacy service. NHS England is responsible for commissioning the essential and advanced services[101]. Enhanced services can be commissioned by a range of different commissioners including ICBs and local authorities.

Essential services and clinical governance

All pharmacies must provide essential services. These include dispensing, disposing of unwanted medicines, supporting self-care and promoting healthy lifestyles.

Advanced services

There are six advanced services within the NHS community pharmacy contractual framework (CPCF). Community pharmacies can choose to provide any of these services if they meet the requirements set out in the Secretary of State's directions. Accredited pharmacists and pharmacies can provide additional services such as appliance use reviews and flu vaccination.

Enhanced (or locally commissioned) services

Enhanced services are locally commissioned and may include services such as stop smoking schemes or emergency contraception.

NHS Prescription Services (part of the NHS Business Services Authority) receives details of all prescriptions dispensed in England. They calculate the amount payable, allowing for the drug and container cost, as well as a service fee. The cost of drugs dispensed is charged to the ICB prescribing budget based upon the GP practice that issued the prescription. Prescriptions from dentists are charged to NHS England.

If a pharmacy signs up to use an electronic prescription service (EPS) to receive prescriptions directly from the prescriber, an additional monthly payment is made, recognising the improvements in efficiency and safety that this brings.

7.11 Ophthalmic services

NHS England is responsible for commissioning all mandatory and additional ophthalmic services[102]. Enhanced services can be commissioned by either NHS England or by an ICB:

- mandatory (or essential) ophthalmic services must be provided - for example, the provision of NHS sight tests
- additional services must be commissioned but not all contractors are obliged to provide them - for example, provision of sight tests in a nursing home
- enhanced services can be commissioned to meet local needs.

[101] NHS, *Community Pharmacy Contractual Framework 2019-2024,* July 2019
[102] NHS England, Optometry commissioning, 2020, 2022

Payments for NHS sight tests for patients who meet set criteria - for example, children under 16 and adults over 60, are made in accordance with the Department of Health and Social Care's general ophthalmic services (GOS) regulations. All other patients pay privately.

7.12 Prescribing

The rising cost of primary care prescribing (over £8bn each year) is a significant cost pressure with drug inflation regularly outstripping inflation on other budgets. Prescribing costs have generally risen faster than general inflation as new, more effective (and often more expensive) drugs become available. However, this has become even more pronounced in recent years partly because of guidance from the National Institute for Health and Care Excellence (NICE). One of NICE's roles is to assess the clinical and cost-effectiveness of new drugs and technologies and this has an impact on both prescription volume and cost. The effects are mitigated to an extent by securing efficiencies from improvements in prescribing practice.

From a financing viewpoint, prescribing is not covered in GPs or dentists' contracts. Instead, as mentioned earlier, the costs of drugs prescribed are calculated by NHS Prescription Services and charged to the relevant ICB (for GP prescriptions) and to NHS England (for dentists). The associated dispensing fees are met by NHS England.

Key learning points

- Primary care is where people normally go when they first develop a health problem and includes GPs, dentists, opticians and pharmacists.
- Most family doctors, dentists, opticians and pharmacists are independent contractors or businesses, not NHS employees.
- General practice is funded to deliver care on a list-based system. This means that the funding received is to cover the primary care needs of their registered population.
- All general practice contractors are governed by the statement of financial entitlements that details the payment framework and methods.
- The NHS long term plan introduced primary care networks (PCNs) to expand integrated community-based healthcare.
- NHS England is responsible for commissioning dental, ophthalmic and community pharmacy services.

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, including a section dedicated to primary care and primary care networks. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

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

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

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 21. 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[103], 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 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.

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[104].

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*[105] . 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*[106].

[103] NHS England, *Adult Improving Access to Psychological Therapies programme*, Accessed August 2022
[104] NHS, *NHS standard contract*, updated 2022
[105] UK Government, *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,* 2014
[106] UK Government, *The Care Quality Commission (Registration) Regulations 2009,* 2009

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).

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 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 at Harrogate District Hospital as well as 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 - for example, The Royal Wolverhampton NHS Trust provides primary care services across nine practices in Wolverhampton and Staffordshire.

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[107]. 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[108].

All NHS providers must have regard to the *NHS constitution*[109], 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.

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[107] 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
[108] Section 1 of the *NHS Act 2006*
[109] 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, 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 Health Education 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, 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). In 2020/21, total revenue income for NHS providers totalled £105.3bn[110].

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 £24m in 2020/21. 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, 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 several funding sources:

[110] Department of Health and Social Care, *Annual report and accounts 2020-21,* January 2022

- internally generated cash from depreciation/ amortisation and retained surpluses and proceeds from the sale of non-current assets (further details are included in chapter 15)
- financing, from the DHSC, 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. Further detail is provided in 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*[111] 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*[112].

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 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 they have 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

[111] UK Government, *National Health Service and Community Care Act 1990,* 1990
[112] 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[113] – 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 they are accountable to the DHSC's accounting officer (via NHS England'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, 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 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*[114]. 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. 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 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

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

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 experience or skills that help the board function well[115]. 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 last issued by NHS Improvement that states that 'accounting officers are responsible to Parliament for the resources under their control'[116].

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.

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.

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[115] NHS England, *Draft code of governance for NHS provider trusts*, May 2022
[116] Monitor, *NHS foundation trust accounting officer memorandum*, August 2015

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 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 ICBs. 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 Integrated care systems

Under the *Health and Care Act 2022*[118], NHS providers retain their current financial statutory duties, structure, and governance. Their relationship with the CQC remains unchanged. However, providers now must have regard to the system financial objectives.

There is 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.

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts working across multiple places to realise the benefits of mutual aid and working at scale. Since April 2022 trusts providing acute or mental health services have been expected to be part of at least one provider collaborative. 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.

Providers of NHS services play a key role in identifying the priorities for change and delivering the solutions for better outcomes for the population. It is expected that the contracts held by the providers

[117] 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.
[118] UK Parliament, *Health and Care Act 2022*, April 2022

of healthcare services will evolve to support longer-term, outcomes-based agreements, with less transactional monitoring.

Collaborative culture

Providers are 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.

As set out in the Act, all NHS bodies (NHS England, ICBs, NHS trusts and NHS foundation trusts) have a new statutory duty to 'have regard to wider effect of decisions'. When making decisions about the exercise of the body's functions, regard must be taken 'to all likely effects of the decision in relation to':

- the health and well-being of the people of England
- the quality of healthcare services provided to individuals in England
- efficient and sustainable use of resources.

Legislation is just one part of the change and much relies on having trust, the right workforce, good leadership and getting the incentives and financial flows right. It is not possible to legislate for collaboration and co-ordination of local services. This requires changes to behaviours, attitudes and relationships. The financial framework and governance arrangements can support this, but it will take time and effort to embed the current cultural changes taking place.

One of the fundamental principles of an ICS is to use the power of partnership working to coalesce around the citizen to deliver health and social care. To improve population health, address inequalities, improve allocative efficiency, and help to support broader social and economic development, there will need to be real clarity on the relative and combined role of all partners on these agendas (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 must all 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 care systems does not impact on the structure of secondary care providers but they are expected to collaborate and coordinate with bodies that deliver healthcare at a local level.

Additional HFMA resources

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HFMA introductory guide to NHS finance

Chapter 9: NHS finance – the role of local authorities, health and wellbeing boards and HealthWatch

Chapter 9. NHS finance – the role of local authorities, health and wellbeing boards and HealthWatch

Overview

This chapter looks at the role of local authorities with a focus on how they work with (and link to) the NHS. It looks at the practical implications of the duties placed on local authorities as a result of the *Health and Social Care Act 2012*[119] and at the ways in which local authorities and the NHS work together. To see where they fit into the NHS structure, refer to the diagram on page 21.

9.1 What are local authorities?

Local authorities, also known as councils, provide public services to local communities and are run by democratically elected councillors who are accountable to their electorate. Local authorities work with local partners (including charities, businesses and other public service providers like the police and the NHS) and residents to determine and deliver local priorities. They provide a wide range of services, either directly themselves or by commissioning them from other organisations. They also have responsibility for the economic, social, and environmental 'wellbeing' of their area.

Local authorities choose how to organise their operations based on their responsibilities. They are organised in different ways in different areas and can fall into one of the following categories:

- two-tier – a county council (responsible for county-wide services - for example, education, transport, planning, fire and public safety, social care, libraries, waste management and trading standards) or a district/ city/ borough council (responsible for rubbish collection, recycling, council tax collection, housing, and planning applications in their area)
- unitary – this type of authority can be a metropolitan council (responsible for an urban area), a London borough or a unitary authority (covering the whole or part of a county or a large town or city) and is responsible for all the services listed above
- town, parish, and community – these councils are the smallest and most local. They exist in certain parts of the country for historical reasons. They work to maintain local amenities such as allotments, bus shelters and play areas and may be consulted on in relation to planning applications and highway issues.

A two-tier or unitary authority can also be part of a combined authority whereby all the local authorities in an area come together in a voluntary arrangement - for example, Greater Manchester. This allows local authorities to work more closely together in relation to economic development, regeneration, and local transport.

All local authorities elect a leader who in turn appoints and chairs the cabinet/ executive. Each cabinet member has a specific area of responsibility - for example, housing or resources.

[119] UK Government, *Health and Social Care Act 2012*, 2012

9.2 How local authorities are financed

Local authorities are required by law to provide certain services - for example, maintaining graveyards, ensuring asbestos is disposed of safely, giving grants to disabled people to adapt their homes and agreeing licenses for pubs and clubs. These are known as statutory services. The main categories include the provision of social care, schools, and roads.

There are three main sources of local government funding. These are government grants, council tax revenues and business rates. Local authority finance[120] is entirely separate from the NHS and so is not discussed further here. However, some NHS money does go to local authorities for two key purposes:

- health improvement – a ring fenced grant for local public health services is allocated to local authorities. In spending this money, local authorities must have regard to the public health outcomes framework[121] and publish a director of public health's annual report on the health of the local population
- integration of health and care services – the better care fund (BCF) requires integrated care boards (ICBs) and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

If councils get into serious financial difficulty and cannot achieve a balanced budget, they may be issued with a section 114 notice under the *Local Government Finance Act 1988*[122]. This prohibits new spending while the sole focus is on maintaining statutory services - for example, safeguarding those who are vulnerable. In some contrast to health bodies in the English NHS, therefore, section 151 of the *Local Government Act 1972*[123] requires every local authority to make arrangements for the proper administration of their financial affairs and requires one officer to be nominated to take responsibility for the administration of those affairs. This essentially makes it a legal duty for a local government body to live within a balanced budget. In the English NHS although similar provisions are made for each NHS body, the equivalent of the section 151 obligation for the NHS sits with the Secretary of State.

9.3 How local authorities link to the NHS

NHS organisations have long been expected to engage with their local communities to improve health and wellbeing and reduce health inequalities. For many years, this has involved NHS organisations working in partnership with local authorities to manage and deliver services in which both parties have an interest.

Social care is the main interface between health organisations and local authorities because people often need social care services when recovering from ill health or when they suffer from a long-term condition. Although the Department of Health and Social Care (DHSC) is responsible for setting national policy for adult social care and securing its funding from HM Treasury within the spending review process (see chapter 10), local authorities deliver the services.

The *Health and Social Care Act 2012* strengthened the role of local authorities. It helped to fulfil the government's objective that, through the involvement of elected councillors, local authorities would bring greater local democratic legitimacy to the NHS and have more influence over commissioning, particularly in relation to public health and social care. The Act was also designed to make it easier to 'further integrate health with adult social care, children's services (including education) and wider services, including disability services, housing, and tackling crime and disorder'.

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120 Local Government Association, *Council funding*, 2021
121 Office for Health Improvement and Disparities, *Public health outcomes framework,* updated February 2022
122 UK Government, *Local Government Finance Act 1988*, 1988
123 UK Government, *Local Government Act 1972,* 1972

As a result, local authorities have a statutory responsibility to join up commissioning of NHS services, social care, public health, and health improvement. Since 2012 several updates to the Act have been made. Local authorities are also required to:

- jointly appoint a director of public health in conjunction with the Office for Health Improvement and Disparities
- jointly commission some services with integrated care boards (ICBs)
- lead joint strategic needs assessments (JSNAs) and joint local health and wellbeing strategies (JLHWS) to ensure coherent and co-coordinated commissioning strategies (a role carried out jointly with ICBs via health and wellbeing boards – see below)
- support local voice and the exercise of patient choice
- lead on local health improvement and prevention activity (with their partners).

In practice, this means that much of the joint working that had gone on prior to 2012 continues but local authorities have statutory responsibilities in relation to health improvement and receive a ring-fenced grant from the NHS allocation.

Building on the sustainability and transformation partnerships (STPs) that were set up in 2016, integrated care systems (ICS) bring together partners across a local population (see chapter 5). In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. 'Place' has become an important focus for health and care integration and in many cases, this aligns with local authority boundaries and existing health and wellbeing boards (HWBs).

The *Health and Care Act 2022*[124] established ICSs on a statutory footing with integrated care boards (ICBs) as the statutory NHS body. The other statutory element is the integrated care partnership (ICP). This is a joint committee of the ICB and includes those local authorities that fall wholly or in part in the area covered by the ICB. The ICP is made up of:

- one member appointed by the ICB
- one member appointed by each of the responsible local authorities
- members appointed by the ICP.

The ICP determines its own procedures including its quorum. Chapter 5 provides further details on the role of ICSs.

Emergency planning

The *Civil Contingencies Act 2004* sets out the roles and responsibilities of emergency responders in England and Wales. All principal local authorities are category one responders under the Act, alongside the emergency services and the NHS[125]. The Act sets out a duty for these bodies to co-operate, usually through a local resilience forum and undertake joint planning to prevent, or to be able to respond to, emergencies

[124] UK Parliament, *Health and Care Act 2022*, April 2022
[125] Cabinet Office, *Preparation and planning for emergencies: responsibilities of responder agencies and others,* February 2013

9.4 Local authorities' statutory roles and responsibilities in relation to the NHS

Health scrutiny

Since 2003, local authorities with social care responsibilities have been able to establish committees of councillors to provide overview and scrutiny of local NHS bodies. The *Health and Social Care Act 2012* extended this scrutiny role to cover any provider of NHS funded services. It also gave local authorities the ability to discharge their health scrutiny functions in 'the way they deem most suitable'. The aim of this scrutiny role is to secure health improvement for local communities by encouraging authorities to look beyond their own service responsibilities to issues of wider concern to local people. This is achieved by giving democratically elected representatives the right to scrutinise how local health services are provided and developed for their constituents.

Local authorities' health scrutiny powers

- Health scrutiny powers and duties of local authorities are summarised below: the right to scrutinise and review health service matters and make reports and recommendations to NHS bodies
- powers to delegate health scrutiny to other authorities, including district councils
- the ability to co-opt from other authorities and to establish joint health overview and scrutiny committees with other first-tier authorities
- authority to place duties on health bodies to consult health overview and scrutiny committees on substantial developments and variations to health services. In relation to local authority overview and scrutiny of NHS services, the 2012 Act:
    - requires officers of all NHS bodies to attend local authority scrutiny committees when requested
    - requires NHS bodies to provide health scrutiny committees with information about the planning, commissioning, provision, and operation of health services
    - requires NHS bodies to respond to reports and recommendations of health scrutiny committees
    - empowers health scrutiny committees to refer proposals for substantial developments or variations in health services to the Secretary of State.

Health and wellbeing boards

To reflect local authorities' strengthened role, the *Health and Social Care Act 2012* required every upper tier local authority to establish a health and wellbeing board (HWB) to provide a forum for public accountability and join up commissioning across the NHS, social care, public health, and other services relating to health and wellbeing. HWBs assumed their powers and duties as statutory committees of (and therefore financed by) local authorities in April 2013.

Core membership of each HWB must include members of ICBs, the director of adult social services, the director of children's services, the director of public health, local HealthWatch (see later in this chapter) and at least one democratically elected councillor. HWBs can also require the attendance of NHS England when relevant. It must be noted that there is a wide variation in HWB memberships, voting structures and remit over and above the statutory requirements.

At a practical level, HWBs should:

- make themselves aware of how quality is being monitored locally, and of the priority issues and concerns in their locality
- where necessary, ensure action is taken and reported on those priority issues
- ensure a joined-up approach and good information-sharing, between agencies
- be aware of the work of the quality surveillance group for their area – that coordinates quality assurance activity for the NHS
- identify the priorities for fuller scrutiny - for example, by HealthWatch and/ or the overview and scrutiny committee.

HWBs lead the development of the joint strategic needs assessment (JSNA) and the high-level joint local health and wellbeing strategies (JLHWS) (see below). They also have a duty to involve service users and the public and work with ICBs to ensure that forward plans (previously commissioning plans) meet local needs. This approach is designed to provide strategic co-ordination to the commissioning of NHS services, social care, and health improvement.

Joint strategic needs assessments (JSNAs)

JSNAs are designed to 'identify the current and future health and wellbeing needs of a local population'[126] and have been in place since their introduction in section 116 of the *Local Government and Public Involvement in Health Act 2007*[127]. The *Health and Social Care Act 2012* placed the responsibility for producing them jointly on local authorities and ICBs. The Act also required local authorities and ICBs to undertake the JSNA through the HWB so, in practice, it is the HWB that pulls the strategy together with local authorities and ICBs ultimately responsible for them and required to 'have regard to them' when exercising their functions.

The *Health and Care Act 2022* notes that the ICP must be given the local authorities' joint strategic needs assessment. The ICP prepares an integrated care strategy that sets out how the assessed needs of the area are to be met by the exercise of the functions of the ICB, NHS England and local authorities. This strategy must consider the extent to which those needs could be met more effectively by making pooled budget arrangements under section 75 of the *NHS Act 2006*[128]. Each new JSNA should result in the refresh of the ICP's integrated care strategy.

Joint local health and wellbeing strategies (JLHWSs)

The 2012 Act required local authorities and ICBs to produce (again via the HWB) a joint local health and wellbeing strategy that sets out plans to address the needs of the local population and reduce inequalities identified in the JSNA. NHS and local authority commissioners must then 'have regard to' the JLHWS when exercising their functions.

Health improvement

As mentioned above, the 2012 Act reintroduced a statutory duty on affected local authorities (upper tier (county councils) and unitary) to improve the health of the local population. The Act also gave the Secretary of State the power to require local authorities to carry out certain health protection functions and to prescribe how they carry out their health improvement activities.

There are also statutory arrangements for local authority leadership in this area, with local directors of public health being appointed jointly by local authorities and the DHSC. These local directors have

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[126] Department of Health and Social Care, *Statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies,* 2013
[127] UK Government, *Local Government and Public Involvement in Health Act 2007,* 2007
[128] UK Government, *National Health Service Act 2006,* 2006

a ring-fenced health improvement grant to deliver national and local priorities (the grant is allocated by the DHSC). There is direct accountability to both the local authority, and (through the Office for Health Improvement and Disparities at the DHSC) to the Secretary of State. As they are employed by the local authority, local directors of public health advise councillors and are part of the senior management team of the local authority.

At a practical level, local authorities are responsible for commissioning a range of health improvement services. A limited number of these services are mandated by government via regulations under section 6c of the *NHS Act 2006*. Other services can be commissioned on a discretionary basis guided by the public health outcomes framework, the JSNA and the JLHWS.

Mandatory services – examples

- to deliver the NHS health check
- to provide population based public health advice to NHS commissioners
- to provide comprehensive sexual health services (excluding abortion, contraceptive services and HIV treatment).

Discretionary services – examples

- lifestyle interventions – for example, to promote physical activity, improve diet and prevent obesity
- drug and alcohol misuse services
- stop smoking services
- local initiatives to reduce seasonal mortality.

As well as commissioning services themselves, local authorities can also work with ICBs and NHS England to ensure services are integrated.

As with other local services, local authorities are accountable primarily to their electorates for work on improving health.

Where NHS funding has been provided, there are additional accountability mechanisms – specifically:

- the Office for Health Improvement and Disparities (OHID) publishes data about national and local performance against the public health outcomes framework so local people will be able to see how their local authority is doing
- each local authority chief finance officer must provide a ‘statement of grant’ showing how the allocation has been spent
- each director of public health must produce (and each local authority publish) an annual report.

Although the DHSC can incentivise progress in health improvement, it does not performance manage local authorities or set targets for them.

9.5 HealthWatch England and local HealthWatch

HealthWatch England is the national body that champions people who use health and social care services and has a key focus on the design of integrated care. HealthWatch England is established

as a committee of the Care Quality Commission (CQC). The chair of HealthWatch England is appointed by the Secretary of State and has a seat on the CQC's board.

In addition to HealthWatch England, each local authority area has a local HealthWatch; these organisations are separately commissioned by local authorities but 'feed into' the national network. Local HealthWatch powers are designed to be 'more like a 'citizen's advice bureau' for health and social care'. HealthWatch provides leadership and support to enable local HealthWatch to deliver their statutory activities and be a powerful advocate for services that work for people.

Each local HealthWatch is concerned with local engagement – collecting and channelling the views of patients, users and the public to decision-makers. They have powers to scrutinise local services (including local authority, NHS, and independent sector services), and this includes visiting and observing their operations. Each local HealthWatch also has responsibilities for supporting people in communities by giving them information or signposting them to the support they need. Local HealthWatch is required by law to be represented on HWBs.

Local authorities, health services. and regulators have a duty in law to respond to issues raised by HealthWatch. Local HealthWatch should:

- keep in touch with local people's experience of services
- channel information from networks, voluntary and community groups, identifying any key themes or trends
- alert commissioners and planning and scrutiny bodies (including the health and wellbeing board and overview and scrutiny committee) to any significant concerns
- carry out bespoke research into people's experience in priority areas, having consulted about what these priorities are
- report to local providers, commissioners, and planning and scrutiny bodies on their findings.

Although ICBs are not accountable formally to their local HealthWatch, they will need to establish arrangements as to how best to interact with this service.

Local HealthWatch organisations are financed via contracts with the relevant local authorities and are accountable to them for their ability to operate effectively and provide value for money.

The *Health and Care Act 2022* notes that the Care Quality Commission (CQC) will have a new duty to review local authority adult social care functions.

9.6 Local strategic partnerships

Section 82 of the *NHS Act 2006* requires NHS bodies and local authorities to co-operate with each other 'to secure and advance the health and welfare of the people of England and Wales'. In England local strategic partnerships (LSPs) have been used to help achieve this aim. Where they are in place, LSPs operate at a strategic level and are led by local authorities. LSPs are non-statutory, non-executive, multi-agency bodies that are designed to bring together different parts of the public sector (including the NHS) as well as the private and voluntary sectors at a local level, so that initiatives and services can support each other and work together.

Section 75 flexibilities

There are several arrangements for joint working between NHS organisations and local authorities included within section 75 of the *NHS Act 2006*. These so-called 'section 75 flexibilities' include:

- pooled budgets
- aligned budgets
- lead commissioning
- integrated provision.

The 2012 Act placed a duty on ICBs and local authorities (through the HWB) to consider how to make best use of the flexibilities when drawing up the JSNA and JLHWS. To reinforce this duty, NHS England has a duty to promote the use of these flexibilities by ICBs.

The white paper *Joining up care for people, places and populations*[129] set the expectation that the use of pooled and aligned budgets will increase, to support integrated approaches to health and care.

Pooled budgets

The pooling of budgets involves partner organisations contributing funds to a single pot, to be spent on agreed projects for designated services. They exist where a local authority and an NHS body combine resources and jointly commission or manage an integrated service. The idea is that, once a pooled budget is introduced the public will experience a seamless service with a single point of access for their health and social care needs. There are some areas that are particularly well suited to pooled budgets - for example, services for people with a learning disability.

Where a pooled budget exists, regulations for England and Wales require that the partners have written agreements setting out:

- the functions covered
- the aims agreed
- the funds that each partner will contribute
- which partner will act as the 'host' (i.e., which organisation will manage the budget and take responsibility for the accounts of the pooled funds and auditing).

The pooling of funds does not override an individual organisation's statutory responsibilities or lines of accountability. It is each body's responsibility to determine the appropriate governance and accounting treatment for their pooled budget, based on their individual circumstances.

The accounting transactions of the 'pool' will therefore need to be reflected in the accounts of the partner bodies as appropriate. How this is reported, will be dependent on the levels of control that can be exercised by the partners (as laid out in the agreement documentation). For instance, at a very simple level, if there were three equal partners, each would reflect their one-third share of the 'pool'.

Since 2010/11 the standard national NHS contract for mental health services has allowed for the incorporation of pooled budget services.

Better care fund (BCF)

Launched through the spending round in June 2013 and highlighted as a key element of public service reform, the BCF[130] seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. BCF plans are jointly developed with local government partners and approved by HWBs. The BCF is intended to:

- deliver better services to older and disabled people who have multiple and complex needs

[129] Department of Health and Social Care, *Joining up care for people, places and populations*, February 2022
[130] NHS England, *Better Care Fund*, Accessed August 2022

- keep people out of hospital
- avoid people staying in hospital for long periods.

Aligned budgets

Aligned budgets can be either an informal or formal (using section 75 flexibilities) arrangement whereby partners align resources to meet agreed aims but have separate accountability for the respective funding streams. The management arrangements can be separate, joint, or led by one partner but with joint performance monitoring arrangements against the objectives. An aligned budget can also be used as an interim stage towards implementing a pooled budget.

Lead commissioning

Under a lead commissioning arrangement, partners agree to delegate commissioning of a service to one lead organisation. As with pooled budgets, lead commissioning was made possible by section 31 of the 1999 Act (now section 75 of the *NHS Act 2006*).

Integrated provision

Integrated provision involves partners joining together their staff, resources, and management structures so that the service is fully combined (or integrated) from managerial level to the front line. One partner acts as the host for the service to be provided. Again, this way of working was made possible by section 31 of the 1999 Act (now section 75 of the *NHS Act 2006*).

9.7 Government grants

Government grants are available to the NHS for community-based projects run in conjunction with local authorities. Typically, these grants are linked to regeneration and renewal programmes in deprived communities where a partnership board with representation from many elements of the local community (including NHS bodies) has successfully bid for and then managed the distribution of the grant. In terms of the financial framework for these projects, the structure is straightforward – the grant is paid directly to the participating NHS body to cover the costs incurred.

9.8 Grants from the NHS to local authorities

NHS bodies have for many years been able to make grants to local authorities for the provision of health services (under sections 256/ 257 of the *NHS Act 2006* as amended). This is broadly permissive and allows the transfer of revenue or capital resources for most health-related functions (excluding emergency ambulance services, surgery, and other similar invasive treatments) and for most social services and housing functions. ICBs and/ or NHS England can make payments to local authorities (or other bodies) towards expenditure on community services - for example, a local authority operating a unit for people with learning difficulties may receive a grant from the NHS body to cover the provision of healthcare to the clients in the unit. Such grants must pay only for medical care and must not contribute towards the provision of social care. They must not involve the transfer of health functions to a local authority.

9.9 Grants from local authorities to the NHS

Section 76 of the *NHS Act 2006* (as amended) is a parallel provision to section 256 and allows the local authority to make payments to NHS bodies for the performance of prescribed functions. Local authorities can make payments to NHS England or ICBs. Again, this includes most hospital and community health services but not surgery, emergency ambulance services, or similar.

Key learning points

- Local authorities, also known as councils, provide public services to local communities and are run by democratically elected councillors who are accountable to their electorate.
- Local authorities are required by law to provide certain services. These are known as statutory services. The main categories are the provision of social care, schools, and roads.
- There are three main sources of local government funding. These are government grants, council tax revenues and business rates. Local authority finance is entirely separate from the NHS.
- Social care is the main interface between health organisations and local authorities because people often need social care services when recovering from ill health or when they suffer from a long-term condition.
- HealthWatch England is the national body that champions people who use health and social care and has a key focus on the design of integrated care.
- Section 82 of the *NHS Act 2006* requires NHS bodies and local authorities to co-operate with each other 'to secure and advance the health and welfare of the people of England and Wales'.

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, including a dedicated section on local government. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 10: How the NHS is financed

Chapter 10. How the NHS is financed

Overview

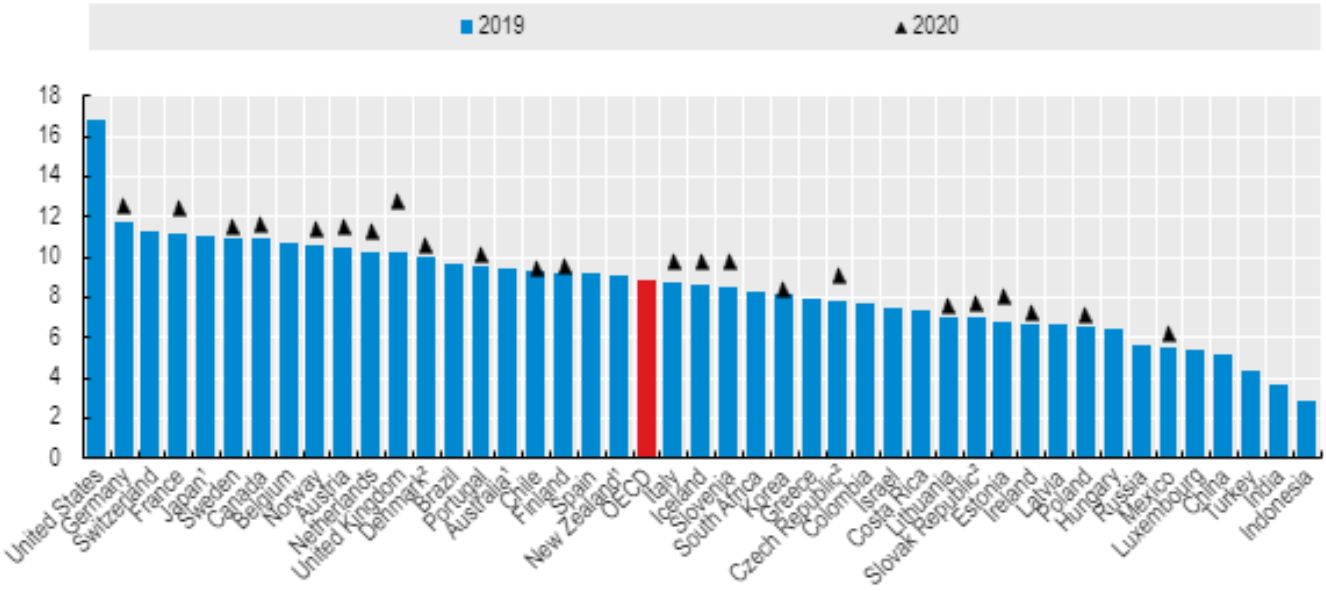
Health spending has always been a topic of political and public interest.

This chapter focuses on how resources are allocated nationally for the NHS and how they are divided amongst the different areas of health spending. It also gives an idea of the scale of UK spending on health compared with other countries.

10.1 UK spending levels

The Organisation for Economic Cooperation and Development (OECD) has published *Health at a Glance 2021*[131], providing a comprehensive group of indicators that looks at population health across OECD members. Health expenditure across OECD member is shown[132]. This shows that during 2019, the United Kingdom spent 10.15% of gross domestic product (GDP or national wealth) on health compared with an average across the 30 OECD countries of 8.84%. Although some countries spend more, 11.70% in Germany and 16.77% in the USA, and have different health systems, UK expenditure on healthcare is broadly in line with other countries and the OECD average.

Health expenditure as a share of GDP, OECD estimates for 2019 with 2020 (where estimate available)



Source: OECD, Health at a glance 2021: OECD indicators, figure 7.1

The levels of spending described above are funded differently depending on the health system in place. Private health insurance is a significant feature of some OECD countries[133]. In the United States, around one third of all spending is via private health insurance. In Switzerland, it is around half, and in the Netherlands, private health insurance accounts for roughly 60% of spend. In around half of other OECD countries, spend through private insurance is approximately 5% or less.

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[131] OECD, *Health at a glance 2021*, November 2021
[132] OECD, *Health at a glance 2021: Health expenditure in relation to GDP*, November 2021

[133] OECD, *Private Health Insurance Spending - Brief*, March 2022

10.2 The role of HM Treasury

The responsibility for allocating and managing the finances of national government lies with the Chancellor of the Exchequer, who leads HM Treasury (the Treasury). To promote better planning of public spending the Treasury undertakes periodic spending reviews to set departmental expenditure limits (DELs) for each government department. DELs usually cover a period of three years.

The DELs announced in the spending reviews are confirmed twice a year – through the main and supplementary estimates[134], where the government sets out how it will finance its spending commitments and makes any necessary or technical adjustments to its spending plans.

The spending review 2020 set out departmental spending plans for a single year, and prioritised funding to support the response to Covid-19 and on the UK's recovery programme[135]. Spending reviews usually cover a longer period, and a three-year budget was set in October 2021[136].

Public expenditure falls into one of two categories:

- DEL spending is expenditure on the running costs of each government department. For the DHSC this includes the costs of running hospitals, including staff costs, as well as the provision of other healthcare services. Departments are not allowed to overspend the annual DEL set as part of the spending review in a year
- annually managed expenditure (AME), is expenditure that cannot reasonably be subject to firm, multi-year limits in the same way as DEL. Examples of such spending are social security benefits that fluctuate depending on the level of unemployment.

Together, DEL plus AME sum to total managed expenditure (TME).

A key issue for any government is the relative level of public spending compared to national wealth (GDP). Relative to GDP (which itself fluctuates from year to year), UK public spending has varied from 35.1% in 1998/99 to a high of 52.0% in 2020/21. This high was due to increased government expenditure due to the Covid-19 pandemic combined with the reduced GDP due to the pandemic. Public spending statistics are released on a regular basis by HM treasury to provide detailed information on public spending[137].

HM Treasury allocates DELs between revenue and capital spending. Revenue spending is for day-to-day items such as salaries and running costs; capital spending is for buying larger items such as buildings and equipment, that have a usable life of over one year.

The *Autumn budget and spending review*[138] set out the resource limits for the DHSC to 2024/25. These were updated in the November 2022 *Autumn statement*[139].

HM Treasury's 2022 Autumn statement resulted in the following pattern of allocations of revenue and capital DELs to government departments:

[134] HM Treasury, *Main estimates*, updated 14 May 2022
[135] HM Treasury, *Spending Review 2020*, updated 15 December 2020
[136] HM Treasury, *Autumn budget and spending review 2021,* October 2021
[137] HM Treasury, *Public Spending Statistics,* updated July 2022
[138] HM Treasury, *Autumn budget and spending review 2021*, updated December 2021
[139] HM Treasury, *Autumn statement 2022*, November 2022

Resource DEL (RDEL) excluding depreciation (table 2.1)

	Outturn 2021/22 £bn	Plan 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Health and Social Care	144.1	168.2	176.2	180.4
Of which: NHS England	*133.7*	*152.6*	*160.4*	*165.9*
Education	70.1	77.1	81.2	82.6
Home Office	14.4	14.6	15.4	15.5
Justice	8.5	9.4	9.8	10.0
Law Officers' Departments	0.7	0.8	0.8	0.8
Defence	31.7	32.1	31.9	32.0
Single Intelligence Account	2.5	2.6	2.3	2.4
Foreign, Commonwealth and Development Office	7.5	8.2	7.8	7.7
DLUHC Local Government	10.7	11.8	15.7	15.3
DLUHC Levelling Up, Housing and Communities	2.6	3.1	2.1	2.1
Transport	3.2	8.3	6.8	5.7
Business, Energy and Industrial Strategy	2.4	2.6	2.7	2.6
Digital, Culture, Media and Sport	1.6	2.0	1.6	1.6
Environment, Food and Rural Affairs	4.1	4.5	4.3	4.2
International Trade	0.5	0.6	0.5	0.5
Work and Pensions	5.7	8.4	8.0	7.1
HM Revenue and Customs	4.6	5.9	5.6	4.6
HM Treasury	0.4	0.4	0.3	0.3
Cabinet Office	0.9	0.7	0.5	0.4
Scotland	32.5	35.3	36.5	36.9

	Outturn 2021/22 £bn	Plan 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Wales	13.7	15.2	15.9	15.6
Northern Ireland	12.5	13.4	13.5	13.6
Small and Independent Bodies	2.4	2.4	2.4	2.4
UK Shared Prosperity Fund	-	-	0.6	1.3
Reserves	-	10.7	13.9	12.9
Ringfenced COVID-19 funding	74.6	-	-	-
Energy support funding in DEL	-	13.9	-	-
TOTAL DEL	**451.8**	**452.2**	**456.2**	**458.6**

Source: *Autumn statement 2022*, HM Treasury

Departmental Capital Budgets - Capital DEL (CDEL), (table 2.2)

	Outturn 2021/22 £bn	Plan 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Health and Social Care	9.0	12.0	11.7	12.6
Education	4.7	6.3	7.0	6.1
Home Office	0.9	1.2	1.0	1.1
Justice	1.4	1.7	2.3	1.5
Law Officers' Departments	0.0	0.1	0.0	0.0
Defence	14.2	19.5	16.5	16.6
Single Intelligence Account	0.9	1.2	1.2	1.2
Foreign, Commonwealth and Development Office	1.7	2.6	3.6	4.1
DLUHC Levelling Up, Housing and Communities	6.2	9.5	6.9	6.8
Levelling Up Fund	-	0.9	1.4	1.4

	Outturn 2021/22 £bn	Plan 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn
Transport	19.0	19.9	19.9	20.5
Business, Energy and Industrial Strategy	20.7	17.8	20.8	21.2
Digital, Culture, Media and Sport	0.5	0.8	1.1	1.2
Environment, Food and Rural Affairs	1.4	2.1	3.0	2.9
International Trade	0.0	0.0	0.0	0.0
Work and Pensions	0.3	0.8	0.6	0.5
HM Revenue and Customs	0.7	0.7	0.6	0.5
HM Treasury	0.0	0.0	0.0	0.0
Cabinet Office	0.3	1.1	1.2	2.7
Scotland	5.1	7.2	5.9	5.6
Wales	3.0	3.3	3.0	2.9
Northern Ireland	1.8	2.1	2.0	1.8
Small and Independent Bodies	0.3	0.4	0.5	0.7
UK Shared Prosperity Fund	-	-	0.1	0.2
Reserves	-	4.1	3.3	3.2
Adjustment for Budget Exchange	-	-2.4	-	-
Ringfenced COVID-19 funding	0.9	-	-	-
Energy support funding in DEL	-	5.5	-	-
Total capital DEL	**93.0**	**118.3**	**113.6**	**115.2**

Source: *Autumn statement 2022*, HM Treasury

Funding for health services in other UK nations is included in the separate Northern Ireland, Scottish and Welsh block grants. Any changes in planned spending in the NHS in England are matched by relative increases within these block grants through an allocation process called the Barnett formula[140]. However, the individual administrations may spend less or more than these amounts on health services depending on their own priorities.

[140] House of Commons Library, *The Barnett formula*, January 2020

10.3 The role of the Department of Health and Social Care

The Department of Health and Social Care (DHSC) decides how the funding it receives from HM Treasury is allocated in England. Health and social services in Northern Ireland, Scotland and Wales are the responsibility of the devolved administrations (see chapters 21 to 23).

Most of the total NHS settlement (see table above) is allocated to NHS England. A percentage of this allocation is set aside for its own commissioning responsibilities and running costs, with the balance allocated to integrated care boards (ICBs).

The DHSC retains part of the allocation to meet:

- its own running costs
- the costs of various central health and miscellaneous services - for example, some centrally administered services and centrally managed projects for the benefit of the NHS (such as clinical negligence); a range of statutory and other arm's length bodies funded centrally - for example, the NHS Business Services Authority and Health Education England (see chapter 3 for details)
- the costs of local authority public health spending – this is covered by a separate ring-fenced budget (from the DHSC's allocation) that is passed to and managed by local authorities[141].

10.4 The role of NHS England

NHS England is responsible for using the funding it receives from the DHSC to deliver the *NHS Mandate*[142] (the mandate). In practice this means that NHS England's allocation must fund the costs of:

- directly commissioning activities – including the primary medical services provided by dentists, community pharmacists and opticians; specialised services; offender and military healthcare
- ICB allocations that fund the services they commission including elective and emergency hospital care, community care and mental health services (see chapter 5 for more information on the role of ICBs)
- the running costs for NHS England itself, its regional teams, local professional networks, clinical senates, and networks
- running ICBs (known as the running cost allowance)
- some services that are commissioned by local authorities.

For 2022/23 the total revenue budget allocated to NHS England to deliver the mandate was £152.6bn. Performance against that mandate will be published in the 2022/23 annual report and accounts.

The 2020/21 NHS England annual report and accounts[143] sets out the performance against the mandate for that year. Revenue departmental expenditure limit 2020/21

[141] Department of Health and Social Care, *Public health ringfenced grant 2022 to 2023: local authority circular,* February 2022
[142] Department of Health and Social Care, *The Government's 2021-22 mandate to NHS England and NHS Improvement*, March 2021

	Plan £bn	Actual £bn	Underspend against plan £bn
Direct commissioning	28.2	27.1	1.1
NHS England administration, central programmes and other	19.4	15.3	4.1
CCGs	101.9	101.7	0.2
Total	**123.4**	**122.4**	**5.4**

10.5 ICB allocations

CCGs received five-year allocations in January 2019, covering the periods 2019/20 to 2023/24[144]. These allocations were based on the five-year funding settlement announced by the Prime Minister in June 2018[145]. Allocations were firm for 2019/20 to 2021/22, with the following two years issued as indicative for planning purposes.

In March 2022[146], NHS England and NHS Improvement issued one-year allocations to integrated care boards (ICBs) for 2022/23, and set out a revised allocation methodology for that period[147].

Once an ICB has been notified of its allocation for the forthcoming period, it plans how to use the funding across the full range of services that it commissions with the overall aim of improving the health and wellbeing of its population. An ICB commissions services from a range of providers including NHS trusts and foundation trusts, the private and voluntary sectors (see chapter 16 for more on commissioning).

10.6 NHS trusts and NHS foundation trusts

Funding secondary care

Most of the community, acute, specialist and mental healthcare in England is provided by NHS trusts or NHS foundation trusts. These trusts meet the costs of providing healthcare services (staff salaries are normally the largest element) and receive income from ICBs (and for some services, from NHS England) via contracts that specify the quantity, quality, and price of services to be provided. Each ICB (or NHS England) is responsible for meeting the cost of services provided to its population in line with the contract's terms. ICBs, NHS England, and providers are responsible for ensuring that patient treatments are clinically appropriate and provided in a cost-effective way.

Trusts also receive some income from other sources such as private patient income, hosting services, car park receipts, leasing of buildings and research and development. For teaching hospitals, the latter can be significant (see chapter 8 for details).

Many trusts also have access to funds donated by members of the public on a charitable basis. However, these can be used only for the purpose for which they were given – for more about charitable funds see chapter 19.

144 NHS, *Allocations 2019/20 to 2023/24*, January 2019
145 UK Government, *Prime Minister sets out 5-year NHS funding plan*, June 2018
146 NHS England, *Allocation of resources 2022/23*, April 2022
147 NHS, *Technical guide to integrated care board allocations 2022/23 to 2024/25*, April 2022

Funding research and development

NHS funded research is overseen by the National Institute for Health Research (NIHR). The NIHR is funded by the DHSC to improve the health and wealth of the nation through research and is headed by the chief scientific adviser and director of science, research, and evidence. The NIHR is a virtual organisation hosted by NHS providers, universities, and life science organisations. Its day-to-day operations are run through six coordinating centres that allow the NIRH to commission and fund research, provide facilities and people within the clinical research network and support those who are carrying out, training, and participating in research.

Funding for NHS bodies can come through the NIHR Central Commissioning Facility that supports various research programmes, as well as a service to support those applying for the research programmes. The following schemes are also managed by this facility:

- applied research collaborations (ARCs) that support applied health and care research that meets the needs of local populations and increases the rate at which research is implemented into day-to-day practice. There are 15 ARCs in England that share a £135m investment announced in July 2019.
- clinical research facilities (CRFs) for experimental medicine. CRFs are purpose-built, cutting-edge facilities with specialist clinical, research and support staff. They are found in 28 NHS hospitals where universities and NHS organisations work together on dedicated programmes of patient-orientated experimental medicine research. In February 2022, CRFs were awarded £161m to be shared by the 28 organisations over five years.
- biomedical research centres (BRCs) – that are collaborations between universities and NHS organisations to translate lab-based breakthroughs into potential new treatments, diagnostics, and medical technologies. The 20 BRCs received £816m from 1 April 2017 to be spent over 5 years.

The NHIR clinical research network coordinating centre manages the clinical research network that comprises

- 15 local clinical research networks (LCRN) covering all of England
- 30 clinical research specialties
- national specialty leads.

NHS bodies and individuals can access funding from the various work streams depending on whether they are one of the lead organisations or undertake work in a particular area of research.

Funding clinicians' training

In addition, some trusts receive substantial sums through placement fees for undergraduate healthcare professionals as well as salary and training costs for post graduate healthcare professionals. These funding flows are governed by Health Education England (HEE) via a system of education tariffs[148].

10.7 Primary care services

Most primary care services are provided by independent contractors such as general medical practitioners (GPs), general dental practitioners (GDPs), pharmacists and ophthalmic practitioners. While they are an integral part of the NHS, these contractors operate as small businesses that contract with the NHS to provide primary care services. Contracts are designed to reward the quality of treatment.

[148] DHSC, *Education and training tariff guidance and prices for 2021/22*, July 2021

NHS England, and ICBs under delegated commissioning arrangements, pay primary care service providers according to nationally negotiated contracts. Local enhanced services cover specific needs of patients in the area are negotiated locally - for example, GP practices receive a global sum to cover the provision of core services to their registered patient list and additional 'quality' payments for achieving goals set out in the quality and outcomes framework (QOF).

The interface between primary and secondary care is not always clear and is becoming more blurred as services become more integrated. GPs with specialist interests are increasingly playing a significant part in delivering patient care outside of the traditional hospital routes. On the other hand, some NHS providers are now employing GPs and are providing primary care services in the community to the local population.

See chapter 7 for more on primary care services.

10.8 What is the money spent on?

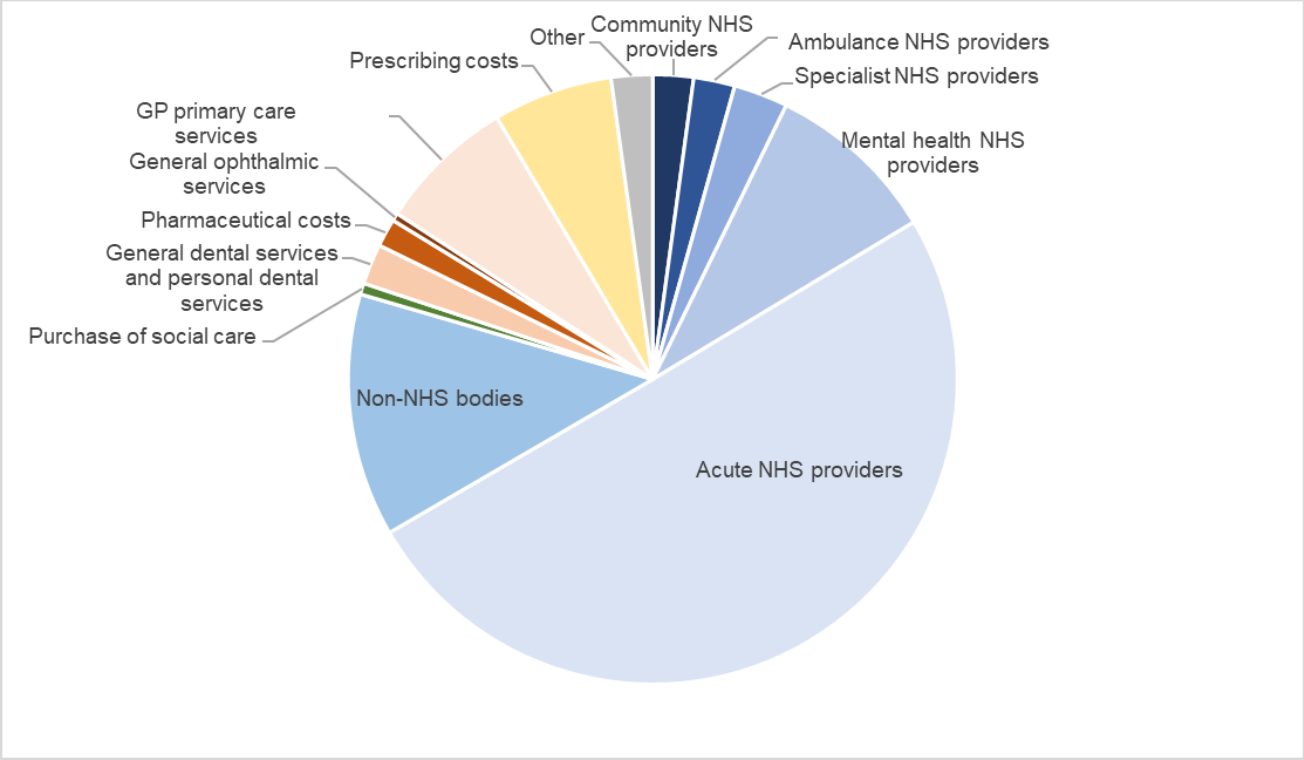
The DHSC publishes consolidated accounts for the whole of the NHS in England each year.

According to the 2020/21 accounts[149], staff costs account for 38% of operating expenditure for the DHSC as a group. Nearly all (94%) of the staff costs are incurred by NHS provider bodies. For NHS provider bodies, 64% of operating costs relate to staff costs.

In 2020/21 the DHSC passed over 80% of its voted funds to NHS England for it to meet the requirements of the NHS Mandate. This percentage is usually over 90% but the impact of Covid-19 meant that the DHSC purchased more services and supplies directly.

Analysis of NHS England's annual report and accounts 2020/21, supplemented by information from the consolidated provider accounts for the same year, reveals that approximately 67% of commissioner's expenditure is on secondary care, while 18% is spent on primary care.

Analysis of NHS England expenditure on goods and services by category 2020/21



[149] DHSC, *DHSC annual report and accounts 2020/21*, January 2022

Key learning points

- The UK spends just over 10% of GDP on health – around the OECD average.
- The government and HM Treasury determine how much money each government department receives based on spending reviews.
- Money is allocated for both day-to-day (revenue) and capital spending.
- The Department of Health and Social Care (DHSC) decides how the budget is used with over 80% of the revenue budget going to NHS England.
- The DHSC keeps some money for central services and arms' length bodies such as Office for Health Improvement and Disparities and Health Education England.
- NHS England allocates the bulk of the money it receives to ICBs but keeps some to fund its own direct commissioning functions and running costs.
- NHS trusts and foundation trusts receive the bulk of their income via contracts with ICBs and NHS England; other sources include income from research and development.
- Primary care services are provided predominantly by independent contractors who receive income via contracts agreed with ICBs or NHS England.

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.

HFMA introductory guide to NHS finance

Chapter 11: How NHS bodies demonstrate financial accountability

Chapter 11. How NHS bodies demonstrate financial accountability

Overview

This chapter looks at the key financial and performance reporting mechanisms that NHS bodies use to demonstrate accountability in financial terms. Its primary focus is on external reporting requirements but there is also a section on reports to budget holders and governing bodies.

11.1 External reporting

Statutory requirements

All NHS bodies have a statutory duty to produce an annual report and accounts[150] with the form and content set out in accounts directions. These directions are contained within the Department of Health and Social Care's (DHSC) group accounting manual (GAM), chapter 2, Annex 3[151] and the foundation trust annual reporting manual (FT ARM), chapter 1, annex 1[152].

The accounts directions are made by different organisations depending on the NHS body, but they all require organisations to prepare true and fair accounts and to maintain appropriate accounting records. The production of the annual report and accounts is the principal means by which NHS bodies discharge their accountability responsibilities to taxpayers and users of services, for their stewardship of public money.

The annual report and accounts (ARA) is a single document that is approved and signed by the governing body and includes an external audit opinion. The ARA must be fair, balanced and understandable, and the accountable officer (usually the chief executive), in signing the ARA, takes personal responsibility that this is the case.

All NHS bodies must publish their ARA and then present it at a public meeting. NHS foundation trusts must lay their annual report and accounts before Parliament prior to publication or presentation at a public meeting. It is considered best practice for the public meeting to be held before 30 September following the end of the relevant financial year.

Annual report

The annual report is primarily a narrative document. It is based on the directors' report and the remuneration report required in the private sector by the *Companies Act 2006*[153], but with additional information reflecting the NHS body's position as a public sector body. The report gives an account of the body's activities and performance over the last financial year.

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[150] For CCGs this duty is set out in the Health and Social Care Act 2012, part 1, section 26, sub section 14Z15 and schedule 2, paragraph 17 (2) – CCGs will prepare a final 'annual' report and accounts for the period 1 April to 31 July 2022. For ICBs, the duty is set out in section 14Z58 of the NHS Act 2006 as inserted by s25 of the Health and Care Act 2022. For NHS trusts, the relevant legislation is section 232 and paragraph 3(1) of schedule 15 of the NHS Act 2006 as amended by part 4, section 154 of the 2012 Act; for NHS foundation trusts (FTs) the relevant legislation is section 30 and paragraph 25(1) of schedule 7 of the NHS Act 2006 as amended by part 4, section 154 of the 2012 Act.

[151] DHSC, *Group accounting manual (chapter 2 annex 3),* June 2022

[152] NHS, *NHS foundation trust annual reporting manual*, updated May 2022

[153] UK Government, *Companies Act 2006,* 2006

The annual report provides an opportunity to set out its achievements in the year and highlight the challenges ahead.

Although the overall layout of the annual report is at each NHS body's discretion, there are mandatory items that must be included; these are *Companies Act 2006,* HM Treasury and NHS specific disclosure requirements. The DHSC, through NHS England, provides specific guidance to NHS bodies in relation to these requirements.

All NHS annual reports include a performance report, which is made up of a short overview of performance as well as more detailed analysis (in 2019/20 and 2020/21 the detailed analysis was optional due to the pressures of the Covid-19 pandemic). The overview sets out:

- information on the NHS body – how it is organised and managed
- the chief executive's summary of the NHS body's performance in the year
- the organisation's main objectives and strategies
- the main risks it faces.

The detailed analysis includes information on the NHS body's performance, including trend analysis and key performance indicators. There is also more detailed risk information and non-financial information on matters such as human rights, diversity and environmental issues.

The annual report must include an accountability report. This is intended to meet key accountability requirements to Parliament, and will include the directors' report, statement of accounting/ accountable officer's responsibilities and the annual governance report. It will also include a remuneration and staff report that discloses policies for senior managers' total rewards (salary and pension), and some other staff information.

There are some disclosures that are required by statute for different NHS bodies - for example, section 14Z58 of the *National Health Service Act 2006*[154] (as amended by the *NHS and Social Care Act 2022*[155]*)* specifically requires that ICBs' annual reports explain:

- the steps the ICB has taken to implement relevant health and wellbeing strategies
- how the ICB has exercised its functions in accordance with its published plans
- how the ICB has had exercised its functions as regards NHS England's published statements
- how it has discharged its duties in relation to areas including:
    - securing continuous improvement in the quality of services
    - reducing health inequalities between patients with respect to their ability to access health services and the outcomes achieved for them
    - involving and consulting with the public
    - promotion of patient choice
    - promotion of innovation, education and training
    - promotion of integration
    - having regard to the wider effect of decisions
    - climate change.

Another example is the requirement in paragraph 26(2) of Schedule 7 of the *National Health Service Act 2006*[156] *(as amended)* for NHS foundation trusts to publish information on directors' remuneration

[154] UK Government, *National Health Service Act 2006*, 2006
[155] UK Government, *Health and Care Act 2022*, 2022
[156] UK Government, *National Health Service Act 2006*, 2006

and the expenses of governors and directors. While NHS trusts are required to make disclosures relating to directors' remuneration in accordance with the GAM, these precise disclosures are not required.

Annual accounts

The format of the annual accounts is specified in each accounts direction and is slightly different depending upon the type of NHS body concerned. However, the main elements are shown below.

The contents of the annual accounts

The four primary statements:

- statement of comprehensive income (for providers) or statement of comprehensive net expenditure (for all other NHS bodies, where financing is primarily from central funding, rather than through income received for services provided)
- statement of financial position
- statement of changes in taxpayers' equity
- statement of cash flows.

Notes to the accounts

- accounting policies
- additional analysis of the primary statements
- any additional disclosures required as per the GAM, or where greater clarity is required to the reader of the accounts.

Statements and certificates:

- directors' statement of responsibilities
- the accounting (or accountable) officer's statement of responsibilities
- the governance statement (see below)
- the auditors' report.

Accounting framework

In preparing their accounts, NHS bodies must follow international financial reporting standards (IFRS) as issued by the IFRS Foundation[157]. These standards are intended to provide a framework for good practice, the common disclosure of information and a benchmark against which an NHS body's audited accounts are judged.

Although NHS bodies must adhere to IFRSs, the government has the final say on how these standards are applied to the public sector (including NHS bodies) with details set out in HM Treasury's *Financial reporting manual (FReM)*[158]. This is because IFRSs are written with profit making organisations in mind and therefore some interpretation is required to allow them to be applied consistently to public sector bodies where there is no profit motive.

The DHSC GAM is consistent with the requirements of the FReM and must be approved by HM Treasury through the Financial Reporting Advisory Board[159]. The GAM sets out the particular reporting requirements for all NHS bodies.

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[157] The IFRS Foundation, *International financial reporting standards,* 2022
[158] HM Treasury, *Financial reporting manual*, updated December 2022
[159] HM Treasury, *Financial Reporting Advisory Board,* 2022

The parts of the GAM that relate to the annual report apply to all NHS bodies apart from NHS foundation trusts. The requirements for NHS foundation trusts' annual reports are set out in the FT ARM that is published by NHS England.

These manuals are updated each year and include a summary of the relevant accounting standards. However, if an NHS body needs a more detailed understanding of a particular aspect, it will refer to the relevant accounting standard in full.

Governance statement

NHS bodies produce an annual governance statement (AGS)[160] that is included in the annual report and accounts. This statement focuses on the stewardship of the body; it sets out how the board has managed and controlled its resources and reports on the NHS body's risk management and control system over the year[161]. Although there is no prescribed format the statement must cover several areas including:

- information about the NHS body's governance framework (including its board committee structure)
- responsibilities for risk management, internal control systems and for reviewing their effectiveness; this includes the board's performance
- the processes and structures used to identify, evaluate and manage the principal and emerging risks faced
- the main features that support regular review, monitoring and assurance
- the process applied to review the effectiveness of risk management and internal control, and the associated systems that have been in place for the year up to the date of approval of the annual report and accounts
- any significant control issues that have emerged during the year and how they are being, or have been, addressed.

Quality accounts

Since April 2010, all providers of acute care (including all NHS provider bodies as well as commercial providers of NHS services) have been required to produce an annual quality account in line with the statutory requirement set out in the Health Act 2009[162] and the associated regulations. The aim is to 'enhance accountability to the public and engage the leaders of an NHS body in their quality improvement agenda' by reporting the continuous improvement in the quality of the services provided.

The required contents of the quality account are set out in the statutory instruments[163] supporting the 2009 Act and guidance issued by the NHS[164].

Quality accounts must be shared for comment with the main commissioner for the provider (whether that is NHS England or a lead ICB), local HealthWatch and the local overview and scrutiny committee. The final agreed quality account must be sent to the Secretary of State and made publicly available by 30 June following the financial year end.

Until 2019/20, alongside this statutory requirement, NHS foundation trusts were also required to produce a quality report. The quality report was the quality account with additional mandated

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[160] NHS England, *requirements for annual governance statements*, 25 February 2022
[161] HM Treasury, *Managing public money (annex 3.1),* updated March 2022
[162] UK Government, *Health Act 2009,* 2009
[163] UK Government, *National Health Service (Quality Accounts) Regulations 2010* (SI 2010/279) as amended by SI 2011/269, SI 2012/3081, SI 2017/744, SI 2018/59 and SI 2020/466, 2010
[164] NHS England, *About Quality Accounts*, 2023

disclosures determined by NHS England and NHS Improvement. The quality report had to be included in the NHS foundation trust's annual report and accounts and therefore had to be produced and finalised within the deadlines for the annual report and accounts.

However, because of Covid-19, quality reports were not required in 2019/20 and 2020/21 and now the quality report is no longer required. Instead, from 2021/22, NHS trusts and NHS foundation trusts are required to report on their performance against quality priorities and indicators in the overview and performance analysis parts of their annual report. The quality priorities and indicators to be reported should be the most pertinent ones for that NHS body set out in the *NHS oversight framework*[165] and should link to the disclosures on quality governance and data quality in the accountability report.

It is for NHS bodies to determine whether they want to ask their auditors to provide assurance over any of the quality metrics that they report.

What quality accounts include

- an overall statement by the chief executive on the quality of health services provided or sub-contracted during the year
- a review of performance against the quality indicators, out of a prescribed set of 15, that are relevant to the services the NHS body provides. For each indicator, performance is reported using specified data sources so there is comparability between providers. For each indicator, the actions taken or to be taken to improve performance are also reported
- at least three areas for improvement including why those areas have been selected and how progress will be reported to patients and the public
- progress on areas of improvement identified in the previous report
- the national, local and clinical audits the NHS body has taken part in
- statements of assurance from the board as required by the regulations
- what others say about the provider including commissioners, local HealthWatch organisations and overview and scrutiny committees
- any other information that the provider body might want to include (for NHS foundation trusts, this section includes other disclosures mandated by NHS England).

External audit

As mentioned above, the NHS body's annual report and accounts are subject to scrutiny from the external auditor and must be signed off by them prior to their publication. To be able to carry out their audit, auditors must be given a copy of the annual report and accounts and complete working papers that fully support the figures and disclosures made by management in the draft annual report and accounts, before the start of the audit so that they have sufficient time to carry out the required work to meet the accounts completion deadline.

The auditors are required to comply with the *Code of audit practice*[166] (the Code) published by the National Audit Office (NAO) that sets out the additional requirements for an audit of an NHS body. The Code requires auditors to follow *International standards on auditing for the UK (ISAs)*[167] when undertaking their work on the annual report and accounts.

The Code sets out the elements that make up the auditor's report on the annual report and accounts; this includes:

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165 NHS, *NHS Oversight Framework 2022/23*, June 2022
166 NAO, *Code of audit practice 2020*, April 2020
167 Financial Reporting Council, *International standard on auditing (UK),* updated May 2022

- an audit opinion on the annual accounts that says whether the financial statements give a 'true and fair' view and whether the financial statements have been properly prepared
- a statement on whether the information published with the annual accounts (usually, the annual report) is consistent with the annual accounts
- a statement that parts of the remuneration report that are subject to audit have been properly prepared
- for ICBs - an opinion on whether in all material respects the expenditure and income recorded in the financial statements has been applied to the purposes intended by Parliament (known as the regularity)
- where the auditor is not satisfied with the arrangements to secure value for money, by exception, a statement in relation to the NHS body's use of resources
- a certificate that closes the audit.

All auditors issue a report to the audit committee that summarises their findings at the end of the audit. This report is called the ISA260 report or report to those charged with governance[168].

Since 2020/21, auditors issue an auditor's annual report that will bring together all of the auditor's work over the year, including their findings and any recommendations. A core element of this report will be the auditor's commentary on the body's value for money (VFM) arrangements. The annual audit report is required to be a clear and understandable commentary of the results of the auditor's work for the general public. NHS bodies are required to publish it alongside their annual report and accounts.

After the accounts have been audited and any necessary amendments made, the governing body is required to formally adopt the accounts and the certificates are signed to demonstrate that approval. The auditor then signs their audit report.

Timetable

The DHSC in conjunction with NHS England, determines the overall timetable for the production and submission of the annual report and accounts. The timetable is set so that the various national consolidated reports and accounts can be produced and laid before Parliament prior to the summer recess.

The deadline for completion of draft accounts and annual reports is usually around the third week in May and with submission of final audited accounts in late May or early June.

For the financial year 2022/23 the submission of the draft annual report and accounts deadline is 27 April 2023. The submission of final audited statements deadline is 30 June 2023.

During the Covid-19 pandemic deadlines were extended, and some requirements were reduced, to reflect the significant issues being faced by organisations, including audit teams. The extended timetable, although only a matter of weeks for NHS bodies, caused a significant issue for the national consolidated accounts for 2019/20 and 2020/21. These were not laid before Parliament until the January after the financial year-end; pre-Covid, this was in the July immediately after the financial year-end. It is expected that it will take several years for the timetable to return to the pre-pandemic deadlines.

[168] Financial Reporting Council, International standard on auditing (UK) 260, communication with those charged with governance, updated May 2022.

Monitoring reports

Providers

As well as preparing the statutory annual report and accounts, NHS provider bodies are required to submit provider finance returns (PFR) to NHS England throughout the year. PFR forms are consistent with the annual accounts but also include additional management information that is used by NHS England to monitor financial performance throughout the year.

At the year end, providers are required to prepare the trust accounts consolidation (TAC) schedules. These are in a standard format and consistent with the annual accounts. They are submitted to NHS England and are used to prepare the consolidated annual report and accounts for the DHSC, as well as consolidated provider accounts and consolidated NHS foundation trust accounts.

Commissioners

All ICBs and NHS England use the same financial ledger - the integrated single financial environment (ISFE). NHS England therefore has access to ICBs' financial information through ISFE, so ICBs do not need to complete consolidation schedules. However, at the end of quarter 3, and at the year-end, ICBs and NHS England regional offices are required to provide to NHS England additional financial information that is not available from ISFE. This facilitates the production of a consolidated report and accounts. The NHS England annual report and accounts consolidates the performance of NHS England with ICBs and shows how the financial requirements of the *NHS mandate*[169] have been achieved in the year.

Financial information submitted during the year is used to prepare financial reports for NHS England board meetings. Consolidated accounts information at year end is used to complete the DHSC consolidated accounts; the DHSC's annual report and accounts shows how the money voted by Parliament for health has been spent.

11.2 Financial performance targets

As well as the statutory requirement to produce an annual report and accounts, NHS bodies are subject to a range of statutory and departmental financial targets. The targets and their nature vary according to the type of NHS body.

NHS England

NHS England's key statutory financial duty is to ensure that in each financial year total spending on health does not exceed the funding available. NHS England must also ensure that:

- the total revenue resource used in a financial year does not exceed the amount specified by the Secretary of State (known as the revenue resource limit or RRL)
- the total capital resource used in a financial year does not exceed the amount specified by the Secretary of State (known as the capital resource limit or CRL).

NHS England is also enabled by the 2012 Act to use some of the funding it receives to establish a contingency fund that can be used to help discharge its functions or to help ICBs discharge their functions.

In relation to revenue and capital resource limits, NHS England's chief executive (the accounting officer) is held to account by the DHSC. NHS England is also required to prepare a consolidated

[169] Department of Health and Social Care, *The Government's 2021-22 mandate to NHS England and NHS Improvement*, March 2021

annual report and accounts for itself and all ICBs, which is a key element in the DHSC's overall resource account.

NHS England also prepares consolidated provider accounts that show how the provider bodies meet their financial duties.

Integrated care boards

ICBs' key financial duty as set out in section 223GB of the *NHS Act 2006* (inserted by section 29 of the *Health and Care Act 2022*), is that each ICB must not spend more in a year than it receives. NHS England can also direct ICBs about their management or use of financial and other resources, imposing limits on expenditure.

ICB budgets include a maximum allowance to cover administration or running costs. Although they can choose to undertake some or all of these roles themselves, they have the flexibility to use the money to buy in the services needed from commissioning support units (CSUs). The running cost allowance was originally based on a price per head of population. In 2016 the published allocation was £22.07 per head of population. The running cost allowance for 2020/21 was set in line with the expectation that clinical commissioning groups (CCGs) would deliver a real terms reduction of 20% from their 2017/18 running cost allowance; this is now applied to the relevant ICB.

The *Health and Care Act 2022* has introduced a new joint financial objective for ICBs, and their partner NHS trusts and NHS foundation trusts. This is that, jointly, the organisations must not spend more than an amount specified by direction of NHS England. In other words, each ICB and its partner NHS provider bodies must not exceed its revenue and capital resource limits.

NHS trusts and NHS foundation trusts

Prior to the *Health and Care Act 2022* coming into force, NHS trusts had a statutory financial duty to achieve a break-even position on revenue and expenditure taking one year with another. However, their financial duty is now to achieve financial duties set by NHS England. Trusts must also remain within a borrowing limit set by the Secretary of State[170].

NHS trusts also have non-statutory (administrative) duties to meet. These are to:

- pay a public dividend capital (PDC)[171] dividend to the DHSC each year
- manage within a pre-set external financing limit (EFL)
- meet the capital resource limit (CRL)
- comply with the better payment practice code[172] for the payment of invoices.

Further information on the first three of these duties is included in Chapter 15

In contrast NHS foundation trusts have no specific statutory financial duties. They are required to pay a PDC dividend and, as public bodies, comply with the better payment practice code but do not have an EFL or CRL.

NHS foundation trusts were intended to operate on a similar basis to commercial organisations, so they must operate effectively, efficiently and economically and remain a going concern.

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[170] See paragraph 3(1) of Schedule 5 of the *NHS Act 2006.*
[171] PDC is a form of long-term government finance. The basis for calculation for the annual dividend payable is set out in chapter 15.
[172] Cabinet Office, *Prompt payment policy,* November 2018

The *Health and Care Act 2022* introduced a new requirement for NHS trusts and NHS foundation trusts, with their partner ICBs to not exceed the revenue and capital spending limits set by NHS England.

The requirement that, at the national level, the DHSC must ensure that capital expenditure does not exceed the funds allocated to it for capital projects by Parliament (the capital departmental expenditure limit (CDEL)) means that capital expenditure has been constrained for all NHS providers (see chapter 15 on capital).

Better payment practice code

All NHS bodies must comply with the better payment practice code. The target is that 95% of invoices, by both value and volume, must be paid within 30 days of receipt. During the Covid-19 pandemic, all public sector bodies were encouraged to pay invoices within seven days.

11.3 Financial performance management

Planning

HM Treasury, DHSC and NHS England require that the financial performance of NHS bodies is monitored throughout the financial year. The primary basis of financial performance management process is the annual financial plan. All NHS bodies are required to undertake medium term financial planning and, as part of this process, the organisation must plan to achieve its financial duties. The plan must cover all expected sources of revenue and expenditure and the full range of responsibilities under the management of the NHS body. Organisational financial plans must take into account the plans of all other NHS bodies in the system and, in aggregate, the ICB-wide plans must ensure that expenditure will be contained within the limits set for the year. All plans are submitted to NHS England.

The formal national planning process has been in place since 2016/17 – NHS England publishes national assumptions along with technical guidance and a submission timetable each year[173]. Plans are produced on an organisation and system wide basis and are for the short-term (one year) and medium term (five-years). In 2019/20 and the first part of 2020/21, the formal planning process was suspended due to the Covid-19 pandemic, but was partly reinstated during 2021/22, with a full process in place for 2022/23. These plans cover both financial and non-financial performance.

ICBs have a statutory duty to prepare an annual commissioning plan[174] known as the joint forward plan (JFP). The plan should set out how an ICB proposes to 'exercise its functions'. The JFP must, as a minimum, describes how the ICB and its partner trusts will provide NHS services that meet the physical and mental health needs of their local population, and include how it plans to spend the funding received. *Guidance on developing the joint forward plan*[175] was issued in December 2023 as part of the operational planning guidance

Reporting financial performance

To ensure effective management of financial resources NHS bodies must report regularly on their financial performance against the plan submitted at the start of the financial year to NHS England. Financial monitoring returns submitted to regulatory bodies during the year underpin this framework. NHS England uses the monitoring returns to take a risk-based approach to determine what oversight and intervention to apply to organisations, and systems.

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[173] NHS England, *NHS operational planning and contracting guidance*, December 2022
[174] Section 14Z11 of the *NHS Act 2006* as inserted by s26 of the *Health and Social Care Act 2012.*
[175] NHS England, Guidance on developing the joint forward plan, December 2022

Chief finance officers are expected to inform the appropriate regulator if there are any significant variances against plans and to ensure that appropriate recovery plans are put into place.

Non-financial performance standards and targets

As well as financial duties, there are several other targets that NHS bodies are required to meet. The *Health and Social Care (Community Health and Standards) Act 2003*[176] established the power for the Secretary of State for Health and Social Care to set standards that are published by the DHSC. Guidance issued by the National Institute for Health and Care Excellence (NICE) is also an important element of the standards system.

11.4 Internal assessment

Internal audit

Internal audit is defined in the *UK public sector internal audit standards*[177] as 'an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes'. These standards have applied to all NHS bodies since April 2013.

As the definition above indicates, the internal audit service fulfils two functions – assurance and consultancy. The first involves providing an independent and objective opinion to the accountable officer, governing body/ board and audit committee on the extent to which risk management, control and governance arrangements support the aims of the NHS body. In this context, risk management, control and governance mean the policies, procedures and operations established to ensure:

- the achievement of objectives
- the appropriate assessment of risk
- the reliability of internal and external reporting and accountability processes
- compliance with applicable laws and regulations
- compliance with the behavioural and ethical standards set for the NHS body.

The second role involves providing an independent and objective consultancy service specifically to help line management improve the NHS body's risk management, control and governance. When performing consultancy services, the internal auditor must maintain objectivity and not take on management responsibility.

All NHS bodies are required to have an internal audit function. On an annual basis, the head of internal audit (HoIA) will provide an assessment of the organisation's governance and risk management arrangements, and on the effectiveness of internal controls. This assessment forms the head of internal audit's opinion and is used by the accountable officer to inform the governance statement.

11.5 Internal reporting

For NHS bodies to run effectively, the board and managers at all levels need to receive up to date financial and non-financial performance information on a timely basis. This information needs to be derived from the same financial system that is used for external reporting purposes – this ensures consistency in reports and that decisions throughout the NHS body are made on the same basis.

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[176] UK Government, *Health and Social Care (Community Health and Standards) Act 2003*, 2003
[177] HM Treasury and Internal Audit Profession, *Public sector internal auditing standards*, updated March 2017

Reporting to NHS boards

NHS boards are responsible for ensuring that there are high standards of financial stewardship through effective financial planning, financial control and ensuring value for money. To achieve this, NHS boards require an effective system of financial and performance reporting that is accurate and timely so that it can take early and corrective action where necessary. It is for the board to decide the form and content of the reports required and it should regularly review its information needs. Many boards receive an integrated report that includes performance against both financial and operational key performance indicators. The board should also make use of assessments carried out by external bodies.

Examples of financial information that is reported each month

- performance against the achievement of statutory and departmental duties and targets
- in-year revenue and expenditure position and year-end forecasts, including an analysis of performance against budgets
- financial risks, the likelihood of them arising and how they will be managed
- activity levels linked to financial data
- progress on the achievement of any cost improvement/ savings programmes and financial recovery plans
- statement of financial position
- cash flow forecast
- aged receivable and payable balances including actions taken and progress made
- losses
- performance of outsourced services
- progress against internal and external audit recommendations
- progress on major capital schemes
- staffing and establishment reports.

As well as considering monthly reports, there is some financial information that the governing body needs to consider every year, including:

- the annual report and accounts
- financial plans
- the auditors annual report.

The board should also be updated and advised regularly on the nature and development of new systems and initiatives in the NHS so that it is better able to understand the implications and prepared to manage the impact when implementation takes place.

Reporting to budget holders

Effective financial management and governance requires that corrective action to be taken where financial plans are not expected to be met. This means that reporting of performance against the plan at a level in the organisation where action can be taken is essential. Reporting to budget holders must therefore be sufficiently detailed to ensure that all significant movements are identified and

issues that need to be corrected are highlighted, to support the budget holder to meet their responsibilities around financial accountability.

Budget monitoring information is produced at a range of levels, allowing managers to see not only summary performance, but also the performance of individual departments and teams. The exact nature of this reporting depends on the NHS body's management structure but in each case, it is essential that the information is timely, accurate, and fit for purpose. To ensure accuracy, financial commitments should be recognised as soon as possible and reflected in the monthly financial reports. Without accurate financial performance reporting at budget holder level, costs cannot be controlled properly. These reports are often referred to as the management accounts. Chapter 14 looks in more detail at revenue planning and budgeting.

Key learning points

- All NHS bodies have a statutory duty to prepare an annual report and accounts that are audited.
- The annual report is a review of the past year and performance against targets.
- The annual accounts must be prepared in accordance with international financial reporting standards. Additional directions, interpretations and guidance is provided by the Department of Health and Social Care and NHS England.
- The governance statement forms part of the annual report and accounts and reflects on the arrangements that the NHS body has in place to manage and control risk.
- Quality accounts must be prepared by bodies providing healthcare and focus on the quality of the care provided and areas for improvement in the future.
- All regulatory bodies undertake financial monitoring throughout the year and require financial information on a regular basis.
- All NHS bodies have financial targets that they must meet. Some are statutory and others are administrative.
- All NHS bodies must have an internal audit service that fulfils two key functions – assurance and consultancy.
- Assurance over the annual report and accounts as well as the NHS body’s arrangements for value for money is provided by the external auditor.
- NHS bodies are responsible for monitoring their own financial performance from the overall corporate level through to budget holders.
- ICBs and their partner trusts have a responsibility to produce joint forward plans that details how they will provide the physical and mental healthcare services that meet the needs of their local populations.

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, including dedicated sections on financial reporting and accounting, and audit. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 12: How the NHS is regulated

Chapter 12. How the NHS is regulated

Overview

This chapter describes how the NHS is regulated and scrutinised by NHS England, the Care Quality Commission, the National Audit Office and local authorities.

12.1 Introduction

NHS organisations are subject to regulation and inspection from a wide range of bodies that are independent of government and the NHS. These include many national agencies and organisations linked to the many different professions involved in the delivery of healthcare, ranging from the Royal Colleges and the General Medical Council to HM Revenue and Customs.

In an environment where delivering high quality services and performance through the effective use of public funds is essential, the role of these bodies and their impact on an organisation's reputation and morale cannot be underestimated. It is essential therefore that NHS organisations, and the systems they are a part of, are aware of the approach and requirements of each regulatory body. Also, appropriate mechanisms must be in place to facilitate the assessment process and respond to any recommendations or advice that is issued.

This chapter focuses on the approach of those bodies that have a direct impact on NHS organisations in terms of their finance and governance arrangements: NHS England; the Care Quality Commission (CQC)[178], the National Audit Office (NAO)[179], and local authorities.

12.2 NHS England

The regulation of integrated care systems (ICSs), providers, and commissioners by NHS England is set out in the *NHS oversight framework*[180].

The *NHS oversight framework* outlines the approach NHS England takes to oversee organisational performance and support the alignment of priorities for ICSs and the organisations within them. It identifies where ICSs and NHS organisations may benefit from, or require, support to meet the standards required of them.

The existing statutory roles and responsibilities of NHS England in relation to commissioners and providers remain unchanged, as do the accountabilities of individual organisations. However, they are now applied in the context of five key principles, that reflect the focus on system performance.

Oversight is characterised by five key principles:

- working with and through ICBs, wherever possible, to tackle problems
- a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
- matching accountability for results with improvement support, as appropriate
- autonomy for ICBs and NHS providers as the default position

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[178] Care Quality Commission, *About us,* 2022
[179] National Audit Office, *About us,* 2022
[180] NHS England, *NHS oversight framework 2022/23,* June 2022

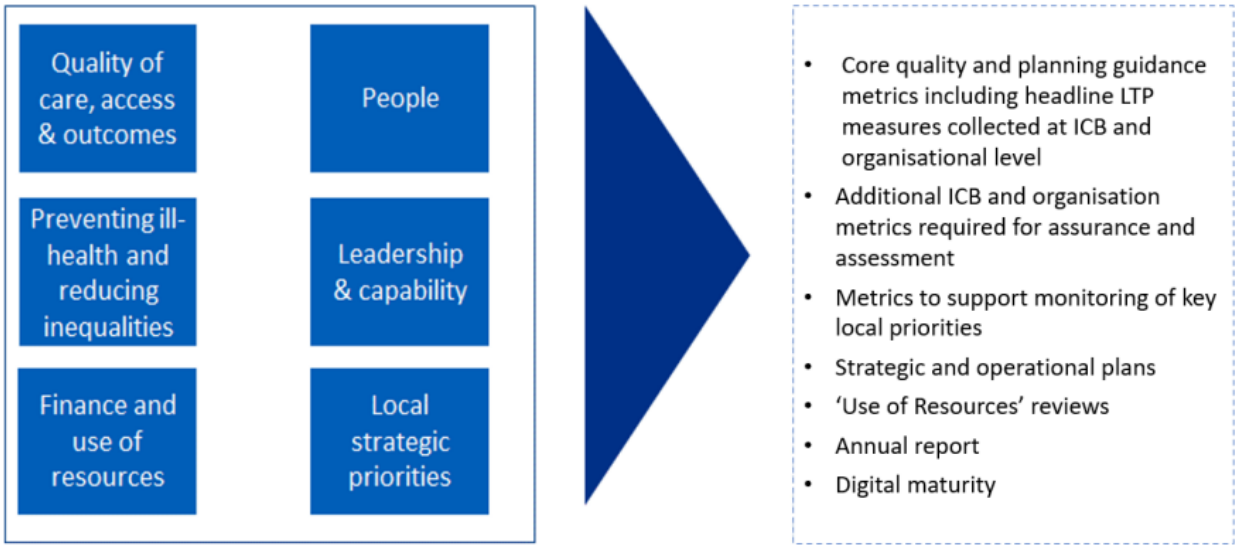
- compassionate leadership behaviours that underpin all oversight interactions.

Regional teams support ICBs to take on greater collaborative responsibility for their use of NHS resources, quality of care and population health, with oversight arrangements for ICSs reflecting their performance and relative maturity. ICBs will be increasingly involved in the oversight and support of the organisations in their system, in partnership with NHS England.

Measuring performance and identifying support needs

The oversight framework is built around five national themes, with a single set of metrics[181] across trusts and integrated care boards. A sixth theme covers local strategic priorities and recognises that each ICB is operating in a unique set of circumstances. The themes are set out below:

Key themes for the oversight framework



NHS England regional teams use data from the metrics and local information and insight to identify where commissioners and providers may need support. The metrics for oversight and assessment purposes include the headline measures described in the *NHS long term plan implementation framework*[182] (LTP) against which the success of the NHS will be assessed.

Ongoing monitoring assesses current performance and trends to ensure early identification of emerging issues or concerns. The regional team will allocate ICBs and trusts to one of four segments, as shown below:

Levels of support

	Segment description	Support needs
1	Consistently high performing	No specific support needs
2	On a development journey (default segment)	Flexible support, targeted to address specific issues

[181] NHS England, *NHS oversight metrics for 2022/23,* June 2022
[182] NHS, *NHS long-term plan implementation framework*, June 2019

3	Significant support needs	Bespoke mandated support
4	Very serious, complex issues	Mandated intensive support through the recovery support programme

Mandated support

Mandated support applies when an ICB or trust has serious problems and where there are concerns that the existing leadership cannot make the necessary improvements without support. It involves the use of enforcement powers.

Two levels of mandated support are set out within the *NHS oversight framework*:

- support led and co-ordinated by NHS England regional teams
- intensive support agreed with the regional teams but delivered through the national recovery support programme.

Mandated support will be delivered within the system context and local system partners are expected to be involved where there are links into the ICS for the cause or solution of the need for support.

Recovery support programme

The recovery support programme is system oriented and focuses on the underlying drivers of the problems. Inclusion in the programme is time limited with clear exit criteria.

An experienced system improvement director will be appointed to support the ICB or trust to develop an improvement plan with an indicative timeline for recovery. In addition, NHS England will consider whether there are any wider structural issues that impact the organisation's ability to operate effectively.

Use of resources assessments

The *Use of resources framework*[183] was developed in conjunction with the CQC and a use of resources assessment is published alongside the quality ratings for each provider.

Regional NHS England teams periodically undertake assessments of providers to understand how effectively they are using resources to provide high-quality, efficient and sustainable care for patients. This includes considering how well providers are meeting financial controls, how financially sustainable they are and how efficiently they use their workforce, clinical and operational services.

Use of resources assessments are based on five key lines of enquiry.

Key lines of enquiry for the use of resources assessment

Use of resources area	Key lines of enquiry
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?

[183] CQC and NHS Improvement, *Use of resources: assessment framework*, August 2017

Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

12.3 Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Its purpose is to 'make sure health and social care services provide people with safe, effective, compassionate, high-quality care' and to encourage care services to improve. Its remit covers:

- NHS providers
- adult social care providers
- independent healthcare providers
- dentists
- private ambulances
- NHS out-of-hours services (that are not GP practices)
- GPs and NHS walk-in centres (that do not provide out of hours services).

The CQC has four core functions:

- to register those who apply to them to provide health and adult social care services
- to use information and data to monitor services and then carry out expert inspections, making a judgement of each service and giving an overall rating
- to ask providers to improve where poor care is found (inadequate or requires improvement) and to enforce this if necessary
- to provide an independent voice on the state of health and adult social care in England, helping to share learning and encourage continuous improvement across the sector.

When the CQC registers and inspects services, it uses its single assessment framework[184] across all sectors, service types and providers. The framework involves:

- ratings and asking five key questions (set out below)
- assessing the extent that those being inspected live up to the commitments set out in the quality statements; the statements link directly to regulations
- compiling evidence across the same six categories – for example, feedback from patients, staff and leaders.

The five key questions asked of every service are:

- is the service safe – are people protected from abuse and avoidable harm?

[184] CQC, *How we will regulate*, 2022

- is the service effective – is the care provided based on the best possible evidence, achieve good outcomes and promote a good quality of life?
- is the service caring – do staff involve and treat people with compassion, kindness, dignity and respect?
- is the service responsive – are services organised so that they meet people's needs?
- is the service well-led – does the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, support learning and innovation, and promote an open and fair culture?

Registration

When registering with the CQC, providers must demonstrate that they meet the CQC's fundamental standards of care (see below), as well as the fit and proper persons requirements for board directors and equivalents. Registration effectively represents a licence to operate.

CQC fundamental standards of care

Person-centred care – you must have care or treatment that is tailored to you and meets your needs and preferences.

Dignity and respect – you must be treated with dignity and respect at all times while you're receiving care and treatment. This includes making sure:

- you have privacy when you need and want it
- everybody is treated as equals
- you are given any support you need to help you remain independent and involved in your local community.

Consent – you (or anybody legally acting on your behalf) must give your consent before any care or treatment is given to you.

Safety – you must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Providers must assess the risks to your health and safety during any care or treatment and make sure their staff have the qualifications, competence, skills and experience to keep you safe.

Safeguarding from abuse – you must not suffer any form of abuse or improper treatment while receiving care. This includes:

- neglect
- degrading treatment
- unnecessary or disproportionate restraint
- inappropriate limits on your freedom.

Food and drink – you must have enough to eat and drink to keep you in good health while you receive care and treatment.

Premises and equipment – the places where you receive care and treatment and the equipment used in it must be clean, suitable and looked after properly. The equipment used in your care and treatment must also be secure and used properly.

Complaints – you must be able to complain about your care and treatment. The provider of your care must have a system in place so they can handle and respond to your complaint. They must investigate it thoroughly and take action if problems are identified.

Good governance – the provider of your care must have plans that ensure they can meet these standards. They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to your health, safety and welfare.

Staffing – the provider of your care must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards. Their staff must be given the support, training and supervision they need to help them do their job.

Fit and proper staff – the provider of your care must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.

Duty of candour – the provider of your care must be open and transparent with you about your care and treatment. Should something go wrong, they must tell you what has happened, provide support and apologise.

Display of ratings – the provider of your care must display their CQC rating in a place where you can see it. They must also include this information on their website and make our latest report on their service available to you.

Monitoring and inspection regime

Once a provider has been registered, it must demonstrate on an ongoing basis that it is meeting the fundamental standards of care.

The CQC uses several statements against which to assess the commitment to delivering high-quality person-centred care of providers, commissioners and system leaders. Known as quality statements, they link directly to the regulations set out in the Health and Care Act 2008 (Regulated Activities) Regulations 2014. To support inspections, information and data is gathered from a range of sources including from people using care, providers and partners.

The CQC inspection teams include inspectors, specialist advisors (experts such as senior NHS doctors), and experts-by-experience (people who have personal experience of using a service or caring for someone who has).

An assessment can come at any time, depending on the evidence collected or information received – for example, through whistleblowing concerns or safeguarding reports.

Inspection reports and ratings

The CQC publishes a report after each inspection, that in most cases includes ratings, providing an overall judgement of the quality of care.

CQC ratings

- outstanding: the service is performing exceptionally well
- good: the service is performing well and meeting our expectations

- requires improvement: the service is not performing as well as it should, and we have told the service how it must improve
- inadequate: the service is performing badly, and we've taken action against the person or organisation that runs it.

Concerns, complaints and whistleblowing

The CQC also gathers information about concerns raised by people using services and staff in three main ways:

- encouraging people and staff to make contact through its website and phone line, and providing opportunities to share concerns with inspectors during visits
- asking national and local partners to share concerns, complaints and whistleblowing information
- requesting information about concerns, complaints and whistleblowing from providers.

12.4 National Audit Office

The National Audit Office (NAO) plays an important role in NHS governance as it scrutinises public spending for Parliament. It does this in two main ways:

- conducting financial audits of all government departments and agencies and many other public bodies – this includes the Department of Health and Social Care (DHSC) and its arm's length bodies
- reporting to Parliament on whether government departments and other bodies have used public money efficiently, effectively and with economy.

The results of NAO reports focused on the DHSC can in turn have an impact at the local level - for example, one of the key findings in the NAO report *NHS financial stability 2019*[185] was that 'the current funding flows in the NHS are complicated and do not support partnership working, integration and the better management of demand'.

The Local Audit and Accountability Act 2014 (the Act) makes the Comptroller and Auditor General (C&AG) responsible for the preparation, publication and maintenance of the Code of Audit Practice. The Code sets out what local auditors are required to do to fulfil their statutory responsibilities under the Act. The Act also gives the C&AG power to issue statutory guidance, to which local external auditors are required to 'have regard', when carrying out their work.

When auditing the DHSC and its arm's length bodies (ALBs) accounts, the NAO obtains assurance from the work carried out by auditors on the underlying accounts of individual NHS providers and NHS commissioners.

12.5 Local authorities

Since January 2003, local authorities with social services responsibilities have been able to establish committees of councillors to provide overview and scrutiny of local NHS bodies by virtue of powers set out in section 38 of the Local Government Act 2000. The aim is to secure health improvement for local communities by encouraging authorities to look beyond their own service responsibilities to issues of wider concern to local people. This is achieved by giving democratically elected representatives the right to scrutinise how local health services are provided and developed for their constituents. This scrutiny role was extended by the Health and Social Care Act 2012 to cover any

[185] National Audit Office, *NHS financial stability,* January 2019

provider of NHS funded services. Local authorities also play a key role in public health and health improvement – see chapter 8 for details.

12.6 Other external bodies

There is a wide range of other organisations with an interest in health that can affect governance arrangements. These include:

- professional bodies on both the clinical and managerial side. These organisations often have their own codes of conduct and disciplinary regimes that apply to their members - for example, the Royal Colleges and other independent audit and assurance bodies that provide an assurance to NHS organisations
- other government departments and agencies - for example, the Department for Levelling Up, Housing and Communities. Some of these, such as the Health and Safety Executive, can have a significant impact on the operation of a trust
- non-departmental public bodies, independent and local organisations - for example, local HealthWatch
- representative bodies - for example, the British Medical Association, the NHS Confederation and UNISON
- think tanks and research organisations, such as the King's Fund, the Health Foundation and the Nuffield Trust
- the public – NHS organisations are required to engage with the public and conduct meaningful consultations.

Key learning points

- NHS organisations must be aware of the approach and requirements of all relevant regulatory and inspection agencies.
- NHS England regulates NHS providers and commissioners, using the NHS oversight framework with the emphasis on system performance.
- The CQC regulates providers of healthcare services via a system of registration and compliance with fundamental standards of care.
- The NAO conducts financial audits of all government departments including the Department of Health and Social Care and its ALBs.
- Local authorities have a scrutiny role that extends to all providers of NHS funded services.

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.

HFMA introductory guide to NHS finance

Chapter 13: Governance – how NHS organisations are structured and run

Chapter 13. Governance – how NHS organisations are structured and run

Overview

This chapter's focus is governance, a subject that has received considerable attention over the years following spectacular failings across all sectors of the economy, including the 2008 banking crisis and the much-publicised failings at Mid Staffordshire NHS Foundation Trust. These (and many other) crises have demonstrated just how important good governance is to the wellbeing of an organisation and made clear that it encompasses everything that an organisation does, not just its administrative and support functions. In the NHS this means that effective governance is as much of a concern to a nurse or consultant as it is to an accountant or manager.

It is now widely agreed that delivering high quality health and social care requires collaboration between organisations. As set out in the *NHS long-term plan*, delivering this way of working requires 'strong governance and accountability mechanisms in place for systems to ensure that the NHS as a whole can secure the best value from its combined resources'[186]. The critical governance issue for systems is how to make decisions that are in the best interests of the population that may however have a negative impact on individual organisations. (See chapter 5 for more on system working).

Governance is a huge subject in its own right; this chapter focuses on key aspects relating to NHS finance. If you want to find out more, the HFMA produces a separate introductory guide to governance[187] and an NHS corporate governance map[188] with links to key tools and guidance.

13.1 What is governance?

The terms 'governance' and 'corporate governance' are now interchangeable, but it was the use of corporate governance as a phrase in the 1992 Cadbury Committee Report[189] that initiated widespread debate in this area. Corporate governance was defined in that report as 'the system by which companies are directed and controlled' and its focus was on how companies were run, structured, led and held to account. This report also identified the three fundamental principles of good governance as openness, integrity, and accountability.

13.2 Governance in the NHS

The NHS has been well aware of the importance of governance for many years, with a wide range of separate regulatory frameworks and ethical codes in operation for the different professions working in NHS organisations. The challenge has been to bring together the practices and information systems of these different disciplines in such a way that they form an integrated and effective organisation--wide governance structure.

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[186] NHS England and NHS Improvement, *The NHS Long-Term Plan,* January 2019
[187] HFMA, *Introductory guide – NHS governance,* April 2017
[188] HFMA, *NHS corporate governance map,* updated February 2021
[189] ICAEW, *The financial aspects of corporate governance*, December 1992

The importance of having an integrated approach to governance (i.e., covering all aspects of governance including financial, clinical, and organisational) along with high standards and an open culture has been heightened by failures that have dented public confidence in the NHS and raised questions over how NHS organisations are run.

Examples of governance failures within the NHS

In 2013 the Francis report into Mid-Staffordshire NHS Foundation Trust[190] found the root cause of hundreds of deaths due to poor care and negligence to be the Trust's (and the Trust board's) focus on achieving NHS foundation trust status, which took its attention away from effective oversight.

In 2015 the Kirkup review of maternity services at Morecombe Bay NHS Foundation Trust[191] included concern that deliberate attempts had been made to cover failings, and that dysfunctional relationships within and between NHS organisations were at the heart of this.

In 2020 the public inquiry into mental health services in Tayside[192] noted that 'governance and leadership lie at the heart of the independent inquiry's final report because good governance and leadership are central to the effective delivery of mental health services in Tayside'.

In 2021 the Comptroller and Auditor General's (C&AG) report[193] on the Department of Health and Social Care's (DHSC) annual report and accounts 2020/21 referred to financial reporting and governance issues at University Hospitals of Leicester NHS Trust (UHL). The local auditor noted that adjustments appeared to have been made in the 2018/19 financial statements at the request of UHL's management to achieve a certain outcome rather than to represent accurately the economic reality of transactions into which UHL entered. The auditor's findings related to accounting judgements and manual intervention associated with the previous senior leadership regime at UHL and continued failures in the management and control of accounting records. The C&AG noted that the position at UHL was unprecedented - an NHS trust had failed to comply with the Secretary of State's direction to prepare true and fair accounts and to maintain appropriate accounting records. Moreover, the restatement of the 2018/19 financial statements reflected both financial control failures and a series of actions taken by UHL in the preparation of those accounts that did not reflect the actual substance of the financial transactions entered by the Trust.

Clear linkages were drawn between the scandals and the governance failings that allowed them to continue uncorrected. Investigations into governance lapses have also underlined the need for an open and questioning culture and governance policies, procedures and structures that are comprehensive and work in practice, not just on paper.

These (and other) incidents have driven home to boards just how wide ranging their responsibilities are and emphasised how important it is to see governance arrangements relating to clinical and quality spheres as an integral part of an organisation's overall approach, rather than the preserve of clinicians. The National Quality Board's report[194] made this clear when it stated that 'final and definitive responsibility for improvements, successful delivery, and equally failures, in the quality of care' lie with the provider organisation's board and leaders.

By now it should be clear why an effective and integrated approach to governance is so important and equally obvious that if an NHS organisation gets it wrong it can have a disastrous impact on

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[190] UK Government, *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*, February 2013
[191] UK Government, *The report of the Morecambe Bay investigation*, March 2015
[192] Independent Inquiry into Mental Health Services in Tayside, *Final report of the independent inquiry into mental health services in Tayside,* February 2020
[193] National Audit Office, *The Department of Health and Social Care annual report and accounts 2019-2020,* January 2021
[194] Department of Health and Social Care, *Quality governance in the NHS – a guide for provider boards*, March 2011

patients and undermine public confidence in the service as a whole. But what does this mean NHS organisations need to do in practice?

Lessons from these governance lapses reinforce the importance of:

- an effective board that blends a strategic focus with a system of oversight and scrutiny, providing effective independent challenge of management
- the importance of an effective audit (and risk assurance) committee
- clarity of decision-making and accountability throughout the organisation
- competent and capable senior management
- a culture of openness, both in terms of communication from the top downwards of vision and values as well as communication upwards about areas of concern
- a focus on ensuring that business as usual is operating as it should, including core clinical services and corporate and administrative management
- values and ethics that are clearly articulated and demonstrated through leadership
- the widest possible involvement of stakeholders and understanding of their needs and interests.

NHS bodies must also recognise that governance is as much about behaviour, values and attitudes as about structures, systems, processes and controls. There is no point having a comprehensive governance framework if no-one is committed to it or understands why it exists and what it is designed to achieve.

13.3 Elements of governance

Effective governance arrangements should underpin all that an organisation does, but it is helpful to break it down across three key elements – we will look at each in turn with a focus on financial aspects:

- culture and values (the people issues) - for example, an organisation's leadership style and tone, openness and adherence to relevant legislation and codes of practice
- structures and processes - for example, statutory and regulatory requirements, board and committee structures and internal policies and procedures
- control frameworks - for example, assurance, risk management, internal, external and clinical audit.

13.4 Organisational culture and values

Every organisation develops its own unique culture and values but to be effective, it is essential that there is 'a system of shared values and beliefs about what is important, what behaviours are appropriate and about feelings and relationships internally and externally'[195]. If everyone within an organisation is to 'buy in' to these shared values they must be meaningful, make sense and be realistic. There is no point having a carefully crafted statement of values if it bears no relation to how things actually feel on the front line - for example, it would be a mistake for an organisation to claim that it has a 'no blame culture' if this is not borne out in practice.

[195] Purcell, J., Hutchinson, S., Swart, J., Kinnie, N. & Rayton, B., 2004, *Vision and Values: Organisational Culture and Values as a Source of Competitive Advantage.* Chartered Institute of Personnel and Development, London, UK

Principles of public life

Everyone involved in the public sector brings their own personality, experience, and attitudes with them. However, the public provides the resources for which they are responsible and, as a result, certain ethical standards and values are expected of them – these standards are known as the *Seven principles of public life*[196] and were set out by the Nolan Committee in 1995.

The Nolan principles of public life

Selflessness – holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability – holders of public office are accountable for their decisions and actions to the public and must submit to whatever scrutiny is appropriate to their office.

Openness – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.

Honesty – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership – holders of public office should promote and support these principles by leadership and example.

The Treasury's guidance document, *Managing public money*[197] sets out the standards that it expects all public services to deliver, which overlap with the Nolan principles:

- honesty
- accountability
- integrity
- reliability.
- transparency
- impartiality
- accuracy
- fairness
- objectivity
- openness

The Treasury adds that organisations should carry these standards out 'in the spirit of, as well as to the letter of, the law in the public interest, to high ethical standards, achieving value for money.'

The introduction of a statutory duty of candour is a direct response to the recommendation made in the Francis inquiry report, that stressed its importance alongside openness and transparency.

[196] Committee on Standards in Public Life, *The seven principles of public life*, May 1995
[197] HM Treasury, Managing Public Money, March 2022

Openness, transparency and candour

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy agreed, regardless of whether a complaint has been made or a question asked about it.

Together, the Nolan principles, the Treasury standards and the recommendations set out in the Francis inquiry report provide a blueprint for the underlying culture and values of any public sector organisation.

Leadership

Effective leadership is also important. The *Good governance standard for public services*[198] recognises this when it states that 'good governance flows from a shared ethos or culture' and that it is 'the governing body that should take the lead in establishing and promoting values for the organisation and its staff.' In other words, the culture and values of an organisation are set from the top. In the context of the NHS this means that the behaviour, approach and leadership style of the board and senior management are critical in establishing an organisation's tone, 'feel' and direction.

NHS Constitution

The *NHS constitution*[199] further emphasises the importance of having clear (and consistently applied) principles underpinning all that the NHS does. All providers and commissioners of NHS care in England have a statutory duty to have regard to the *NHS constitution* in all their decisions and actions.

Of particular note in governance terms are the principles and values set out in the Constitution as these must underpin everything that an organisation does.

Principles

- the NHS provides a comprehensive service, available to all
- access to NHS services is based on clinical need, not an individual's ability to pay
- the NHS aspires to the highest standards of excellence and professionalism
- the patient will be at the heart of everything the NHS does
- the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- the NHS is accountable to the public, communities and patients that it serves.

[198] Joseph Rowntree Foundation, *Good governance standard for public services,* 2005
[199] Department of Health and Social Care, *NHS constitution for England,* updated January 2021

Values

- working together for patients
- respect and dignity
- commitment to quality of care
- compassion
- improving lives
- everyone counts.

The *Francis inquiry report* recognised the importance of the Constitution when it stated that:

- it 'should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.' (recommendation 3)
- its core values 'should be given priority of place and the overriding value should be that patients are put first and everything done by the NHS and everyone associated with it should be informed by this ethos'. (recommendation 4)

Legislation

There are two Acts of Parliament that are worthy of note here as they both have links to an organisation's culture:

- the *Freedom of Information Act 2000*[200] means that NHS bodies are required to answer questions from members of the public and make information available to them. In addition, the government has introduced requirements in relation to transparency which requires the publication of items of spend over £25,000.
- the *Bribery Act 2010*[201] applies to both organisations and individuals and means that NHS bodies must ensure that they have in place adequate procedures to prevent bribery taking place. If they fail to do this, organisations can be prosecuted for the failure to prevent a bribe being paid on the organisation's behalf - for example, when placing a contract for a major service or investment.

Codes of practice

Since the early 1990s, several codes of practice[202] have been issued to provide practical guidance on behavioural aspects of governance. For the most part, the content of these codes has been incorporated into legislation or tailored guidance but the key messages that were set out in the *Code of conduct: code of accountability in the NHS*[203] are worth repeating – namely that board members must adhere to three crucial public sector values that are at the heart of the NHS:

- accountability – everything done by those who work in the NHS must be able to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct
- probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties
- openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients, and the public.

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[200] UK Government, *Freedom of Information Act 2000,* 2000
[201] UK Government, *Bribery Act 2010*, 2010
[202] Including, the *Code of conduct: code of accountability in the NHS* (1994), the *Code of conduct for NHS managers* (2002) and *NHS foundations trusts: code of governance* (2014)
[203] Department of Health, *Code of conduct: code of accountability in the NHS*, updated July 2004

Each ICB[204] has a constitution setting out the board membership and governance arrangements for the organisation. This requires that 'The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.'

NHS trust and ICB board members are expected to follow the *Standards for Members of NHS Boards and Governing Bodies in England*[205] issued by the Professional Standards Authority. These standards cover personal behaviour, technical competence, and business practices.

The Financial Reporting Council *Guidance on board effectiveness*[206] identifies the following signs of a possible culture problem:

- silo thinking
- dominant chief executive
- leadership arrogance
- pressure to meet the numbers/ overambitious targets
- lack of access to information
- low levels of meaningful engagement between leadership and employees
- lack of openness to challenge
- tolerance of regulatory or code of ethics breaches
- short-term focus
- misaligned incentives.

13.5 Structures and processes

Organisational structures

The government (via the Secretary of State, the Department of Health and Social Care (DHSC) and its arm's length bodies (ALBs)) sets the structural arrangements that must be followed for the 'top' management and leadership structures of NHS organisations.

Although these structures vary according to the type of organisation, two basic principles apply to all – each must have its own governing body (the board) and a designated 'accountable' (or 'accounting') officer.

In addition, FTs have a council of governors to represent local interests and which 'binds a trust to its patients, service users, staff, and stakeholders'[207]. The council's key role is to 'hold the non-executive directors, individually and collectively, to account for the performance of the board of directors and to represent the interests of the FT's members and of the public'. Governors are also expected to act in the best interests of the FT and are responsible for sharing information about key decisions with their membership community.

[204] NHS England, *The constitutions of integrated care boards (ICBs),* July 2022
[205] Professional Standards Authority, *Standards for members of NHS boards and clinical commissioning group governing bodies in England*, November 2013
[206] Financial Reporting Council, *Guidance on board effectiveness*, July 2018
[207] Monitor, *Your statutory duties: a reference guide for NHS foundation trust governors*, August 2013

The purpose of the board

The board is responsible for the strategies and actions of the organisation and is accountable to its members (in the case of FTs), the public and, ultimately, to Parliament. The board also monitors the achievement of the organisation's objectives (and looks for potential problems and risks that might prevent them from being achieved) and receives assurances that things are working as they should.

Given its status and role, there is a range of responsibilities and decisions that the board cannot delegate. These are referred to as being 'reserved to the board'.

Examples of activities reserved to the board

- financial stewardship responsibilities - for example, adopting the annual report and accounts that all NHS bodies are required to produce
- determining the organisation's strategy and policies and setting its strategic direction
- appointing senior executives
- overseeing the delivery of services
- standards of governance and behaviour.

In addition, an NHS organisation's board is free to agree other issues that only it will deal with and must also decide which responsibilities it will delegate by drawing up a scheme of delegation.

The composition of the board

The board brings together in a decision-making forum the executive directors and the non-executive directors (NEDs) of the organisation and is separate from the day-to-day management structure. Each board is led by an independent, non-executive chairperson.

NEDs play a particularly important role on the board as they provide independent, constructive challenge and a breadth of experience. By balancing the views of executive directors, they also ensure that power is not concentrated in a few hands so preventing any individual or small group from dominating the board's decision-making.

The exact structure of each board is different for each type of NHS body and is set out in legislation and associated regulations[208].

The boards of both non-foundation trusts and FTs comprise a chairperson, executive members (who are employees of the NHS organisation) and independent NEDs, who must be in the majority. The executive directors must include a medical director and nursing director as well as the chief executive and chief finance officer (CFO).

ICB boards must include at least two independent members, at least one registered nurse and a doctor. The ICB's chief executive and CFO must also be members of the board.

Appointments to the board

In FTs the council of governors appoints the NEDs in line with a code of governance; this recommends that there 'should be a formal, rigorous and transparent procedure for the appointment or election of new members to the boards of directors' and that appointments should be made 'on merit and based on objective criteria.' To ensure that this is the case in practice, the code recommends a nomination committee to ensure that independence is enshrined in the process and appointments are made on the basis of need (in terms of the board's needs) and competency (in

[208] For non-foundation NHS trusts: regulations 2 and 4 of the 1990 Trust Membership and Procedure Regulations (SI 1990/2024). For FTs: schedule 7 to the NHS Act 2006.

relation to the individual's ability). The code also states that it is 'desirable' for there to be a majority of governor votes on nominations committees. Final decisions about the appointment of NEDs must be taken at a meeting of the council of governors.

In NHS trusts, NHS England is responsible for appointing, re-appointing (and where necessary terminating) chairs and NEDs. Appointees are chosen from lay people within the community that the organisation serves and are selected with a view to ensuring a balance of skills and experience - for example, there may be NEDs with professional qualifications in law or accountancy and others who have experience as a user of NHS services.

ICBs appoint their own independent members.

Board committees

To help a governing body discharge its duties effectively, several committees are normally established. Although it is up to each organisation to decide what committee structure best suits its needs, there are several mandatory committees, discussed in turn below. For ICBs, the constitution sets out how it will discharge its functions including what committees and sub-committees are in place. It is usual for a board to also have additional committees that are not mandated, such as finance and performance, or quality and governance.

Oversight is achieved by a combination of reports to the board and the more detailed scrutiny undertaken by board sub-committees. Boards should agree what information is reported to the board as a whole and what information is provided to the board's sub-committees.

Audit committee

Every NHS organisation must have an audit committee that reports to the board. This committee's distinctive characteristic is that it comprises only independent non-executive members – there is usually at least three, to allow for a quorum of two. In addition, the chairperson of the organisation should not be a member, although may attend by invitation. The fact that only non-executives can be members should allow the audit committee to operate independently of executive management and to be objective when considering the opinions from independent auditors, and scrutinising the arrangements put in place and operated by the organisation's executive.

The chief executive and all other executive directors attend whenever they are invited by the audit committee chair and, in particular, to provide assurances and explanations to the committee when it is discussing audit reports or other matters within their areas of responsibility.

Detailed guidance about the role of audit committees is set out in the HFMA's *Audit committee handbook*[209] and its supplement[210]. This makes clear that one of the audit committee's key duties is to 'review 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), that supports the achievement of the organisation's objectives'.

Auditor panels

Non-foundation NHS trusts and ICBs must also have an auditor panel to advise on the selection, appointment, and removal of external auditors and on maintaining an independent relationship with them. This applies to appointments that started on or after 1 April 2017. In most cases, existing audit committees (or members of those committees) are nominated to act as the auditor panel.

[209] HFMA, *Audit committee handbook,* March 2018
[210] HFMA, *NHS audit committee handbook supplement*, November 2022

In FTs it is the responsibility of the council of governors to appoint, re-appoint and remove the external auditor and approve their remuneration and terms of engagement. Support and guidance are provided by the audit committee.

Remuneration committee

The remuneration (and terms of service) committee is another committee that is mandatory for all NHS organisations and reports to the board. Its role is to advise the board about the pay, other benefits and terms of employment for the chief executive and other senior staff.

In FTs, the remuneration committee should be composed of NEDs including at least three who are independent.

In NHS trusts, the committee's membership comprises at least two NEDs and the trust's chairperson.

For ICBs, only members of the board can belong to the remuneration committee.

Accountable or accounting officers

Every NHS organisation has an 'accountable' (or 'accounting') officer. This is a formal role conferred upon the organisation's chief officer (usually the chief executive).

The role of the accountable officer is a key element in governance terms with a line of accountability for the proper stewardship of public money and assets and for the organisation's performance stretching up to Parliament. The accountable officer is also accountable to the organisation's board for meeting the objectives it sets, for day-to-day management and for ensuring that governance arrangements are effective.

For non-foundation NHS trusts, accountable officers are accountable to the NHS England's accountable officer who is in turn accountable to the DHSC's accounting officer (and on to the Secretary of State and Parliament). For FTs, accounting officers are accountable directly to Parliament (with NHS England providing regulatory oversight)[211]. For ICBs, the accountable officers are accountable to NHS England's accountable officer who is in turn accountable to the DHSC's accounting officer (and on to the Secretary of State and Parliament).

Chief finance officers

CFOs (also called finance directors or directors of finance) of health organisations are automatically executive directors with a seat on the board. This is in line with the Treasury's guide *Managing public money* which states that the CFO should 'have board status equivalent to other board members' and that he or she should be 'a member of the senior leadership team'. Where a CFO fulfils the role for more than one organisation, he or she must be on the board of each organisation.

Executive management

Each NHS organisation must have an effective management structure designed to achieve its statutory duties and implement the strategic objectives and policies agreed by the board. This structure will vary between organisations but should ensure that all areas of responsibility are clearly accountable to a manager and ultimately to an executive director.

[211] This is the reason for the two slightly different terms – an accounting officer - for example, in a foundation trust or the Department of Health and Social Care is directly accountable to Parliament (via the Public Accounts Committee) but an accountable officer - for example, in an ICB or NHS trust, is responsible to an accounting officer of a government department who is in turn accountable to Parliament.

Fit and proper persons

All NHS provider organisations have a duty[212] not to appoint a person to an executive level post (including associate directors) or to a non-executive position unless they are judged to be a 'fit and proper person'. In other words that they:

- are of good character
- have the necessary qualifications, skills and experience
- can perform the work that they are employed for
- can supply information as set out in the regulations as required by the Care Quality Commission (CQC).

The 2019 review[213] of the fit and proper persons test for senior managers, led by Tom Kark QC, said new competency standards should be created for directors on NHS boards and where training is needed it should be made available. This was accepted, together with a recommendation that the government should set up a national database of directors' qualifications, previous employment, and performance.

Organisational processes

Effective internal procedures and controls are an essential part of an effective framework of governance. Collectively these are sometimes referred to as business rules. Key elements that NHS organisations need to think about in relation to finance are:

- standing orders
- procedures for dealing with any conflicts of interest
- standing financial instructions
- policies and procedures.

Standing orders (SOs)

All NHS organisations must have standing orders (SOs) that provide a comprehensive framework for carrying out activities and are therefore a critical element in the governance framework. Effectively, SOs are the link to an organisation's statutory powers and translate these powers into a series of practical rules designed to protect the interests of both the organisation and its staff. In FTs and ICBs, SOs form part of the constitution.

What standing orders contain

Most provisions within SOs relate to the business of running the board and structure of its committees - for example:

- the composition of the board and committees
- how meetings are run
- form, content, and frequency of reports
- what constitutes a quorum
- record of attendance
- voting procedures.

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[212] As set out in the *Health and Social Care Act 2008* (Regulated Activities) Regulations 2014
[213] Department of Health and Social Care, *Kark review of the fit and proper persons test,* March 2019

Other areas covered include:

- appointment of committees and sub–committees
- scheme of delegation – a detailed listing of what the board alone can decide on and who it empowers to take actions or make decisions on its behalf
- decisions reserved to the board – those decisions that the board cannot delegate
- standards of business conduct - for example, relating to how contracts should be awarded to prevent bias
- declarations of interest
- register of interests and hospitality
- duties and obligations of board members.

Conflicts of interest

One area covered by SOs that often receives particular attention relates to standards of business conduct and declarations of interest and registers of interests/ hospitality. In 2017, NHS England published *Conflicts of interest in the NHS - guidance for staff and organisations*[214], applicable to clinical commissioning groups (CCGs) (via the statutory guidance to CCGs), NHS trusts, NHS foundation trusts and NHS England (through the standards of business conduct). It introduced common principles for managing conflicts of interest; provides advice about what to do in common situations; and supports good judgement about how interests should be approached and managed.

Board members must declare any personal or business interests or relationships that may influence (or be perceived to influence) their judgement or decisions. The fundamental principle is that no one should use their public position for private gain, either for their own benefit or for the benefit of those close to them - for example, if a board member or member of staff has any interest in a contract, that interest must be disclosed, and they must take no part in the evaluation process or decision.

It is important that both actual and potential conflicts of interest are declared and managed as any outside interest, hospitality or sponsorship represents a risk of a conflict arising. The procedures followed to manage conflicts of interest also help protect individuals from any subsequent allegations of bias.

In addition, the *Bribery Act 2010* makes it an offence to accept gifts or hospitality as an inducement or reward for doing something in your public role and staff are advised to refuse to accept such gifts or hospitality rather than declare them subsequently. There is usually some leeway for minor gifts - for example, pens or diaries, but the offer of higher value items should be questioned. The key point here is that board members and staff must be open about any gifts they have received or been offered. A simple concept is to think about how it would look on the front page of the local newspaper: if the action or gift could not be defended then it should not be carried out or accepted.

Standing financial instructions (SFIs)

SFIs cover financial aspects in more depth and set out detailed procedures and responsibilities. They are designed to ensure that NHS organisations account fully and openly for all that they do through setting the financial control environment and scheme of delegation. SFIs are detailed rules that must be complied with. Although FTs are not required to have SFIs many do, and others have written financial procedures that fulfil the same function.

Other policies and procedures

For NHS bodies to run smoothly and effectively, many more policies and procedures (both financial and non-financial) are required, all of which contribute to the achievement of the organisation's

[214] NHS England, *Conflicts of interest in the NHS - guidance for staff and organisations,* February 2017

overarching objectives. These policies and procedures cover a wide variety of areas and are usually pulled together in manuals and made available to all staff via the organisation's intranet. They should include a whistleblowing policy, to ensure that concerns raised by staff and other stakeholders about possible improprieties in financial, clinical or safety matters are taken seriously, without adverse consequences for the person raising that concern. Existence of any particular policy is not in itself sufficient; the policy must be up to date and applied effectively.

13.6 Control frameworks

Internal control

Internal control comprises the systems and processes that an organisation has in place to assist and ensure that things are running as they should, and that the organisation is achieving its objectives and meeting its legal and other obligations. It includes the governance framework, risk management, information and communications, monitoring processes, and assurance activities.

The board is responsible for ensuring that there is an effective system of internal control and that it:

- identifies and prioritises the risks to the achievement of the organisation's objectives
- evaluates the likelihood of those risks being realised and the consequent impact
- manages the risk efficiently, effectively and economically.

In practice, this means that at the core of an effective internal control system there needs to be a structured approach to identifying objectives, risks, and mitigations. In the NHS, this structure is reported through an assurance framework underpinned by a risk management system.

Assurance framework

The HFMA's *NHS audit committee handbook*[215] describes the assurance framework as 'the key source of evidence that links the organisation's 'mission critical' strategic objectives to risks, controls and assurances, and is the main tool that the governing body uses in discharging its overall responsibility for internal control'.

Each organisation designs its own 'assurance framework' (sometimes referred to as a board assurance framework or BAF) based on a sound understanding of the strategic risks that could prevent the organisation achieving its agreed objectives and the potential effect each risk could have on those objectives.

However, there are several essential components identified in the Department of Health's 2003 publication *Building an assurance framework: a practical guide*[216] as set out below.

How to build an assurance framework

1. Establish strategic objectives
2. Identify the principal (or strategic) risks that may threaten the achievement of these objectives
3. Identify and evaluate the design of key controls intended to manage these principal risks
4. Identify the arrangements for obtaining assurance on the effectiveness of these key controls
5. Evaluate the reliability of the assurances identified

[215] HFMA, *NHS audit committee handbook,* March 2018
[216] Department of Health, *Building an assurance framework: a practical guide,* 2003

6. Identify positive assurances and areas where there are gaps in controls and/ or assurances

7. Put in place plans to take corrective action where gaps in controls and/ or assurances have been identified in relation to principal (strategic) risks

8. Maintain dynamic risk management arrangements including, crucially, a well-founded risk register.

The management of risk

In an organisation the management of risk is a formal process to ensure that all the main risks are identified, their importance is assessed and appropriate ways of reducing them agreed and implemented. One of the biggest mistakes that people make is thinking that filling in the risk register is the same as managing the risks. It is not. Managing risk involves management action while a register is simply a recording device.

Risk is subjective and the extent that an organisation manages risk depends on what level of risk it can live with. This is known as risk appetite.

For an organisation's assurance framework to be effective it must be underpinned by a robust approach to risk management. This involves identifying and managing risks, particularly those that present the biggest challenge in management terms.

There are several ways – individually or in combination - in which managers can mitigate risk. These are often described as the 'five ts':

- terminate the action and therefore avoid the risk completely
- transfer the risk, or the management of the risk, to another person or organisation because they are better able to manage it
- tolerate the risk, without any further action
- take the risk because the potential gains are expected to outweigh the potential losses
- treat the risk through a range of management or mitigation tools (usually seen as internal controls).

The basics of managing risk are straightforward – it is about being aware of potential problems, thinking through what effect they could have and planning ahead to prevent the worst-case scenario.

The three lines of defence model

The 'three lines of defence' model[217] helps senior managers and the board get information systematically on how objectives are being met and risks are being managed. The term 'defence' is used as the model shows how directors might protect themselves from any allegations of not having due processes.

The first line of defence is reporting by line management on the operation of the controls they are responsible for. The second line of defence is that of management oversight functions - for example, management of risk or compliance. The third line of defence is internal audit (and similar functions) that are inside the organisation but operate to professional standards to provide 'independent' assurance to the board. Additional (or fourth line) assurance comes from external sources - for example, external auditors, inspectors, and regulators.

[217] Chartered Institute of Internal Auditors, *Application of the three lines model,* 2020

Internal audit

All NHS bodies are required to have an internal audit function that plays a key role in assurance by providing an independent and objective opinion to the accountable/ accounting officer, board, and audit committee on the extent to which the management of risk, control and governance arrangements support the aims of the organisation. Each year the head of internal audit must produce an opinion that is used by the accountable or accounting officer to inform the governance statement. This statement forms part of each organisation's annual accounts and draws together 'position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism'. See chapter 11 for more details about this statement and the annual accounts.

Clinical audit

Another important element of the management of risk and assurance framework is clinical audit – a process that is carried out by healthcare professionals themselves and involves:

- setting standards
- measuring current practice
- comparing results with standards
- changing the way things are done
- re-auditing to make sure practice has improved.

In its guide, *Best practice in clinical audit*[218], the National Institute for Health and Care Excellence (NICE) states that it sees clinical audit as being 'the component of clinical governance that offers the greatest potential to assess the quality of care routinely provided for NHS users' and that it (clinical audit) 'should therefore be at the very heart of clinical governance systems'.

For NHS boards, managing clinical risk is just as important (if not more so) as managing financial and business risk. Good clinical audit is, therefore, an enormous asset and source of assurance.

Counter fraud and corruption

The emphasis on dealing with fraud and corruption in the NHS has increased significantly over recent years. The NHS Counter Fraud Authority (NHSCFA)[219] is a special health authority tasked to lead the fight against fraud, bribery and corruption in the NHS.

In January 2021, the NHSCFA rolled out new counter fraud requirements, applicable to all NHS funded services, in relation to the *Government Functional Standard GovS 013: counter fraud*[220]. The standard sets expectations for the management of fraud, bribery, and corruption across government and wider public services.

[218] National Institute for Health and Care Excellence, *Best practice in clinical audit,* 2002
[219] NHS Counter Fraud Authority, *About us,* 2022
[220] UK Government, *Government Functional Standard GovS 013: Counter Fraud*, August 2021

Key learning points

- The three fundamental principles of governance are openness, integrity and accountability.
- An effective approach to governance should underpin everything that an organisation does.
- Clinical and financial scandals have shown clear links to governance failings – if an NHS organisation gets its approach to governance wrong it can have a catastrophic impact.
- There are three key elements to governance – culture and values; policies structures and processes; control frameworks.
- Good leadership and management are crucial to sound governance as is a shared ethos or culture and a 'tone' that is set from the top.
- Everyone who works in the public sector should adhere to the seven principles of public life.
- The principles and values set out in the *NHS Constitution* should underpin all that an organisation does.
- Every NHS organisation must have a board, audit and remuneration committees, an accountable/ accounting officer and a chief finance officer.
- The board (that includes both executive and non-executive members) is responsible for the strategies and actions of the organisation and is ultimately accountable to the public and Parliament.
- One of the audit committee's key roles is to review the system of integrated governance, management of risk and internal control across the whole of the organisation's activities.
- The remuneration committee advises the board about pay, benefits and terms of employment of senior staff.
- The accountable/ accounting officer is accountable to the organisation and (ultimately) to Parliament.
- Standing orders provide a framework for carrying out activities and translate statutory powers and duties into practical rules that all must abide by.
- Organisations need an effective and comprehensive system of internal control that is designed to ensure that things are running as they should.
- All NHS organisations must have clear objectives and an understanding of the risks that could prevent their achievement, the possible impact and how they can be avoided.
- An assurance framework links key objectives and risks with the main sources of assurance used by the board to ensure effective internal control.
- Managing clinical risk is just as important (if not more so) as financial and business risk, clinical audit is therefore a key source of assurance in this area.
- Counter fraud is overseen by the NHS Counter Fraud Authority.

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, including a section dedicated to risk management and governance. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 14: Revenue planning and budgeting

Chapter 14. Revenue planning and budgeting

Overview

NHS organisations are responsible for spending taxpayers' money to ensure that patients have access to high quality care, free at the point of delivery. As this is taxpayers' money there is an absolute requirement to demonstrate that the money is used well and for its intended purpose. Every NHS organisation also has a specific statutory duty to make 'proper arrangements for securing economy, efficiency and effectiveness in its use of resources'. To be able to meet this requirement, each organisation needs to plan the activities it will deliver or commission and establish the associated resource implications – not just in terms of money but also in relation to staffing, equipment, supplies and so on.

Planning and budgeting take place in two areas, revenue and capital, that are then brought together in an overall plan. This chapter focuses on the revenue side – in other words, how NHS organisations plan and budget for their day-to-day activities. Capital planning is covered in chapter 15.

14.1 Why are revenue planning and budgeting important?

Revenue planning and budgeting are integral parts of an organisation's business planning process and help it by establishing:

- an agreed way ahead
- key aims and objectives
- how those aims will be achieved and by when
- a framework for day-to-day operations and decisions
- a performance management and accountability framework.

14.2 What the planning process involves – key documents

The planning process enables the NHS to allocate its resources to meet both national and local priorities. It is designed to facilitate the efficient and effective delivery of high-quality services, demonstrate accountability and ensure consistency with national policy and local plans, targets and outcomes frameworks. It also supports integrated care systems (ICSs) to work together to develop joint plans to improve population health, through ensuring that system wide priorities are agreed, and all partners are resourced appropriately. To find out more about the role of the ICS, see chapter 5.

During the Covid-19 pandemic the normal planning process was suspended. However, full planning guidance has been issued for 2022/23[221], supported by several other supporting guidance documents, covering revenue finance and contracting[222], capital[223], and elective recovery[224].

[221] NHS, *2022/23 priorities and operational planning guidance*, December 2021
[222] NHS, *2022/23 priorities and operational planning guidance: revenue finance and contracting guidance*, April 2022
[223] NHS, *2022/23 priorities and operational planning guidance: capital guidance for 2022-25*, April 2022
[224] NHS, *2022/23 priorities and operational planning guidance: elective recovery planning support guidance*, April 2022

Together, these four documents provide the information that local systems and organisations need to develop their plans for 2022/23 and beyond.

There are several key documents that are required as part of the planning process:

- a system level implementation plan that address the requirements published in the NHS long term plan[225]
- an annual system operating plan for the local health economy, covering shared priorities and parameters for organisational planning to meet the implementation plan. This is supported by system level activity, financial and workforce plans
- an annual organisational operating plan to support the delivery of the system operating plan. This is supported by organisational level activity, financial and workforce plans
- a long-term (usually 3 to 5 years) strategic business plan for the organisation. This is sometimes referred to as the integrated business plan (IBP)
- a long-term financial plan for the organisation that looks at best case and downside scenarios.

NHS long term plan implementation plan

The *NHS long-term plan* implementation plan sets out what the system plans to deliver over the next five years, linking to the priorities set out in the *NHS long term plan implementation framework*[226]. Current plans cover the period from April 2020 to March 2024. The plan includes a description of local need and how services will be developed to address this need.

Plans are expected to align with the following principles:

- **clinically-led**: In practice this means that systems will need to identify and support senior clinicians to lead on the development of implementation proposals for all NHS long term plan commitments that have clinical implications and on the totality of their plan.
- **locally owned**: Build on existing engagement with local communities to ensure they can meaningfully input into the development of local plans.
- **realistic workforce planning**: Systems should set out realistic workforce assumptions, matched to activity and their financial envelope.
- **financially balanced**: Systems need to show how they will deliver the commitments in the plans within the resources available.
- **delivery of all commitments in the *NHS long term plan* and national access standards**
- **phased based on local need**: While the *NHS long term plan* must be delivered in full, this does not mean that all initiatives should be implemented simultaneously everywhere. The scale and pace of local implementation should be based on local need and priorities.
- **reducing local health inequalities and unwarranted variation**: System plans should set out how they will use their allocated funding to deliver tangible improvements in health outcomes and patient experience and help reduce local health inequalities.
- **focussed on prevention**: System plans must consider not just how to deliver health services but how to prevent ill health.

[225] NHS England, *The NHS long term plan,* January 2019
[226] NHS England, *Long term plan implementation framework,* June 2019

- **engaged with local authorities**: System plans should expect to be developed in conjunction with local authorities and with consideration of the need to integrate with relevant local authority services.
- **driving innovation**: All system plans must consider how to harness innovation locally.

Strategic business plan

Each individual NHS organisation also has its own individual long-term strategic business plan. The business plan is the written end product of a process that identifies the aims, objectives and resource requirements of the organisation over a three-to-five-year period. It is a detailed document that sets out the assumptions that underlie service plans and budgets for the period covered.

What a business plan includes

- an activity and income and expenditure plan, together with cashflow plan
- details of planned service developments
- savings/ waste reduction or cost improvement plans (CIPs)
- performance measures
- workforce implications
- a strategy for the organisation's support services - for example, the estate and information technology
- an analysis of the needs and priorities of the wider health community and how and where the organisation fits in; it is particularly important that this is in line with the requirements set out by the integrated care partnership in the integrated care strategy.

The business plan is considered and approved by the organisation's board and then used as a benchmark against which to measure progress towards achieving the organisation's aims and objectives. In practice, this means that the business plan is kept under constant review and updated to reflect the impact of external changes - for example, government announcements, and internal developments such as clinical techniques.

Long term financial plan

Accompanying the business plan, a long-term financial plan is used by NHS organisations to look at the financial impact of achieving their goals over the medium to long term (again over a three to five year period). This plan focuses on the assumptions made in the business plan and enables the organisation to see how potential changes - for example, local demographics could affect financial viability. The long-term financial plan also includes an analysis of best case and downside scenarios – enabling the organisation to anticipate what might happen if things do not go as planned and have strategies in place to mitigate the impact if they do.

Operational plan

Operational plans show how national targets - for example, as set out in the *NHS constitution*[227] and the *NHS long term plan* and local priorities - for example, as set out in joint local health and wellbeing strategies and joint strategic needs assessments developed by health and wellbeing boards (see chapter 8) will be delivered within available resources. They are used by the ICB to outline how it intends to address health inequalities, improve health outcomes and better focus healthcare provision in line with integrated care partnership intentions and strategies, national and local priorities. For providers, the focus of an operational plan is how they will deliver the services agreed

[227] Department of Health and Social Care, *The NHS constitution for England*, March 2012 (updated January 2021)

with commissioners as well as meet their own objectives and priorities - for example, the need to achieve required savings or carry out service re-design or integration.

Operational plans are reviewed regularly throughout the year and if significant issues arise that affect progress, adjustments are made - for example, if serious financial problems develop in the health economy.

Financial plan

Alongside the operational plan, all NHS organisations must produce an annual financial plan (usually referred to as the budget) that shows the expected income and expenditure of its planned activities for the coming year (both revenue and capital) and demonstrates that the organisation will achieve its financial duties. Chapter 11 looks in detail at these duties but in relation to the budget, the key statutory requirement for NHS providers and commissioners is that they must not spend more money than they have coming in, in other words, they must at least break-even (achieve a 'balanced budget') or deliver a surplus. Although NHS foundation trusts do not have a specific statutory duty to break-even, they must remain solvent if they are to continue as going concerns.

To assess the financial position accurately, the budget must cover all expected sources of income and expenditure across the full range of activities for which the organisation is responsible and take account of other non-financial information, such as activity levels, savings schemes and staffing requirements. The budget is approved by the board in March and is then used to monitor progress and performance throughout the year so that an organisation knows how much income it is receiving, what it is spending, and how much it is overspending or saving at any point in time.

For commissioners, the expenditure side of the budget is based on the activity levels that they have commissioned from providers to meet their commissioning intentions. For providers, the expenditure budget is based on the capacity and workforce they need to have available to meet these levels of activity. This will include the costs of running a service, department or organisation on a day-to-day basis - for example, to meet the costs of staff pay, travel expenses, overheads, drugs and other consumables. Providers will also have a budget for income - for example, split between income for patient care activity, teaching and education, and other areas such as research and development activity and commercial activities such as catering and the treatment of private patients.

The capital budget is based on plans for major spending on land, buildings, equipment and other durable items that are expected to be used for more than one year and have a value of £5,000 or more. This expenditure is subject to separate funding and regulations (see chapter 15 for details).

14.3 Budgeting in practice

Approaches

Although organisations refer to their budget (singular), it is actually made up of a series of separate budgets for each activity, service, department or practice. Each part of the organisation develops its own financial, workforce and activity plans to indicate how it will use its share of the money to meet needs and priorities within the overall strategy. There are three basic budgeting approaches: historic, zero-based and activity-based. The NHS tends to use a combination of all three.

Historic or incremental budgeting – this uses the previous year's budget, adjusted for known changes - for example, as required in cost improvement programmes, cost rises (such as, pay awards and other inflationary factors) and developments - for example, if a new service is introduced

or another discontinued or if National Institute for Health and Care Excellence (NICE) guidance changes. Allowance is also made for the financial consequences of any new policy developments.

Zero-based budgeting – this involves starting with a blank sheet of paper each year and results in a completely fresh financial plan. It tends to be used for the introduction of new services or when activities are under review.

Activity-based budgeting – this approach looks at what drives costs and is linked to activity levels. It requires those involved in setting the budget to know and understand the costs of delivering particular activities and services - for example, being clear about what costs are fixed and those that are variable (i.e. costs that will increase or decrease as activity increases or decreases – see chapter 17 for more on costing). The aim is to ensure that no matter what the actual level of activity, the correct resources are available to fund it.

Budget management

Another important feature of any budget in the NHS is that it is not the sole responsibility of the finance experts. It is essential to have a single named individual responsible (at the operational/ service level) for developing and managing each budget (the budget holder or manager). That person uses their knowledge and experience to help develop the budget and has the authority to take decisions relating to it. This means that responsibility for a budget must be aligned with the ability to control income and expenditure (i.e., the ability to take decisions that will incur a cost or result in a flow of income). To be effective, a budget holder must understand what needs to be delivered and which organisational, local and national objectives they contribute to. As such, the finance manager will provide information, advice and support, but ultimate responsibility lies with the budget holder.

In practice, this means that each budget is managed at the lowest practicable level in the organisation by the person who understands the activity or service covered and who is responsible for committing the expenditure. This is known as devolved budget management.

Budget monitoring

Once a budget is agreed, it is used by the budget holder to monitor how the budget is performing via regular (usually monthly) monitoring. In other words, actual performance is compared with what was planned so that, when necessary, corrective action can be taken - for example, there may be an unexpected increase in the cost of equipment, or a new initiative may fail to deliver the level of savings expected.

14.4 The planning process – key external constraints

Given that all NHS organisations are statutory bodies, they do not have a free hand when it comes to developing their plans. Instead, they must follow national planning guidance, reflect national policy imperatives, meet targets and financial duties set by government and reflect local priorities. The main factors that directly affect revenue planning are:

- the *NHS constitution*
- the *NHS outcomes framework*[228],[229]
- the *NHS long term plan*
- annual planning guidance
- efficiency requirements

[228] NHS Digital, *About the NHS Outcomes Framework (NHS OF)*, 2022
[229] NHS Digital, *NHS outcomes framework*, March 2022

- quality, innovation, productivity and prevention (QIPP) plans
- allocations – the money received from the Treasury via the DHSC or NHS England
- the national tariff document
- National Institute for Health and Care Excellence (NICE) guidelines
- local system planning.

The *NHS constitution* and the *NHS outcomes framework*

The *NHS constitution* and the *NHS outcomes framework* are key documents for all NHS organisations as they set out overall objectives and responsibilities that apply across the board. The Constitution's focus is on overarching rights, values and principles. The *NHS outcomes framework* has a more direct impact on day-to-day planning as it sets out what NHS organisations are expected to achieve in terms of healthcare outcomes for patients across five broad domains. For each domain several areas for improvement are identified but there are no set targets associated with them.

NHS outcomes framework – the five domains

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill-health or following injury
4. Ensuring people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Annual planning guidance

The current planning guidance, *2022/23 priorities and operational planning guidance*, covers the period during which CCGs were abolished and integrated care boards (ICBs) established. The planning guidance stated that CCGs would remain as statutory organisations until the end of June 2022, meaning that CCGs were required to work closely with designate ICB leaders to develop plans.

Plans for 2022/23 focussed on local systems, with every NHS provider fully mapped to a single system. This means that each organisation's financial position will contribute to the achievement of financial balance for a single system. Trusts were also required to submit organisational plans, in line with the system plan submission.

Five-year system plans will be required from ICBs in March 2023. During 2022/23, ICBs are expected to undertake preparatory work to ensure that system plans reflect local priorities, with specific objectives aligning to the four primary purposes of an ICS:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS support broader social and economic development.

ICB plans are also expected to reflect national priorities for the NHS and consider the additional responsibilities that ICBs will take on for commissioning primary care and some specialised services.

Efficiency requirements

The NHS budget is now growing at a much slower rate than over recent years but demand for its services continues to rise. This means that all NHS organisations must deliver year on year real cost savings and reflect this in their annual plans. During the Covid-19 pandemic, the efficiency requirement was removed, however a 1.1% efficiency target has been set for 2022/23.

Organisations also experience inflationary pressures such as the rising cost of utilities or consumable items, meaning that further efficiencies are required to address these financial demands, if not funded through increases in their allocation or income.

At a more detailed level, if the cost of an organisation's plans to purchase and/ or deliver services exceeds its anticipated levels of income, further savings must be included within the budget to bring it back in line with the available resources.

QIPP plans

To help achieve efficiency targets while maintaining and improving quality, DHSC introduced the 'quality, innovation, productivity and prevention (QIPP) challenge'. In practice, this means organisations seek to follow the 'lean management principles' of avoiding duplication, preventing errors that need to be corrected, and stopping ineffective practices. International evidence has shown that it is possible to improve the quality of care and patient experience while reducing costs. ICBs are responsible for leading the QIPP agenda, but all NHS organisations have a role to play in its delivery.

Allocations

As mentioned earlier in this chapter, all non-foundation NHS organisations must achieve a balanced budget each year (and FTs must remain solvent) and so the income level they receive is of critical importance. For commissioners the key factor is the funding allocation they receive from NHS England and for providers, the income secured through contracts with commissioners. The 2022/23 financial framework is system-based with a funding envelope issued to cover all organisations within an ICS. For more about the allocation process and how services are funded, see chapter 10.

The national tariff

Another set of guidelines that both commissioners and providers must take account of when preparing their plans relate to the national tariff – the NHS payment mechanism.

The *2022/23 national tariff payment system*[230] moves almost all secondary healthcare services, including acute, community, ambulance and mental health onto an aligned payments and incentive approach building on the blended payments introduced in 2019/20. The approach covers all contracts between providers and commissioners in the same system, as well as all contracts over £30m where providers and commissioners are in different systems. The £30m threshold is based upon ICB level contracts, requiring partners to work together in their ICB footprints. All specialised commissioning activity will be covered by these arrangements.

A blended payment is made up of a fixed and variable element. The fixed payment is locally determined and does not need to be built from individual prices/ tariffs. Prices are still published, as in previous tariffs, but are mostly used for guidance rather than mandated for use. The variable element can be used to incentivise specified activity or quality objectives.

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[230] NHS, *2022/23 national tariff payment system,* March 2022

See chapter 19 for more about the national tariff.

NICE guidelines

NICE provides national guidance and advice that is designed to improve the quality of health and social care. Of particular importance in planning terms are its quality standards – these are developed in collaboration with relevant professions using a variety of evidence sources.

The quality standards are also used to inform payment mechanisms and incentive schemes – for example, the Quality and Outcomes Framework (QOF); see chapter 6 for more details.

14.5 Planning process – other influences

As well as reflecting national guidelines in its annual financial and operational plans, an organisation must allow for a range of other factors - for example:

- service developments (as outlined in its business plan)
- nationally agreed changes to pay and agreed increments for staff
- the impact of changes in clinical practice
- changes in drugs or medical devices used (NICE guidelines are relevant here)
- income streams that are no longer available or received
- changes in national and/or local priorities.

Key learning points

- The planning process is designed to ensure efficient and effective delivery of services, demonstrate public accountability, and ensure consistency with national and local plans and targets.
- The *NHS long-term plan* implementation plan is designed to meet the needs of the health and social care system in a geographical area.
- The business plan sets out the assumptions that underpin service plans and budgets.
- The operational plan shows how national targets and local priorities will be delivered within the resources available and forms the first year of the NHS long-term plan implementation plan.
- The financial plan or budget shows organisations' expected income and spending levels for the year ahead and demonstrates how their financial duties will be met.
- Although organisations refer to the budget, it is made up of a series of separate budgets for individual activities or services.
- There are three main budgeting approaches (historic, zero-based and activity-based), all of which are used in the NHS.
- Budgets are managed by budget holders who monitor actual performance during the year and take corrective action when needed.
- When NHS organisations develop their plans, they must take into consideration both external and internal requirements. Of particular importance are the *NHS constitution*, the *NHS outcomes framework* and the annual planning guidance.

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, including sections dedicated to the financial regime and the *NHS long term plan*. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 15: Capital funding, planning and accounting

Chapter 15. Capital funding, planning and accounting

Overview

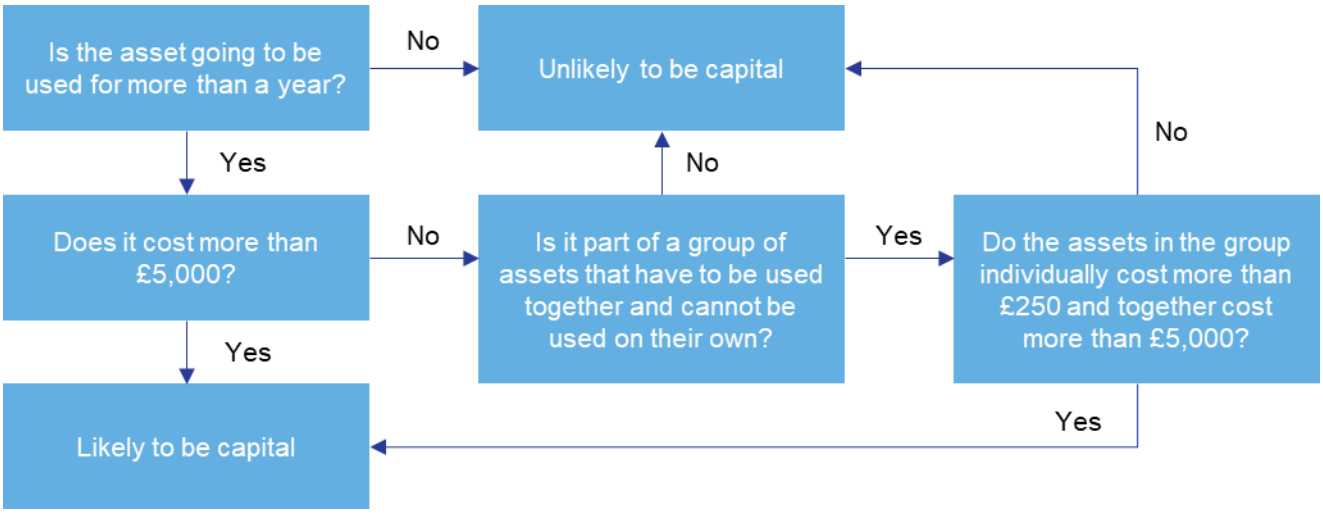
This chapter looks at what capital is and how it is controlled and funded in the NHS. It also runs through the various sources of capital funding and explains how to account for non-current assets and changes in their values.

15.1 What is capital in the NHS?

In the public sector, expenditure is classified as either revenue (spending on day-to-day operations) or capital (spending on assets that will be used for more than a year). Capital spending is incurred when an asset intended for use on a long-term basis is acquired – this is also described as capital investment.

Deciding whether expenditure meets the definition of capital or not can be difficult, but the flow diagram identifies the first questions that need to be asked. The de-minimis level of £5,000 is intended to reduce the administrative burden on NHS bodies of managing their capital assets (for more information see the section below on asset registers). Likewise, the grouped asset concept is intended to align the management of assets to the accounting regime.

Definition of a capital asset



The assets are referred to as non-current assets or property, plant and equipment and intangible assets. They are defined as:

- being held for delivering services or for administrative purposes
- having a useful life greater than one year
- having a cost that can be measured reliably
- generating future economic benefits or service potential for the organisation.

Non-current assets can be both tangible (things that physically exist) and intangible (assets that do not exist as physical entities) – examples are shown below.

Types of asset

Tangible assets	Intangible assets
Land	Software licences
Buildings	Development costs for software and systems
Dwellings	Licences and trademarks
Assets in the course of construction	Patents
Plant and machinery	
Transport equipment	
Information technology equipment (including integral software)	
Fixtures and fittings	

15.2 The capital regime – allocations, limits and controls

Allocations

The amount that can be spent on capital across the Department of Health and Social Care (DHSC) group is set by the government, usually as part of the spending review process. The amount that can be spent in any one year is called the capital departmental expenditure limit (CDEL)

Overall responsibility for ensuring that the allocation is not overspent rests with the DHSC. The limit is set for each year and any unspent allocation is lost at the end of the year. It is therefore important that the limit is reached but not overspent. However, this does not mean that costs should be incurred solely to ensure the limit is reached; all investments must be appropriate and provide value for money.

The *Autumn budget and spending review*[231] set out the resource limits for the DHSC to 2024/25. These were updated In the spring statement 2022[232], and subsequently in the November 2022 *Autumn statement*[233].

CDEL to 2024/25

	Out-turn 2021/22 £bn	Plans 2022/23 £bn	Plans 2023/24 £bn	Plans 2024/25 £bn
Core CDEL	9.0	12.0	11.7	12.6

Source: *Autumn statement 2022*, HM Treasury

[231] HM Treasury, *Autumn budget and spending review 2021*, updated December 2021
[232] HM Treasury, *Spring Statement 2022*, March 2022
[233] HM Treasury, *Autumn statement 2022*, November 2022

In the spending review 2020[234], the government announced multi-year capital health programmes focussed on new hospitals:

Multi-year new hospital programme

	Plan 2021/22 £bn	Plan 2022/23 £bn	Plan 2023/24 £bn	Plan 2024/25 £bn	Plan Total £bn
Hospital building programme	0.6	0.6	0.9	1.7	**3.7**
Hospital upgrade programme	0.7	0.5	0.3	0.2	**1.7**

Most capital expenditure is incurred by the provider sector. In 2020/21, excluding central Covid-19 allocations, 78% of the DHSC's capital spend was incurred by providers (£7.1m)[235]. Providers' spending is controlled by restricting the amount of finance that they can access. These controls are explained below.

The rest of the CDEL is spent on NHS England and DHSC led investment in primary care, community care and social care, Covid-19 and central research and development.

System capital allocations

In 2022/23, the NHS capital allocation for providers is £7.9bn[236]:

- £4.1bn system allocation – this includes funding for critical infrastructure risks, diagnostic equipment, and Covid-19 responses and must cover day-to-day operational investments
- £1.1bn nationally allocated funds to cover strategic projects already announced and hospital upgrades/ new builds
- £2.7bn other national capital investment such as community diagnostic hubs, national technology funding and the mental health dormitory replacement programme.

Allocations at a system level, and the needs for a revised capital allocation process, were described in the health infrastructure plan (HIP)[237]. The HIP identified three key requirements to make NHS infrastructure fit for the future:

- a new five-year rolling programme of investment in NHS infrastructure that takes a strategic approach to improving hospitals, primary and community care estates, and health infrastructure
- a reformed system underpinning capital to ensure it reaches the frontline when and where it is needed
- backing the wider health and care sectors with funding to strengthen health infrastructure in related sectors that support the NHS.

[234] HM Treasury, *Spending Review 2020*, December 2020
[235] DHSC, *Annual report and accounts 2020/21*, January 2022
[236] NHS, *Capital guidance 2022 to 2025*, April 2022
[237] DHSC, *Health infrastructure plan*, updated October 2019

The NHS system capital allocation is largely based on the overall value, and the depreciation costs, of the NHS provider estate[238].

Capital resource limit

System allocations are provided to integrated care boards (ICBs), with each organisation receiving a capital resource limit (CRL) for the financial year.

It is for integrated care systems (ICSs) to determine which capital projects at which NHS bodies get priority. This will be managed through the integrated care boards (ICBs), and each ICB and its partners trusts are subject to a capital resource limit (CRL) on their combined capital resource.

Each ICB and its partner trusts are required to agree an annual system capital plan, in advance of the start of the financial year. As some trusts will operate across several ICS, this will require some trusts to agree multiple system and capital plans and be involved in the governance and decision-making of multiple ICBs' capital programmes.

For ICBs, remaining within this limit is a statutory duty, they should not exceed it and it is monitored throughout the year. The DHSC (rather than statute) requires NHS trusts to remain within their CRL.

Very few ICBs will themselves incur capital expenditure as the assets that they use are generally owned and managed by NHS Property Services Ltd. Similarly, leases of properties developed under NHS local improvement Finance Trust (LIFT) arrangements are held and managed by Community Health Partnerships Ltd (see later in this chapter).

Performance against the CRL must be reported in the annual report and accounts. The organisations should not spend more than the CRL after adjusting for asset disposals and grants and/ or donations towards the purchase of non-current assets. Underspends against the CRL cannot be carried forward to the following financial year unless they are agreed in advance and built into submitted plans.

For an ICB, its own CRL represents the amount of financing given to it for capital expenditure. For NHS trusts, the CRL consists of both internally generated resources (through depreciation) together with any central capital financing provided.

NHS foundation trusts do not have a CRL. In theory, they can incur any amount of capital expenditure, as long as they can afford it, either through retained surpluses or public dividend capital. In practice, the DHSC will limit access to borrowing in order to ensure that the overall departmental CDEL is not overspent. The devolution of capital allocations to system level is intended to ensure that cash rich NHS foundation trusts do not spend more than their fair share of the CDEL. The *Health and Care Act 2022* includes a clause that enables the DHSC to impose capital spending limits on NHS foundation trusts where they are not working effectively to prioritise capital expenditure within their system and risk breaching either the system allocation or national CDEL.

External financing limit (EFL)

This was established to control the amount of cash that could be spent on capital in a year. It is set to include all sources of capital finance:

- from the DHSC in the form of public dividend capital (PDC)[239] and/ or loans
- through internal sources by building up cash balances
- via external sources (including finance leases).

[238] The King's Fund, *Review of the current capital allocation methodology for system envelopes*, March 2022
[239] PDC is a type of government finance – it is discussed later in the chapter.

This means that the EFL is a 'financing limit' – i.e., the maximum amount of cash that can be accessed through external borrowing. Achievement of the EFL is an absolute financial duty. There is no tolerance above the EFL target as it is designed to control the cash expenditure of the NHS as a whole to the level agreed by Parliament.

By controlling net cash flows, the EFL sets a limit on the level of cash that an NHS trust may:

- draw from either external sources or its own cash reserves (a positive EFL) or
- repay to external sources for capital borrowing (a negative EFL).

ICBs and NHS foundation trusts do not have an EFL.

15.3 Planning the capital programme

There is an absolute requirement when spending public money to demonstrate that it has been used wisely and for its intended purpose. As a result, NHS organisations need to plan, monitor, and manage their capital investments.

Affordability

The overriding constraint when planning for capital is that organisations must not spend more than they have available and can afford, both in relation to the initial cost of the non-current assets and the associated on-going revenue costs. This means thinking through several factors including:

- the appropriateness of the investment in relation to the local system/ organisation's service requirements, whether this be infrastructure or equipment
- the risk of not investing, or of investing in a low-risk area at the expense of being able to address a higher risk
- on-going maintenance costs, both as regards the new investment, or from not investing (older estate and equipment will generally have much higher maintenance costs)
- depreciation costs. Non-current assets wear out over their 'useful life' and an annual (non-cash) charge is made to the revenue account to reflect this (see later for more about depreciation)
- the cost of financing – for example, the impact on PDC dividend. This is a cash charge paid to the DHSC that is based on the average net assets of the organisation. An increase in non-current assets will result in an increase in the dividend charged (see later in this chapter for more about PDC). Interest charges from finance leases or loans would also result in a financing cost.

Business cases

Most NHS organisations will have a rolling programme of capital investment to ensure that its asset base is fit for purpose. When additional capital investment is needed, the first stage is to develop a business case to consider the options available, their impact and affordability. The scale of the investment will determine how detailed the business case needs to be. NHS England provides detailed guidance on the development and completion of business cases[240]. In the context of capital spending, a business case is usually a written statement of the need for investment in capital. The business case process is designed to lead to a consideration of changing circumstances, future requirements/ opportunities and an agreed corporate view of the best way forward. The business case proposal will be backed up by sound and reasoned assumptions and projections. It is helpful to use a standard format so that key issues are covered.

[240] NHS England, *Capital regime, investment and property business case approvals guidance for NHS providers*, updated 2020

What a business case includes

- the strategic 'fit' of the proposed investment within the local health economy, including a clear and concise statement of need
- effective project management arrangements, clear lines of communication and details of those key individuals who will be personally accountable
- an indication that the proposal has the support and approval of key stakeholders including commissioners, staff and patients
- quantified analyses of the investment and its lifetime costs, benefits and cash flows
- quantified analyses of the costs/ benefits of any alternative methods of financing the investment
- evidence-based information to support the proposal in terms of priority, cost-effectiveness, clinical service management and the best use of scarce resources
- if a major investment is being considered, the business case should also bring together the arguments for the preferred option (including current and future service requirements), affordability, the organisation's competitive service position and the ability to complete the project within the specified budget and in line with agreed timescales.

Delegated limits

Business cases for NHS trusts, and for NHS foundation trusts that are deemed to be in financial distress, are subject to a system of 'delegated limits'. This means that the capital value of a project determines what approvals are required. Business cases with a financial value of less than £15m can be approved by the provider body's board. Above this level, external approval is required as shown below.

Delegated limits for non-foundation NHS trusts

Financial value of the capital investment	Approving person or group
£15m to £30m	NHS England and DHSC
£30m to £50m	NHS England Resources Committee and DHSC
Over £50m	NHS England Board approval, DHSC and HM Treasury

NHS foundation trusts that are not deemed to be in financial distress are not subject to strict limits. However, significant or material transactions, deemed to be a higher risk, must be reported to NHS England and some will require detailed review and approval[241].

15.4 Sources of capital

The potential sources of funding for capital investments vary by type of NHS organisation.

[241] NHS Improvement, *Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts, Annex 13: Guidance for foundation trusts that are not in financial distress,* November 2016

As mentioned earlier, it is unlikely that ICBs will have significant levels of non-current assets. However, if an ICB does enter a capital programme, the only source of funding available to it is internally generated funds, leases or a capital allocation provided by NHS England.

NHS trusts and NHS foundation trusts have access to several funding sources:

- internally generated resources (via retained surpluses, depreciation and proceeds from the sale of non-current assets)
- borrowing (including PDC)
- leases
- donations and grants.

Until 2018, public private partnerships or private finance initiatives (PFI) were also options to fund capital projects. However, in the October 2018 budget the Chancellor announced that PFI schemes would no longer be used.

Internally generated resources

The main source of capital funding is from internally generated resources – the cash balances built up through retained surpluses, depreciation, and proceeds from the sale of non-current assets.

All NHS bodies must make a charge to expenditure to reflect the cost of using an asset over its useful life, and this is known as depreciation. This charge does not involve actual cash being paid out (it is 'non-cash') and so an organisation that breaks even or achieves a surplus on its revenue account will generate a cash surplus equivalent to the value of the depreciation charge (all other things being equal).

That cash balance and/ or any surplus is available to invest in capital projects, such as replacing equipment, enhancing existing assets or building new ones, subject to the organisation meeting the capital controls set out earlier in the chapter. It can also be used for revenue purposes – for example, maintenance or sustaining the working capital[242] position.

Another source of finance is the sale of existing assets. While an NHS foundation trust can retain the total proceeds from the sale of an asset, the amount of money that an NHS trust can retain is capped to match its delegated limit and is also reflected in its CRL.

Borrowing and public dividend capital

The way in which money can be borrowed depends on the type of organisation considering the loan.

Under the *National Health Service Act 2006*[243], the DHSC is required to produce guidance in relation to the powers that it has to provide financial assistance to NHS providers[244]. In this context, financial assistance includes the provision of loans, issue of PDC, giving of grants and other payments.

From 2020/21 onwards, the way that financial assistance is provided has changed. The DHSC no longer issue loans, other than in exceptional circumstances. Instead, public dividend capital (PDC) is issued to support capital investment where the NHS provider does not have sufficient internally generated resource.

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[242] Working capital is the money and assets that an organisation can call upon to finance its day-to-day operations (it is the difference between current assets and liabilities and is reported in the statement of financial position as net current assets/ liabilities). If working capital dips too low, organisations risk running out of cash and may need a loan to smooth out cash flows.
[243] Section 42A of the NHS Act 2006 which was inserted by section 163 of the Health and Social Care Act 2012
[244] DHSC, *Secretary of State's guidance under section 42A of the NHS Act 2006*, July 2020

NHS provider bodies can borrow from the open market, including commercial loans from banks and other private lending organisations. NHS trusts and foundation trusts in financial distress need to be able to demonstrate that this is better value for money than financing through the DHSC, and will need the approval of the DHSC to borrow from outside of the group. NHS foundation trusts that are not in financial distress can borrow externally if they can demonstrate the affordability of the loan. However, in reality NHS bodies access finance through the DHSC.

The Secretary of State determines the terms on which PDC is provided, such as whether it is repayable. Usually, PDC does not have to be repaid. Interest is not payable on PDC, instead, a PDC dividend is paid to the DHSC based on the average net assets of the NHS provider body. The calculation of the dividend is discussed later in this chapter.

Public private partnerships

New schemes cannot be entered into since the Chancellor's announcement in 2018.

Private finance initiative (PFI)

PFI schemes were used for several years to finance capital investment. The schemes involved the creation of partnerships between the public and private sectors. The financing of the construction of the asset was the responsibility of the PFI provider so the capital investment was funded without recourse to public money.

Private companies were contracted to design and build the assets that were then 'leased back' to the public sector, usually over a period of around 30 years.

The contract set out in detail the obligations of each party over the agreed period. The contract usually contained a service element relating to the building - for example, cleaning, catering, security and maintenance.

Private finance

Following a review of public private partnerships by the Treasury in 2012, a new approach to private sector involvement in public sector infrastructure projects was developed to replace traditional PFI schemes. Under this approach, the government acted as a minority equity co-investor with investments managed by a commercially focused central unit located within HM Treasury.

Local improvement finance trusts (LIFT)

Local improvement finance trusts (LIFTs) were used to develop and improve primary care and community-based facilities. These were delivered by Community Health Partnerships (CHP) – a limited company wholly owned by the DHSC. A partnership was established with the local health economy through a LIFT company. This is a limited company with the NHS, CHP, and the private sector partner as shareholders. The company owns and maintains the building and leases the premises back to the NHS.

There are a small number of LIFT schemes where an NHS provider body is the lead lessor, and their interests are not held by CHP.

Leases

A lease is often considered a suitable alternative to the outright purchase of a non-current asset.

A lease is defined as a 'contract, or part of a contract, that conveys the right to use an asset (the underlying asset) for a period of time in exchange for consideration'.

From 1 April 2022, the accounting treatment for leases changed. The change has an impact on what is charged against CDEL as well as the profile of revenue expenditure over the life of the lease. More than an accounting change, it also affects financial reporting and financial management throughout the NHS body.

Under IFRS 16, lessees will account for all leases as a right-of-use asset, and with a liability to pay for that right[245]. At the commencement of a lease, the lessee's initial measurement of the right-of-use asset is at cost, which in general, will be the same as the initial measurement of the lease liability. This will ensure that the accounts will include the assets being used by an organisation to provide services, together with the associated liabilities, and the impacts on cashflows.

All new leases, as well as some changes to lease terms, will count as a capital investment and will impact on CDEL. HM Treasury will adjust CDEL from 2022/23 to ensure that the change to the accounting standard does not affect the resources available to public sector bodies. NHS bodies were asked to submit information to the DHSC in January 2022 about the leases that they plan to enter into from 2022/23 that would not have been capital under the previous accounting arrangements.

Under the previous accounting arrangements (IAS 17), leases were categorised as either operating leases or finance leases. Only finance leases, where the lessee took substantially all the economic benefits and risks of asset ownership, counted as capital investment. Operating leases were treated as an in-year rental cost.

Lessors will continue to distinguish between operating and finance leases. This means that where two NHS bodies enter into a lease arrangement, they might both reflect the asset in their accounts. The lessee as a right to use the asset and the lessor as the owner of that asset.

Donations and grants

Charitable donations can be an important source of funds to support capital investment, but the trustees (usually the NHS corporate body) must ensure that the expenditure is in line with the charitable fund's purpose as set out in its governing documents.

Some NHS bodies may also receive grants from bodies such as the Lottery Fund to finance the purchase of non-current assets.

Charitable donations and grants are recognised as income by the NHS body in the year that any conditions attached to the donation are met. When a donation or grant is used to buy a non-current asset, this means that the income is recognised in the year that the asset is purchased. However, the cost of the asset is spread over the life of that asset in the form of depreciation charges that results in a timing difference between the recognition of the income and expenditure. This timing difference is adjusted for when determining whether the NHS body has met its financial duties.

For more about NHS charitable funds, see chapter 19.

[245] Leases with a term of less than 12 months and leases for assets with a value of less than £5,000 are accounted for as a cost when payment is made to the lessor.

15.5 The cost of capital

In terms of the cost of capital, there are three elements – PDC; depreciation; and interest. Each is discussed in turn below.

PDC dividend

The PDC dividend is derived by applying a percentage rate of return to an organisation's average relevant net assets, calculated as follows:

Average relevant net assets calculation

The average of the organisation's relevant net assets (i.e., the opening balance at 1 April added to the closing balance at 31 March divided by 2):

Total public dividend capital and reserves (x)	
Less	the net book value of donated assets and grant funded assets
Less	charitable funds
Less	net cash balances in government banking service (GBS) accounts
Less	outstanding PDC dividend prepayments
Plus	outstanding PDC dividend payables
Less	approved expenditure on Covid-19 capital assets
Less	assets under construction for nationally directed schemes
Plus	cash support for revenue requirements PDC drawn down in-year
Equals	Total relevant net assets

The percentage used is currently 3.5%; the dividend is payable to the DHSC in two instalments during the year.

Depreciation

Depreciation is calculated annually to reflect the cost of 'using up' the asset during its useful life – several assumptions are used:

- land is considered to have an infinite life and is not depreciated
- buildings, installations and fittings are depreciated over their assessed useful lives, with both the value and life expectancy determined periodically by a qualified valuer
- assets in the course of construction are not depreciated until they are brought into use
- equipment is depreciated over its useful economic life
- leased assets are depreciated over the shorter of the lease term remaining or the asset's remaining economic life.

Depreciation is usually calculated on a 'straight line basis' which means it is assumed that the asset will be used up evenly over its life. As depreciation is calculated on asset values that are subject to revaluation, the depreciation charge and total value of the assets held will vary each year.

Interest

Where an NHS body has borrowed to fund capital expenditure, interest will be payable. Interest is also payable on lease arrangements.

15.6 Accounting for capital

Accounting for capital can be complicated and is often an area of the accounts subject to additional audit scrutiny. This is because, by its very nature, the amounts involved are usually material[246] but also because there can be a significant level of judgement and estimation in the valuation of the assets.

Accounting standards

HM Treasury has developed a *Financial reporting manual*[247] that sets out how accounting standards should be implemented in the public sector. The DHSC's *Group accounting manual* also includes guidance on accounting for non-current assets. The following accounting standards[248] are of particular relevance when accounting for capital:

- IAS 16 Property, plant and equipment
- IAS 20 Accounting for government grants and disclosure of government assistance
- IAS 36 Impairment of assets
- IAS 38 Intangible assets
- IAS 40 Investment property
- IFRS 5 Non-current assets held for sale and discontinued operation
- IFRIC 12 Service concession arrangements
- IFRS 16 Leases.

Valuation

One of the reasons that accounting for capital can be complicated is that, in the public sector, non-current assets are not recorded in the accounts at the amount that they cost to buy. Instead, they are held at 'fair value'. In accounting terms, fair value has a specific meaning, but it is essentially the amount that the asset could be bought for on the open market.

On acquisition, non-current assets are recorded at their cost, and for equipment assets, this will, by its nature, be a reasonable estimate of their initial fair value. Equipment is usually valued at depreciated historic cost where they have short useful economic lives or low value.

Property assets will require annual review to ensure the valuation included is a reasonable estimate of fair value. The nature and timing of a revaluation is dependent on several factors which are discussed below.

For NHS organisations, identifying the fair value for property assets is difficult as they are held to provide services and there is a limited open market for NHS assets. Specialised property, such as hospitals for which a market value cannot be determined easily, are valued at the cost of replacing it with an equivalent, modern one (not an exact replica of what currently exists). This is the 'depreciated

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[246] Materiality is an accounting concept that allows the preparers and auditors of accounts to make a judgement about whether an item or transaction will influence the reader/user of the accounts. If it is decided that it would influence the reader/user of the accounts, then the item is material and should be included and explained in the accounts. Immaterial items do not need to be explained.
[247] HM Treasury, *Guidance on annual reports and accounts,* December 2021
[248] IFRS, *Issued standards,* 2022

replacement cost' approach, also known as the 'modern equivalent asset basis'. Determining the modern equivalent asset valuation for a hospital can only be done by a professional valuer and will be done in conjunction with the NHS body's finance and estates teams[249].

Assets that are not specialised, such as offices and some clinics, are valued based on what they could be sold for.

The timing of the valuation is a matter of judgment. Under IAS 16, organisations must consider whether the recorded value of their assets continues to reflect fair value taking into account market volatility - for example, if the local property market is particularly volatile or the organisation embarks upon a significant capital expenditure project, annual revaluations may be needed to keep the recorded value up to date.

Each year, an assessment must be made of whether the valuations are materially correct or not. This will involve consideration of the volatility of the property market and usually requires discussion with a professional valuer. In years where a professional valuation has not been undertaken, the value given to land and buildings will need to be reviewed and any changes appropriately evidenced to support the preparation of the accounts. Valuation may also be required when:

- there is a major change in use
- an asset formerly under construction is brought into use.

Most intangible assets (i.e., assets that have a financial value even though they are not visible - for example, software licences that run for more than a year) are recorded at cost less 'amortisation' (the equivalent to depreciation for intangible assets) as a proxy for fair value. However, where a market value is readily available then this should be used.

Gains

Gains (or increases) in asset value may occur following a revaluation by an external reviewer or, for equipment assets, by a review undertaken by the finance and/ or estates departments to provide a new fair value.

The gain is not treated in the same way as revenue or income. Instead, it is taken to a specific revaluation reserve held within the financing section of the organisation's statement of financial position.

Losses (including impairments)

Impairments occur where there is a loss (or reduction) in the value of a non-current asset compared to its recorded value. This can be due to:

- a loss of economic benefit to an asset itself - for example, it is physically damaged
- a change in the asset or its environment that has permanently reduced its capacity to provide services.

IAS 36 is relevant here. However, HM Treasury guidance diverges from IAS 36 and requires organisations to identify the cause of impairment as the result of either:

- the consumption of economic benefits or service potential or
- a loss following revaluation.

[249] HFMA, *Property, plant and equipment: accounting and valuation issues*, December 2019

In the first scenario, the resulting loss is charged to operating expenses in the year that the impairment occurs.

However, where there has been a previous upward revaluation for the asset and a revaluation reserve balance exists, a transfer is made from the revaluation reserve to the general fund/ retained earnings.

In the second scenario, a revaluation loss, the reduction should initially be charged to the revaluation reserve to the extent that a balance exists for the asset. Any remaining amount is charged to operating expenses.

If impaired assets then have an upward valuation, the charge made to expenditure can be reversed to the extent that the upward revaluation reverses the original impairment. It is therefore important to record all impairment charges by individual asset to enable entries to be reversed if needed.

Asset sale or disposal

When assets are sold or scrapped, the difference between the value at which they are held, and the amount of income received is the profit or loss on disposal. In the case of assets that are scrapped the income will be nil so there is likely to be a loss on disposal.

Profits on sale are reflected in other operating income. Losses are an operating expense in the year of disposal.

Leases

As mentioned earlier, leases are a complex area in accounting terms.

When a lease is entered into, the right of use asset is recorded in the asset register with a corresponding matching lease liability. The asset is treated as if it had been bought outright as soon as it becomes operational. It forms part of average relevant net assets for PDC dividend calculations, is subject to depreciation and is revalued in the same way as any owned asset. The lease liability is written down as the capital element is repaid. The interest payments on the lease are treated as an expense each year.

The profile of the expenditure on leases that would have been operating leases under the old accounting arrangements has changed. Under the old arrangements, operating lease rentals were charged to revenue as they were incurred, usually on a straight-line basis. Now, interest payments are higher at the start of the lease and lower at the end whereas depreciation charges are on a straight line over the length of the lease.

PFI and LIFT schemes

PFI and LIFT schemes are also complicated arrangements to account for. Relevant accounting standards are *IFRIC 12 Service Concession Arrangements* and *SIC 29 Service Concession Arrangements: Disclosures*.

Key components in accounting for PFI and LIFT schemes

Organisations consider whether the scheme represents a service concession under IFRIC 12 for which several specific ‘tests’ exist, and if not, whether the scheme is a lease arrangement.

Where the scheme is a service concession under IFRIC 12, the asset is recognised in the organisation's accounts at 'fair value' – the capital cost of the asset at the inception of the scheme that is determined using the contractor's financial model.

The accounting arrangements for the liability to make unitary payments over the life of the contract will change as a result of IFRS 16. Where the unitary payments vary in accordance with changes to the retail price index (RPI) or another index, the liability will be remeasured when the index changes. Detailed guidance is being developed as this will be a complex exercise.

The unitary payment (i.e., the payment made by the public sector organisation to its private sector partner) is allocated between:

- payment for services
- payment for the property:
    - repayment of the liability
    - interest charge relating to the lease
- life cycle costs relating to future capital expenditure.

Depreciation and other changes in value must be accounted for as with any other asset owned by the organisation.

Donated assets

Assets funded by donation require specific identification in the asset register. The most common method of receiving a donated asset is for it to be purchased by the NHS organisation and for an invoice to be raised to the charitable body funding the asset; this can help with identification. It is worth noting that donated assets do not form part of the PDC dividend calculation.

Income will fluctuate in line with the receipt of new donated assets, either improving or worsening the revenue position of the NHS body according to whether more or less donated income is received as compared to the depreciation charge on the overall value of donated assets.

15.7 Asset registers

Every NHS organisation maintains a register of its non-current assets (tangible and intangible) so that they can be managed effectively and to demonstrate accountability. The register records a range of information about each asset and is used to help in the preparation of the organisation's financial accounts and helps enable replacement programmes.

Asset registers – what they record for each asset

- identification, description and location of the asset – assets should be tagged with a unique identifier
- date, method of acquisition and initial capital outlay
- how the asset has been financed - for example, is it owned, leased, donated or covered by a PFI agreement. From 2020/21, whether the asset was purchased using Covid-19 funds will also need to be documented
- opening value on the 1 April of each financial year
- any additions to the asset and the year that they were made

- the value if reclassified for sale
- gains from revaluation (so that there is a clear link to the revaluation reserve)
- impairments (i.e., a loss in value) including any reversals
- cumulative depreciation charges and estimated life
- closing value on 31 March of each financial year.

Key learning points

- Non-current assets deliver a benefit to an organisation over a period of time.
- Non-current assets can be tangible or intangible.
- In order to account appropriately for non-current assets, a detailed asset register must be maintained and kept up to date.
- Organisations work within a system of controls and financial limits to ensure that capital expenditure does not exceed the DHSC's capital departmental expenditure limit (CDEL).
- It is important to consider capital needs and plan to meet them; organisations must consider the affordability of financing capital investment as well as the on-going revenue costs within the context of the capital controls.
- A well-structured, logical and concise business case can help explain the case for capital investment. It may be subject to external approval depending on its value.
- The potential sources of funding for capital investments vary by type of NHS organisation; not every option is available to every type of organisation.
- Capital expenditure is funded from several sources: internally generated resources; leases, grants and donations. NHS organisations also have access to public dividend capital (PDC).
- Most of the capital expenditure incurred in the NHS is incurred by provider bodies.
- Commissioners do not hold many non-current assets.
- NHS Property Services Ltd holds most of the assets used by ICBs.
- LIFT schemes are held by Community Health Partnerships Ltd.
- Commissioners have limited access to sources of capital funding.
- Accounting for capital can be complicated and requires management to make many judgements.

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, including a section dedicated to capital. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 16: Commissioning

Chapter 16. Levels of activity with the provider across the Commissioning

Overview

This chapter explains what commissioning is, what it aims to achieve and what it involves in practice. In particular it works through the 'commissioning cycle' and explains what each step involves.

16.1 What is commissioning?

The Department of Health and Social Care (DHSC) has described commissioning as 'the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers'. However, what it boils down to in practice is commissioners negotiating agreements with service providers (NHS, private and voluntary sectors) to meet the health needs of a particular population. Contracting is one element of the commissioning process, as can be seen later in the chapter (section 16.3).

16.2 The aim of commissioning

Service quality is the focus for NHS commissioners and the organising principle that underlies all that they do. This means that the overarching goals for commissioning are to achieve the following within available funds:

- improved health outcomes
- reduced health inequalities
- improved provider quality
- increased productivity.

Commissioners are constrained by the fact that demand for healthcare always exceeds the level of funds available and so there is a need for them to make choices and to prioritise availability of services. This involves a focus on local needs, targets and desired outcomes together with reviewing services in the search for greater effectiveness, economy and efficiency. As a result, not all NHS services are available everywhere in the same way.

NHS commissioners are also expected to achieve improvements in relation to the five domains set out in the *NHS outcomes framework*[250] and follow national planning guidance issued each year.

NHS outcomes framework domains

Domain 1	Preventing people from dying prematurely.
Domain 2	Enhancing quality of life for people with long-term conditions.
Domain 3	Helping people to recover from episodes of ill health or following injury.
Domain 4	Ensuring that people have a positive experience of care.
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

[250] NHS Digital, *About the NHS outcomes framework (NHS OF),* March 2022

16.3 Who are the commissioners in the NHS and how do they approach their responsibilities?

The *Health and Social Care Act 2012* led to the creation of NHS England and GP led clinical commissioning groups (CCGs), both with a role in commissioning services for patients. The creation of CCGs placed primary care clinicians at the heart of the commissioning process, fully accountable for managing the funding they received from NHS England and negotiating contracts with providers of services.

The *Health and Care Act 2022*[251] established integrated care boards (ICBs) and abolished CCGs. The functions, staff, assets and liabilities of CCGs transferred to ICBs. Now, there is a greater emphasis on collaboration, with the ICB the statutory commissioning body within an integrated care system (ICS). NHS England directly commissions some services, and some are commissioned jointly with ICBs.

Local authorities are also involved as they are responsible for health improvement and public health spending and are parties to pooled budgets[252] with ICBs.

These organisations' structures, accountabilities and roles are described in chapters 4, 5 and 8.

16.4 The commissioning cycle

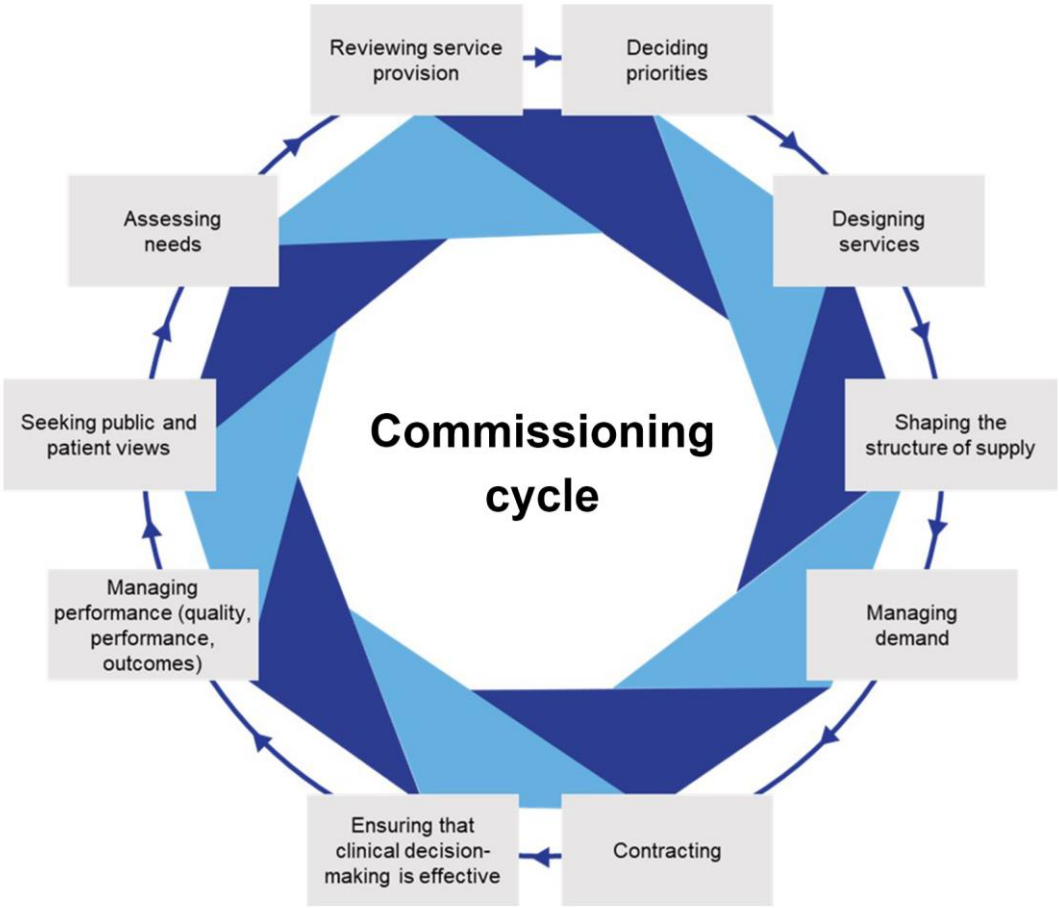
Commissioning does not follow a pre-set template and cannot be done once and forgotten about rather it is a continuous process with many different elements. It is only by going through the entire process, often referred to as 'the commissioning cycle', that a realistic commissioning plan can be drawn up and an associated budget developed. This cycle is shown below in diagrammatic form[253]:

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

[252] A type of partnership arrangement where NHS organisations and local authorities contribute an agreed level of resource into a single pot that is then used to commission or deliver health and social care services.

[253] Adapted from the Department of Health's 2006 guidance *Health reform in England: update and commissioning framework*

The commissioning cycle



These activities are usually grouped into three key phases – planning, procurement and managing/ monitoring.

Planning

Assessing health needs

Assessing health needs involves planning ahead so that an integrated care system (ICS) and the organisations within it, know what services are needed to meet the requirements of the population served. This cannot be done in isolation, commissioners must work with others across the ICS and within the wider community - for example, local authority and public health professionals, local authority health and wellbeing boards (HWBs), patients and the local community, to gather the information they need. Providers should also be involved in this process to highlight areas where services could be developed or challenges that need addressing, such as waiting lists.

In looking at needs, it is important that the focus is on commissioning services that will result in good patient outcomes - for example, the test of effective commissioning for knee operations could be whether patients can return to work, or drive again, rather than the number of operations that are carried out over a set period of time. As we will see later, this outcomes focus involves thinking about developing new and innovative ways of contracting which incentivises providers to deliver the desired outcomes.

There are several tools that can help commissioners to decide where to focus attention that cover both individual organisations and wider population management for local systems, including:

- benchmarking data - for example, through the NHS Benchmarking Network who carry out a wide range of benchmarking projects across commissioning and provider sectors
- Integrated Care Board (ICB) outcomes indicator set – produced and maintained by NHS Digital, this provides comparative information about the quality of health services commissioned and health outcomes achieved. It contains indicators from the NHS outcomes framework that can be broken down to ICB level and other additional indicators - for example, linked to the National Institute for Health and Social Care Excellence's (NICE) quality standards
- system transformation diagnostic reports that draw on a wide range of information sources and datasets from across the NHS and local government to identify high-impact areas where system level focus could improve outcomes and performance
- atlas of variation - maps that place health economies into quintiles of performance for individual outcome and efficiency measures.

Reviewing service provision and identifying gaps or areas where change is needed

This stage involves:

- looking at outcomes from services – in other words, are services delivering what they should
- reviewing the latest guidance and assessing its impact - for example, from NICE
- analysing feedback from service users
- being aware of any guidance or recommendations that inspectors or regulators have issued - for example, Care Quality Commission (CQC)
- using the local joint strategic needs assessments (JSNAs) and the joint local health and wellbeing strategies (JLHWSs) – both led by HWBs (see chapter 8).

Deciding priorities

This involves commissioners taking decisions within their ICSs about exactly how to spend the limited pot of money that they have available. Inevitably, not all needs can be met, and so relative priorities must be established in a logical and objective way. Commissioners need to link these decisions to national priorities, performance targets (national and local), business rules (how providers of NHS services are reimbursed), as well as to their overall objectives, plans and budgets. They must also take account of patient choice and the views of the local community and other partners. Another consideration is the need for openness and transparency in the approach to deciding priorities so that everyone can understand why decisions are made and see that the approach is objective and impartial.

Procurement

Once planning has been carried out, the next stage is for commissioners to contract for the services that are required while bearing in mind the need to provide for both competition and patient choice. This may involve a procurement exercise that will take into consideration those services already provided and the underlying relationship with service providers themselves.

Designing services

The first step in this process is to ensure that the way services are designed is in line with the agreed priorities. This may involve reshaping the way things are delivered in consultation with ICS partners, GP practices and other providers. This is where NHS England's commissioning guidelines and model care pathways fit in.

Shaping the structure of supply

Once commissioners are clear about what it is they want to buy, they need to make sure this is specified clearly so that service providers know exactly what they are expected to deliver. In some instances, commissioners may also need to encourage changes in provision to meet the requirements of their population - for example, so that services are provided closer to home or in different ways to fill gaps in the range of services available. This involves working with ICS partners, local authorities and potential service providers to:

- develop service specifications
- understand any barriers that might prevent potential providers from coming forward and (in some cases and where it is appropriate) addressing them
- identify incentives that could stimulate supply - for example, using multi-year contracts that recognise that the level of work will increase gradually, or that service changes will be incremental or staged.

Managing demand while ensuring appropriate access to care

Managing demand is one of the trickiest aspects of commissioning as the care and services that patients need during the year must be matched with contracts that are agreed in advance, available capacity and financial resources. Effective demand management is therefore inextricably linked to shaping the supply of services and ensuring that the services that are available are clinically appropriate. It also involves reducing clinical variation in referrals made by GPs, and in consultants' clinical practice.

Patient activity tends to be classified in two main ways, non-elective and elective:

- non-elective activity is the consequence of individuals feeling unwell, becoming unwell or having accidents. This may occur as a patient attendance at a GP practice, urgent care centre or accident and emergency department. The patient may arrive themselves (self-presenting) or conveyed via the ambulance service. Patients may subsequently require admission to secondary or tertiary care for further investigation or treatment. Generally, non-elective activity must be dealt with at the time of presentation and is inherently unpredictable
- as the name suggests, elective or planned care consists of interventions or interactions that are known about and planned. At primary care level this may be through regular appointments, follow ups or health checks. In relation to community and outpatient services it consists of booked appointments, while at secondary and acute care it will be planned admissions for procedures or investigations. NHS providers plan elective care by considering both assessments of the volume of urgent cases, and with regards to capacity. However, this can be significantly affected by increases in non-elective patient activity that reduces overall system capacity. A simple example of this, is the impact that the Covid pandemic has had on elective activity, but there can also be significant local pressures that can arise and are not easily predictable.

In practical terms, managing demand means that commissioners must:

- have access to reliable, timely activity monitoring information - for example, in relation to referral patterns
- anticipate in-year changes - for example, in screening programmes, care pathways, new providers, NICE guidance
- have activity management plans in place
- identify and follow best practice
- ensure that enough resources are devoted to health promotion and education, preventative measures and communication
- have effective communication plans in place - for example, the use of social media to encourage patients to access the appropriate part of the healthcare system
- be prepared to review services for effectiveness and value for money and restrict access to or decommission services that give less benefit.

Increasingly, commissioners also look beyond the costs of individual treatments that may be needed during a year to consider the likely total cost of patient care across several years (this may include social care costs). There are several tools and techniques that commissioners can use to join up information so that they can assess future demand in this way - for example,

- risk stratification – to identify patients with long term conditions who may need closer management or those who use hospital services regularly and are more likely to have re-admissions
- predictive modelling – by identifying the probability of future events affecting groups of patients, interventions can be planned and executed.

Contracting

Contracting is a key stage in any procurement process but, unlike other sectors of the economy, the NHS uses a standard contract[254] for the commissioning of all NHS clinical services (except primary care[255]). This contract can be adapted to suit a broad range of services and delivery models – in other words the standard contract provides a framework that can then be added to locally.

The healthcare services that are covered by the contract may be provided by NHS or other public or private sector providers (i.e., by any qualified provider). Contracts should be signed before the start of the financial year with any disputes resolved swiftly. Contracts have traditionally taken a variety of forms, from block to cost per case. In the longer term, block arrangements are generally constrained by capacity, while cost per case arrangements can flex to meet demand. In the short term, both will be constrained by capacity to meet the expected levels of activity. Commissioners must enforce the standard terms of the contract.

The Covid-19 pandemic meant that all contracts were moved onto a block payment basis, as activity levels were dramatically affected. These arrangements remained in place until March 2022. From 1 April 2022, most contracts moved to an aligned payment and incentive approach. This model consists of a fixed payment that covers most of the activity, with a variable element to incentivise particular policy priorities.

See chapter 19 for more about how NHS services are paid for.

NHS England is responsible for reviewing and updating the standard contract documentation. Details are available on its website[256].

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[254] NHS England, *2022/23 NHS Standard Contract*, March 2022
[255] Primary care contracts are explained in further in chapters 4 and 6.
[256] NHS England, *NHS Standard Contract*, March 2022

In letting contracts, guidance was issued (in 2014) regarding how commissioners were to consider competition[257]. However, it is recognised that competition does not support the collaborative approach of ICSs. NHS England and NHS Improvement consulted on changes to procurement rules[258,259] to reduce unnecessary competitive tenders and support the development of partnerships. The outcome of the supplementary consultation on the *Provider selection regime* has not yet been published (as of August 2022).

The role of GPs

With their detailed knowledge of patients' needs, GPs are at the forefront of demand management, specifying services and developing new care pathways. They can also influence how their patients behave - for example, by encouraging self-care and preventative measures and by educating them about which services should be accessed when - for example, when to use pharmacy services rather than minor injuries units. This can help reduce the number of referrals and improve the overall quality of patient care.

It is important to promote the choices open to patients, particularly where the GP is also a service provider - for example, the GP may be part of a consortium that operates a private clinic to which patients could be referred. It would therefore be appropriate for a patient to be made aware of these facts so that they can take this into consideration when deciding about their treatment or care.

Managing and monitoring

Ensuring effective clinical decision-making

Although contracts are agreed by NHS England or ICBs, each referral that a primary care clinician (usually a GP) makes is effectively a mini commissioning decision that commits money. Ideally, those making these decisions need to:

- recognise the broader context
- be aware of service options
- be able to justify their decisions
- accept peer review of performance
- understand the implications of their decisions.

While clinicians will make a decision based on their clinical judgement and the needs of the patient, the ICB provides clear thresholds and pathways to enable GPs to refer patients into the right service, once the level of need is established.

Managing performance

Commissioners need to ensure that the services they have bought are delivered in line with the specifications set out in their contracts in terms of quality, quantity, and price. They must also review performance in relation to:

- achieving national standards
- quality – the NHS standard contract between commissioners and providers allows for a proportion of providers' income to be conditional on quality, innovation and the achievement of local quality improvement goals

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[257] Monitor, *Procurement, choice and competition in the NHS*, May 2014
[258] NHS, *NHS provider selection regime: consultation on proposals,* February 2021
[259] Department of Health and Social Care, *Provider selection regime: supplementary consultation on the detail of proposals for regulations,* February 2022

- never events – there is a national set of never events[260] that must be included as part of contract agreements with providers. Any such events must be reported to the CQC via the national reporting and learning system[261] as well as to the relevant commissioner. Examples include wrong site surgery and retained instrument post operation
- key performance indicators – regular review of performance against national and local key performance indicators - for example, the time taken from referral to the commencement of treatment helps to keep service delivery on track and identify potential issues for greater focus
- outcomes – the achievement of defined outcomes for patients are closely monitored - for example, review time against minimum cluster review periods for mental health patients
- activity management - for example, analysing referrals to providers or agreeing an extension to a provider's waiting list to keep activity within the agreed contract.

Undertaking patient and public feedback

Every ICB has a duty to prepare a forward plan before the start of each year that shows how it intends to use its budget and improve outcomes for patients. These plans are prepared with ICS partners to ensure consistency across all organisations in terms of priorities and assumed activity levels. As mentioned earlier, these plans are discussed with the relevant HWB to ensure that they reflect the JSNA and JLHWS. ICBs (and NHS England) are also under a duty to ensure that people who receive services 'are involved in its planning and development, and to promote and extend public and patient involvement and choice.' This means making use of patient satisfaction surveys and using these to inform the next commissioning round. To ensure that this information is available, the requirement for patient feedback is often built into service specifications.

16.5 Effective commissioning

To be effective commissioners need to:

- have the necessary skills and experience (either themselves or via commissioning support units/ services – see chapter 4)
- engage with a broad range of clinicians
- improve community engagement
- ensure choice for patients.

They must also have access to information and skills that will support their decisions. To help them in this area, a national information system known as the secondary uses service (SUS)[262] collects patient level activity information from providers and makes anonymised data available to commissioners.

Other important sources of information include:

- population risk assessments
- referral patterns – ICBs monitor variations in referrals and query referral practice where appropriate
- details of past spending patterns and how these compare - for example, with other GP practices
- information to monitor actual activity against plans and expenditure against budgets

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[260] NHS England, *Revised never events policy framework*, January 2018
[261] NHS Improvement, *NRLS reporting,* 2022
[262] NHS Digital, *Secondary uses service (SUS)*, 2021

- additional data made available by service providers.

These other sources of information are particularly important as ICBs do not have access to identifiable patient data: while ensuring patient confidentiality this means that understanding pathways and individuals' use of different services can be challenging. This situation is exacerbated when working with other public services such as local authorities.

Key learning points

- Commissioners negotiate agreements with service providers to meet the health needs of their population.
- The key players in the commissioning field are currently NHS England, ICBs and local authorities.
- The aim is to improve health outcomes, reduce health inequalities, improve provider quality and increase productivity.
- Commissioners must make tough choices as demand for healthcare services always exceeds the level of funds available.
- Commissioning is a continuous process with many different elements grouped under three phases – planning, procurement and managing/ monitoring.
- A standard NHS contract is used by commissioners for all providers of secondary and community services.
- Commissioners must ensure national standards are met by providers - for example, those set out in the NHS Constitution.
- Contracts allow for a proportion of providers' income to depend on quality.
- Never events must be included as part of contract agreements. When they occur, they must be reported to the Care Quality Commission (CQC).

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, including a section dedicated to commissioning. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 17: Costing

Chapter 17. Costing

Overview

This chapter describes what costing is, how it is undertaken in the NHS, and how cost data is used.

17.1 Introduction

Understanding the cost of caring for patients is vitally important, both locally and nationally, when making decisions about how to manage and deliver sustainable high-quality services.

The *NHS long term plan*[263] aims to get the most value for patients out of every pound of taxpayers' investment. Robust and detailed cost data is vital for supporting this aim, allowing the NHS to understand service costs, reduce unwarranted variation and develop new models of care.

Good cost data can help NHS organisations and systems to understand variations in the way that patients are treated and the impact on available resources. When this information is linked to health outcome measures, the NHS can make value-based rather than volume-based decisions.

Providers of NHS services have increasingly large amounts of data about their service users and patients, with the roll-out of patient-level costing (PLICS) across the NHS. Cost data needs to be presented in a way that is clinically meaningful so that clinical teams are keen to work with finance teams to use the data to support service improvement.

Robust cost data is also vital for informing the payment system - the system of financial flows that moves money around the health service; see chapter 18 for more details.

17.2 What is costing?

Costing is the quantification, in financial terms, of the value of resources consumed in carrying out a particular activity or producing a certain unit of output.

Costing involves:

- being clear about the activity whose costs you are seeking to identify – it must be defined clearly and unambiguously
- making sure that the correct costs of everything and everyone involved in carrying out that activity are included in the costing calculation.

It is also important to analyse the costs themselves, how they are related to what is being costed and how they behave. We will look in more detail at these cost classifications later in this chapter.

17.3 What is costing information used for?

In the NHS, costing involves looking closely at healthcare services and identifying how much they cost. This can be at a variety of levels - for example, the total annual cost of the orthopaedic department in a hospital, the cost of a particular activity or group of procedures within that department (for instance, hip replacements) or the cost of treating an individual patient undergoing a

[263] NHS, *The NHS long term plan*, January 2019

hip replacement. Patient pathways often cross organisational boundaries, and it is important to understand costs across the whole pathway.

The NHS needs costing information for a variety of reasons, including the following:

Informing value-based decisions

Robust cost data, linked with quality and outcome data, is fundamental to understanding and measuring value. Value is covered in more detail in chapter 18.

Improving efficiency and effectiveness

Costing provides clinical and operational teams with the evidence to ensure that resources are used in the most effective way possible to provide high-quality care and support the reduction in unwarranted variation. Both Getting It Right First Time (GIRFT)[264] and the model health system (formerly the model hospital) use cost as well as other data to benchmark healthcare services.

Understanding patient pathways

Understanding how resources are allocated across a local health system (system costs) is key as the NHS moves to a more integrated approach to designing, planning and delivering services. Systems require cost and activity data describing the whole patient pathway across multiple services and organisations as they look to develop new models of care.

Developing payment systems

Cost data is used to inform the payment system. Future payment systems will support the activities that create patient value and focus more on system costs than price.

17.4 Patient-level costing

NHS costing has gone through a significant transformation, moving from costing based on averages to costing the actual care individual patients receive. Reference costs were based on average cost per contact derived from total service cost, apportionment of overheads and annual activity. They have now been replaced by patient-level costing. This:

- brings together healthcare activity information with financial information in one place
- costs the actual care an individual patient receives
- provides detailed information about how resources are used at patient-level - for example, staff, drugs, diagnostic tests
- supports the measurement of value.

All acute, ambulance, community and mental health services are required by NHS England to calculate their costs at patient level.

Patient-level costing can play a vital role in improving the efficiency and effectiveness of how patient care is delivered, bringing together information about the resources consumed by individual patients on a daily basis and combining this with the cost of the resource. When patient-level costs are analysed alongside other performance and quality information, they become even more powerful in understanding the delivery and performance of services. Patient-level costs also facilitate much more meaningful and constructive discussions with clinical teams.

[264] GIRFT, *Getting it right first time national programme*, 2022

17.5 The importance of high-quality data for costing

To generate reliable and robust cost information, costing accountants need access to high-quality data that describes the needs of the patients and the treatments received. At a patient level, this data may include the type of intervention, drugs prescribed for the patient, or consumable items used in their treatment. At an organisational level, this data may include information around estates costs, ancillary staff, or transport requirements. Even with the best costing processes in place, if the underlying clinical and operational data is of poor quality, cost data will be inaccurate.

17.6 Approved costing guidance

To ensure that costs are calculated on a consistent basis, NHS England issues annual *Approved costing guidance*[265] that sets out the costing standards to be used by providers of NHS services as well as collection guidance for submission.

Costing standards

The information requirement standard specifies the activity information and associated data fields required for patient-level costing.

The costing process standards cover the costing process from the general ledger to the patient unit cost and reconciliation to audited accounts.

The costing method standards cover the costing of high-volume and high-value areas - for example, medical staffing.

The guidance explains the approach to costing and cost collection that should be followed and sets out what service providers will need to do in this area to meet the conditions of their provider licence.

Costing principles

NHS England's guidance sets out three principles that should underpin good costing processes in an organisation:

- materiality - costing effort should focus on high-value and high-volume services
- data and information – high-quality activity data must be combined with financial data to generate costs that reflect the actual care received by patients
- engagement and use – costing teams should actively engage with stakeholders to encourage the use of cost information to drive service efficiency and improvement.

17.7 Cost classifications

To improve the ability to analyse information, costs are classified in two ways:

- direct, indirect or an overhead – to examine how costs relate to an element of patient care
- fixed, semi-fixed or variable – to examine how costs behave and inform the way that they can be controlled.

Direct costs

Direct costs relate directly to the delivery of patient care and arise as a result of individual patient episodes of care - for example, within a hospital ward the cost of drugs supplied and consumed can

[265] NHS, *Approved costing guidance 2022,* March 2022

be directly attributed to that ward by the pharmacy system. Hence, drugs would be a direct cost of the ward.

Indirect costs

Indirect costs are indirectly related to the delivery of patient care but cannot always be specifically identified to individual patients. Examples include catering and linen services.

Overheads

Overhead costs are the costs of support services that contribute to the general running of an organisation. These costs cannot be easily attributed to patients and need to be allocated via an appropriate cost driver (something that causes a change in the level of costs). For example, the total heating costs of a hospital may be apportioned to individual departments using floor area or cubic capacity. The assumption is that the larger the floor area occupied by a department the greater the amount of heating used. The key principle is that overheads are apportioned on a logical and consistent basis.

Fixed costs

Fixed costs are costs that do not change as activity changes over a 12-month period - for example, property rates.

Semi-fixed costs

Semi-fixed costs are fixed for a given level of activity but change in steps as activity levels exceed or fall below these given levels - for example, additional nursing staff costs may be incurred when the number of patients being treated rises above a certain level.

Variable costs

Variable costs vary proportionately with changes in activity. In other words, they are directly affected by the number of patients treated or seen - for example, drugs and consumables costs.

NHS England's costing standards classify costs as:

- patient facing costs - those costs that relate directly to delivering patient care and are caused or driven by patient activity
- overheads - those costs that do not relate directly to delivering patient care but to running the organisation or services that support the delivery of patient care - for example, the finance department.

17.8 National cost collection

The national cost collection has three annual publications[266]:

- national schedule of NHS costs: these show the national average unit cost for each service
- the national cost collection index (NCCI) measures the relative efficiency of NHS organisations from an index centred around 100 - for example, an NCCI of 110 suggests a provider's costs are 10% above average; a score of 90 suggests they are 10% below average
- database of source data: this allows a more detailed analysis of organisation level costs.

[266] NHS, *2019/20 national cost collection,* June 2021

Key learning points

- Costing involves quantifying the value of resources used to carry out an activity.
- Costing is not an end in itself – it is used to help deliver improvements in healthcare services and plays a key role in supporting the delivery of sustainable high-quality services.
- Costing information has many uses at both organisational and national levels.
- NHS England's *Approved costing guidance* sets out the principles and standards that NHS organisations must follow when calculating patient-level costs. It also contains guidance on the national cost collection.
- Costs are classified as direct, indirect or an overhead – here the focus is on how costs relate to an element of patient care.
- Costs can also be viewed in relation to how they behave – as fixed, semi-fixed or variable.
- A national cost collection index is published each year – this allows comparisons between NHS organisations.

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, including a section dedicated to quality, costing and value. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 18: Value and efficiency

Chapter 18. Value and efficiency

Overview

This chapter describes how the NHS maximises the use of its resources by focusing on value and efficiency.

18.1 Maximising the use of resources for patient care

When the government published the *NHS long term plan*[267], it made it clear that the plan needed to ensure that the NHS allocation is well spent. In the background to the plan, it states that every penny must be invested on the things that matter most. This includes high quality lifesaving treatment, care for patients and their families, reducing pressure on staff, and investing in new technologies. In essence, the need for a plan that delivers value, getting the best outcomes for the least cost.

As the country emerges from the immediate needs of the Covid-19 pandemic, finances are once again constrained. The focus on efficiency in the NHS has increased and expectations are high around the efficiencies that can be achieved through changing working practices. Revitalising savings programmes (sometimes known as waste reduction or cost improvement programmes) and focusing on value will be essential to ensure that resources are being used efficiently and effectively.

The move to greater system working with the introduction of integrated care systems (ICSs) supports the aim of the *NHS long term plan* to improve population health in a financially sustainable way. Value and efficiency are being considered at system level as well as within individual organisations.

18.2 What do we mean by value?

National Audit Office definition

The National Audit Office (NAO)[268] uses three criteria to assess the value for money of government spending, which they describe as the 'optimal use of resources to achieve the intended outcomes':

Economy: minimising the cost of resources used or required (inputs) – spending less

Efficiency: the relationship between the output from goods or services and the resources to produce them – spending well

Effectiveness: the relationship between the intended and actual results of public spending (outcomes) – spending wisely.

Value-based healthcare and the value equation

The notion of value in healthcare has largely been based on the work of Professor Robert Kaplan and Professor Michael Porter of Harvard Business School in the US, who stated that the value of healthcare should be measured in terms of patient outcomes against cost, referred to as the value equation[269].

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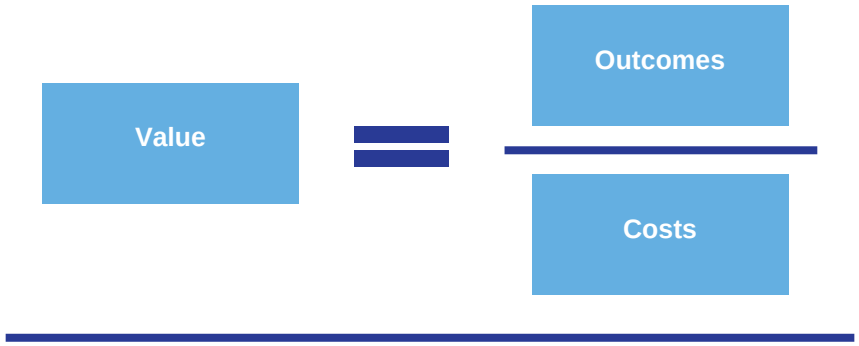
[267] NHS, The NHS Long Term Plan, 2019
[268] National Audit Office, *Assessing value for money,* 2021
[269] Robert S. Kaplan Michael E. Porter, Harvard Business Review, *The Big Idea: How to Solve the Cost Crisis in Health Care,* September 2011

The value equation



Outcomes are the full set of patient outcomes over the patient pathway

Costs are the total costs of resources used to care for a patient over the patient pathway

Allocative value

Technical value is about optimising the use of resources to achieve the best possible outcomes for people being treated within a given pathway or process. Achieving technical value is important for both individual organisations and systems, but a preceding question for systems is 'how should we allocate healthcare resources across the system to maximise outcomes for our local population?' This is often described as allocative value or allocative efficiency.

The NHS needs to consider allocative value as well as technical value. A hospital might optimise its treatment pathway such that admitted patients receive the best possible care in that setting. But this is only part of the patient's pathway; real value might be delivered if the patient had not been admitted in the first place. If a patient had been identified earlier as needing support and then that support had been provided in a community setting, it may well have delivered better outcomes for the patient by avoiding a hospital admission and – at a system-level, reducing overall costs of treatment.

The Triple Aim

Population health is a key component of the 'Triple Aim'. The Institute for Healthcare Improvement Triple Aim is a framework that describes an approach to optimising health system performance. It believes new ways of working must be developed to simultaneously pursue three goals:

- improving the patient experience of care (including quality and satisfaction)
- improving the health of populations
- reducing the per capita cost of healthcare.

The triple aim[270] concept continues to evolve, and it has been discussed that this should be a quintuple aim[271], with two further aims that address:

- improving the work life of healthcare staff – for example, to address stress
- health equity for all individuals.

[270] Institute for Healthcare Improvement, IHI Triple Aim Initiative, 2022
[271] Nundy S, Cooper LA, Mate KS. *The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity,* JAMA, January 2022

18.3 Outcome measures

Outcome data is a key building block when measuring value. Although the NHS collects a lot of clinical data, many of the measures focus on inputs, processes, or outputs, rather than outcomes.

As well as looking at clinical outcomes, it is important to measure value in terms of the outcomes that matter to patients - for example, patient-reported outcomes measures (PROMS) and experience measures (PREMS).

The International Consortium for Health Outcomes Measurement (ICHOM)[272] has developed standard sets of outcome measures for a wide range of medical conditions.

18.4 Financial efficiency programmes

NHS organisations must implement efficiency plans to support the delivery of high-quality care within the limited resources available. These plans are often known as cost improvement programmes (CIPs) or waste reduction programmes. They focus on either using existing resources in a more efficient way - for example, increasing the number of patients treated within a theatre session, or reducing the level of resources required to deliver the same level of healthcare services; both are ways of improving productivity.

The approach can involve maximising the use of resources required to deliver current service models, or more fundamentally changing the way services are delivered by redesigning clinical pathways. This is commonly known as transformational change.

18.5 The role of clinical and financial collaboration in improving value

Good collaborative relationships are required between clinicians, operational staff and finance, to ensure value is at the centre of decision-making. Every clinical decision is a financial decision, and clinical and finance professionals need to share responsibility for deciding priorities and allocating resources. Quality and productivity improvements become possible when clinical and finance staff collaborate, as their joint efforts can highlight inconsistencies in service delivery, reduce waste, improve patient safety, and identify new pathways of care.

The lack of appropriate finance training, early in their career, means that senior clinicians often do not have the expertise they need in this area. Likewise finance staff can struggle to understand the clinical world and need to think about how best to present financial information and data to clinical teams. Getting the right people in the room with the relevant skillsets, looking at activity, outcome and cost data that is clinically meaningful, is a powerful driver for service transformation and quality improvement.

The HFMA briefing *Exploring the role of the NHS finance business partner*[273] notes the important role of business partners in supporting the delivery of safe, effective and financially sustainable clinical services. They have a critical role in supporting the decision-making of those responsible for the commitment of resources, both clinicians and operational managers.

[272] International Consortium for Healthcare Outcomes Measurement, *Our mission,* 2022
[273] HFMA, *Exploring the role of the NHS finance business partner,* November 2019

18.6 National initiatives supporting the value and efficiency agenda in England

There are several initiatives currently underway in England that support the value and efficiency agenda:

- Getting It Right First Time (GIRFT)[274]
- patient-level costing (PLICS)[275]
- the model health system[276].

GIRFT

GIRFT is designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The programme is led by frontline clinicians who are expert in the areas they are reviewing. There are over forty clinical workstreams underway, covering acute surgical and medical specialties, as well as mental health.

Lord Carter's operational and productivity reviews and the model hospital

Between 2016 and 2018, Lord Carter of Coles published a series of operational and productivity reviews[277,278,279], that identified significant unwarranted variation across key resource areas in acute, community, mental health and ambulance services. By eliminating variation in quality and efficiency, the reports concluded that the NHS would deliver better services for patients and save money.

The model hospital was initially developed to meet recommendations set out in Lord Carter's review of acute hospitals. It provides a comparative view of NHS operational productivity at a provider level. It is broken down into six sections offering different perspectives from which to review hospital activity: board-level oversight; clinical service lines; corporate service lines; people; care settings; and clinical support services. Using a weighted activity unit (WAU) it helps NHS trusts compare their productivity on a like-for-like basis.

The different versions of the model hospital for acute, mental health, community and ambulance services, are incorporated into the model health system. This provides operational and system-level data across local ICS areas.

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[274] GIRFT, *Getting it right first time national programme*, accessed August 2022
[275] See chapter 17
[276] NHS England, *Model health system*, accessed August 2022
[277] Department of Health and Social Care, *Productivity in NHS hospitals,* June 2015
[278] NHS, *Lord Carter's review into unwarranted variations in mental health and community health services,* May 2018
[279] NHS, *Lord Carter's review into unwarranted variation in NHS ambulance trusts,* September 2018

Key learning points

- Constrained finances mean that the NHS must continually consider how to improve value and efficiency.
- NHS organisations must implement efficiency programmes, commonly known as cost improvement programmes, to either use the existing resources in a more efficient way or reduce the level of resources required to deliver the same level of healthcare services.
- The value equation and allocative value provide the NHS with a framework for maximising the use of resources for patient care at an organisational and system level.
- Collaboration between finance staff and clinicians is key to improving value.
- National initiatives such as GIRFT and the model health system both support the value agenda in England.

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, including sections dedicated to quality, costing and value, and delivering efficiencies. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 19: How NHS services are paid for

Chapter 19. How NHS services are paid for

Overview

This chapter sets out how funding is transferred from commissioners to providers of healthcare services. It considers the evolution of the payment mechanism, the legal framework surrounding it and the way that payments can be used to influence behaviour.

Primary care funding flows are covered in chapter 6.

19.1 What is a payment mechanism?

A payment mechanism is a system of financial flows to move money around the health service and is used to reimburse providers of NHS healthcare in England. The payment mechanism can be used to incentivise provider and healthcare system behaviour, depending upon current priorities. The payment mechanism sets out the elements that contribute to the payment amount, such as activity undertaken, quality of care and patient outcomes, as well as any penalty regime for under or non-achievement. The NHS standard contract described in chapter 16 plays an important role in supporting the application of the payment mechanism, through setting out the conditions that apply in a particular context.

The NHS has traditionally used a combination of different payment mechanisms across all services but, from 2022/23 most secondary care services have moved to a single payment mechanism, the aligned payment and incentive approach[280].

This is a type of blended payment (see below) and was first introduced in 2021/22. It is intended to be a steppingstone in the development of the updated payment systems for 2023/25[281], and to provide a stable transition from the block payment arrangements that were used during the Covid pandemic.

19.2 Types of payment

Activity based payment

An activity-based payment is a sum linked to either a single unit of care, such as an outpatient appointment or a spell (a continuous period of time spent as a patient within a trust), or a pathway, where several related units are linked together as one. Acute care and ambulance services have traditionally been paid on this basis.

Block payment

A block payment is a lump sum amount that covers all activity undertaken. Payments for all services are bundled together and it is not directly linked to activity levels. Community health and mental health services have traditionally been paid on this basis.

[280] NHS England, *Guidance on the aligned payment and incentive approach,* February 2022
[281] NHS England, *2023/25 NHS payment scheme consultation,* December 2022

Blended payment

NHS England has had a blended payment approach for most of the activity across all secondary and tertiary care settings from 2022/23. This is made up of a fixed payment, like a block, with a variable element to address particular policy issues. More information is included later in this chapter.

19.3 Evolution of the payment mechanism

Payment by results

The first version of the payment mechanism - payment by results (PbR), was a key element in the NHS reform agenda set out in the 2000 NHS Plan[282]. The government at that time wanted to be sure that the large increases in resources that it planned over a five-year period would be used to develop and deliver a higher volume and quality of clinical services. To achieve there needed to be a financial system that contained the right balance of reward, incentive and equity, and therefore, PbR was introduced.

PbR was originally designed to bring about fundamental change to the way funds moved between commissioners and providers for the payment of secondary care services. PbR did not affect the way funds flowed to commissioners but it affected the way that commissioners spent that allocation. Commissioners paid providers for each patient seen or treated, in many cases at the national pre-set rate. Therefore, if more patients were treated than originally planned, the commissioner would spend more money, causing a financial pressure for the commissioner.

PbR affected the income received by providers; they were paid for the actual work they did, often at a national pre-set rate, or tariff. Therefore, if more or less patients were treated than planned, the provider may have had more or less income than anticipated.

National tariff[283]

Prior to the Health and Social Care Act 2012[284], national prices were set by the Department of Health and Social Care (DHSC). The Act transferred the responsibility of the NHS payment system to NHS England and NHS Improvement (Monitor, as it was at the time). The national tariff was developed and introduced in 2014 with the intention that it would support both commissioners and providers to address the challenges facing them, in three ways:

- by offering more freedom to encourage the development of new service models
- by providing greater financial certainty to underpin effective planning
- by maintaining incentives to provide care more efficiently.

The national tariff was a legal framework that covered prices for treatments and procedures, the methodology for setting them and the underpinning rules. Under the national tariff, payments made to providers of care for NHS patients, be they from the NHS, private or independent sector, were linked to the activity and services actually provided. For most secondary care activity, payment was based on a national pre-set price for a defined measure of output or activity while recognising the type, mix, complexity and severity of the treatment provided.

Prior to 2022/23, the national tariff primarily covered elective (including outpatients) and non-elective acute care (including urgent and emergency care), and ambulance services. It did not cover all healthcare services but for those services included within it, the rules of the tariff had to be followed.

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[282] NHS, *The NHS plan*, July 2000
[283] NHS England, *National tariff,* 2022
[284] HM Government. *Health and social care act 2012, 2012*

However, there was provision within the tariff for local variation to prices and currencies, through an agreed process. This flexibility was included to enable service transformation.

The national tariff also set out the national efficiency requirement that applied to all secondary healthcare services. Billing, payment and activity reporting processes were set out in the national tariff document, along with payment for NHS funded services provided by local authorities. All licensed healthcare providers were required to comply with the national tariff and provide information to support its development.

Covid-19 arrangements

The local administration of the national tariff created a significant number of transactions, reconciliations, and queries to ensure that the correct activity was being charged to the correct commissioner, within the agreed contract terms.

The Covid-19 pandemic completely disrupted the normal flow of activity within the NHS, forcing the cancellation of routine procedures and elective care, as well as the repurposing of facilities and the redeployment of staff to support Covid-19 patients. The national tariff could not be used in this situation as organisations had little certainty over activity and had to respond to the changing demands of the pandemic. The enforced drop in activity would have created significant deficits if tariff payments had been maintained.

Consequently, all organisations were moved to a block payment based upon the month 9 agreement of balances process from 2019/20 - the most recent agreed position at the time. This simplification of the financial regime allowed the NHS to focus on the immediate needs of the pandemic. It freed up staff normally employed in transactional finance roles to support their clinical colleagues and it allowed organisations to work freely together without the normal financial barriers to cooperation.

While it was accepted that the simplified financial regime was not sustainable and may be causing wastage, many welcomed the reduction in transactional processing that freed up staff to focus on more transformational work. In addition, the positive outcomes of effectively removing financial barriers were something that the NHS wished to retain, driving the next, and most recent, change to the payment system.

Aligned payment and incentive approach

The 2019/20 national tariff introduced blended payments for emergency care and some mental health services, with the intention that the approach would be gradually expanded to other services in future years. However, with the move away from an activity-based approach due to Covid-19, an opportunity arose to move faster.

The *2022/23 national tariff payment system*[285] moves almost all secondary healthcare services, including acute, community, ambulance and mental health onto an aligned payments and incentive approach building on the blended payments introduced in 2019/20. The approach covers all contracts between providers and commissioners in the same system, as well as all contracts over £30m where providers and commissioners are in different systems. All specialised commissioning activity will be covered by these arrangements.

A blended payment is made up of a fixed and variable element. The fixed payment is locally determined and does not need to be built from individual prices/ tariffs. This element of the payment makes up most of the value. Ultimately, it is expected to be based on the costs of delivering a level of activity that conforms to the integrated care system's (ICS) plan. The payment value is expected to evolve over time to become more reflective of the actual costs of delivering the defined activity.

[285] NHS, *2022/23 national tariff payment system,* March 2022

Prices have still been published, as in previous tariffs, but are not mandated for use. These prices could also be used where blended payments do not apply - for example, contracts below the threshold value.

The variable element can be used to incentivise specified activity or quality objectives. In 2022/23, the variable element is being used to support national efforts to recover elective activity.

There will still need to be some national prices due to the conditions of the *Health and Social Care Act 2012*. These are appropriate for diagnostic imaging services.

Any independent sector activity commissioned through a national framework or subcontracted by NHS providers, would be based on published tariff prices.

The aligned payment and incentive approach is designed to support:

- more efficient allocation of resources, including a focus on health maintenance and prevention activities
- collaborative system behaviours and collective management of system financial resources
- a focus on patient value, high quality care and good patient outcomes
- transparency and accountability to provide assurance that resources are being put to best use.

However, there is a danger that moving to fixed payments could reduce accountability and visibility of how resources are spent locally. The aligned payment and incentive approach will continue to evolve, to ensure that it meets these objectives.

2023/25 NHS Payment Scheme consultation

To support the move to system working, the *Health and Care Act 2022*[286] sets out several changes to the legislation surrounding the payment mechanism.

From 1 April 2023 the National tariff payment system will be replaced by the NHS payment scheme (NHSPS). The overall scope of the NHSPS will not change. It will still cover transactions between providers and the commissioners of NHS funded care, including acute, ambulance, community and mental health services and will not apply to payments for primary care services. The 2023/25 NHS payment scheme – a consultation notice [287] looks at the rules that will apply to activity that is within scope:

- contracts with NHS providers over £500k per annum will use the aligned payment and incentive (API) approach (fixed element and variable element, paying 100% of NHSPS prices for elective activity)
- contracts with NHS providers under £500k per annum will use the low volume activity (LVA) approach of block payments (nationally set values)
- contracts with non-NHS providers where there is a nationally set price will be accompanied by activity-based payments (activity x unit prices)
- contracts with non-NHS providers where there is a no nationally set price are subject to local payment arrangements (payment approach is locally determined).

Once the consultation has concluded, NHS England will publish a document called the *NHS payment scheme* containing the rules for determining the price that is payable by a commissioner for the

[286] UK Parliament, *Health and Care Act 2022*, April 2022
[287] NHS England, *2023/25 NHS payment scheme – a consultation notice*, December 2022

provision of healthcare services or public health functions. Both commissioners and providers must comply with the rules.

The publication will need to be updated regularly and NHS England must undertake a consultation process (of at least 28 days) with all integrated care boards (ICBs) and provider bodies as well as any other person or body that is considered appropriate. This is accompanied by an objection process.

The payment scheme can be amended during the financial year for which it has effect unless the amendment is so significant as to require a new edition of the scheme.

19.4 Importance of currency

For the payment mechanism to work, it is important to decide what is being paid for, what is the unit of healthcare or 'currency'? Different parts of the NHS use different currencies to best reflect the way that patients are treated, and care delivered. The healthcare resource group (HRG) is the currency used for admitted patient care (covering a spell of care from admission to discharge), procedures undertaken in outpatients and accident and emergency attendances.

HRGs group services that are clinically similar and require similar resources for treatment and care. The HRG applies to a procedure or treatment regardless of where it takes place and supports the provision of components of healthcare outside of hospitals with 'unbundled tariffs' whereby the payment or tariff can be shared between different providers. It provides the ability to differentiate between procedures and treatments, recognising the different costs associated with treating patients of different ages, those with multiple co-morbidities (related chronic illnesses) or where there are additional complications. Overall, there are around 4,000 different HRGs.

The currency for outpatient attendances is the attendance itself, split between first and follow-up attendances, the broad medical area (defined by a treatment function code) and whether the attendance relates to a single professional or a multi-professional team.

The currency used for adult mental health and learning disability services is the 'care cluster'. It describes the common needs of a group of patients/ service users over a period of time. Each of the 21 clusters includes several different diagnostic codes; the mental health clustering tool enables service users to be matched with the appropriate cluster. However, clustering has not been universally adopted across the sector. NHS England is currently working to develop a new mental health currency model.

NHS community health services do not yet have a defined currency model. Work is ongoing to develop currencies that reflect the way that care is delivered in this sector, recognising that care tends to be over a longer period with multiple interventions as people manage long term conditions. As this is similar to mental health services, currencies for the two sectors are being developed to complement each other.

For ambulance services, four broad activities are used as the currency here:

- urgent and emergency care calls answered (price per call)
- hear and treat/ refer (price per patient)
- see and treat/ refer (price per incident)
- see, treat and convey (price per incident).

Prices for each of these categories are locally agreed.

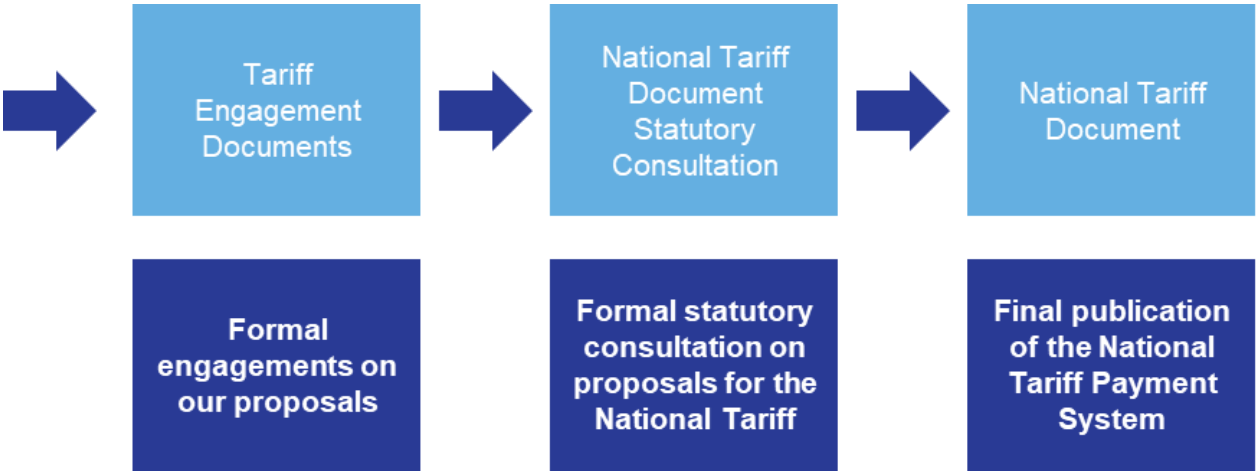
Currencies do not have to have a payment attached but they provide an agreed way to count and measure activity. They therefore underpin all payments approaches where it is necessary to understand activity in order to fund a service at the correct level.

19.5 Setting the national tariff

Legal framework

The *Health and Social Care Act 2012* set out in law the process of producing the national tariff and the associated documents. Previously, NHS England and NHS Improvement worked to a staged process for the development and publication of the *National tariff*[288] document as set out below:

Development of the National tariff



The stages, timing and documents and their statutory basis that applied are set out in the table below:

Basis for development of the *National tariff*

Stage	Documents released	Statutory basis
National tariff engagement	Tariff engagement documents	Not applicable
Statutory consultation	Proposed *National tariff document* for the coming year including proposed final prices	Section 119 of the *Health and Social Care Act 2012*
Publication of the *National tariff*	Final *National tariff document* for the coming financial year	Section 116 of the *Health and Social Care Act 2012*

The *National tariff document* (NTD)[289] was fundamental; it detailed:

- the services covered by the payment mechanism and their prices where applicable

[288] The *Health and Social Care Act 2012* requires the document to be called the 'national tariff'
[289] NHS England, *National tariff payment system document, annexes and supporting documents*, 2022

- how the prices have been calculated
- variations to nationally set prices
- how and when the local agreement of a change to a national price may be appropriate
- the underpinning rules associated with payment.

This process continues under the NHS Payment Scheme (NHSPS).

Key learning points

- A payment mechanism is the way that funding is transferred from a commissioner to a provider.
- The NHS has used several different approaches, each of which has its own advantages and disadvantages.
- The *Health and Social Care Act 2012* required the NHS to publish a national tariff which sets out prices for most acute sector activity.
- The *Health and Care Act 2022* sets out several changes to the legislation surrounding NHS payments, to support the move to system working and an aligned payment and incentive approach.
- Introduced in 2022/23, the aligned payment and incentive approach encourages collaborative system working and the more effective allocation of resources.
- The NHS payment scheme (NHSPS) continues to develop with further work during 2022/23, and engagement across the health system.

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.

HFMA introductory guide to NHS finance

Chapter 20: NHS charitable funds

Chapter 20. NHS charitable funds

Overview

This chapter looks at the management of funds held on trust and is based on the legislative framework as it applies to England and Wales. The key Act is the *Charities Act 2011 (*as amended by the *Charities Act 2022)* which brought together all relevant charities' legislation from previous years (other than a few minor provisions) including Acts passed in 1992, 1993 and 2006.

20.1 Background

There are over 230 NHS charities in the UK that collectively give £1m every day to the NHS (NHS Charities Together[290]). Most of these charities have a single corporate trustee, an NHS body, but 26 NHS charities in England are now independent charities that appoint their own individual trustees.

The majority of the funds given come from a small number of significant NHS charities - for example, the Great Ormond Street Hospital Children's Charity. Most NHS charities operate at a much lower level. The NHS saw an increase in charitable donations during the Covid pandemic and therefore the level of charitable giving is expected to reduce in the coming years.

There is no single total held for all NHS charities; some charities are independent such as Great Ormond Street Hospital Children's Charity or the Barts charity, and these are not consolidated into the Department of health and Social Care's (DHSC) accounts. However, the vast majority of NHS charities are consolidated, and as at 31 March 2021, these had a value of £640m. If the value of independent charities were to be added to this total, the value would significantly increase.

The accumulation of these funds is, in part, a consequence of the historical funding of early health services through charitable sources. When the NHS was created, most existing charitable assets were pooled into hospital endowments funds. The main exceptions to this were teaching and university hospitals, that retained control of their endowments through boards of governors and management committees respectively.

Over the years, the NHS has been reorganised many times and laws passed to allow the charitable funds to transfer to NHS organisations that can use them for their intended purpose.

More recently, charitable funds have been boosted through capital growth and income from investments, legacies, donations and fundraising appeals. During the Covid-19 pandemic, the national emergency appeal managed by NHS Charities Together raised over £140m[291], and in addition to this, individual NHS charities will have run local appeals.

20.2 Regulation – roles and responsibilities

Department of Health and Social Care

The DHSC no longer has a role in relation to regulating NHS charities in England although it needs to be informed when an NHS charity moves to independent status and may be involved in conversations at an earlier stage of that decision process.

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[290] NHS Charities Together, *About us: who we are,* 2022
[291] NHS Charities Together, *Covid-19 appeal impact report*, December 2020

NHS charities (those with a corporate trustee) are designated by the Office of National Statistics (ONS) as public sector bodies. This means that they need to be consolidated into the DHSC's annual report and accounts. Therefore, NHS bodies in England will need to submit information about their charitable funds to NHS England at the financial year end. Independent NHS charities are not consolidated into the DHSC's annual report and accounts.

Devolved governments

Northern Ireland - The Department for Communities is responsible for the policy and legal framework for charities in Northern Ireland, including the appointment and removal of trustees.

Wales - Welsh ministers have authority under the *NHS (Wales) Act 2006* to appoint/ remove trustees and to hold and administer NHS charitable funds.

Scotland - Scottish ministers have authority under the *National Health Service (Scotland) Act 1978* to appoint or remove trustees and to manage NHS charitable funds.

All NHS charities in the devolved nations have their associated NHS body, local health board, NHS trust or health and social care trust, as their corporate trustee. They are consolidated into the local health body corporate trustee's accounts as well as the devolved government's accounts.

Further details are provided in the *Devolved nations* chapters of this guide.

Charity Commission for England and Wales

The Charity Commission for England and Wales[292] (the Commission) is the statutory organisation that regulates charities in England and Wales. Its aim is to maintain public confidence in the integrity of charity which it does by encouraging better methods of administration, giving advice to trustees and investigating and correcting abuse. The Commission has the power to change the objectives of a charity where this is necessary and where trustees do not have the power to do so themselves.

All charities in England and Wales must apply to register with the Commission if either:

- the annual income of the charity is at least £5,000
- the charity is established as a charitable incorporated organisation (CIO).

Only exempt charities and certain excepted charities are not required to register.

In England and Wales, all registered charities are required to make an annual return to the Commission within 10 months of the financial year end (so, for NHS charities with a 31 March year end this is the end of January the following year)[293]. In addition, the following information is required by the same deadline:

- charities with an annual income of less than £10,000 must submit their income and expenditure
- charities with an annual income over £10,000 but less than £25,000 must file an annual return that asks questions about the charity, its financial position, funding sources, where it operates and how it is managed and submit its annual report and accounts
- charities with an annual income over £25,000 must file an annual return and submit their annual report and accounts with the statement from the independent examiner or auditor.

[292] UK Government, *Charity commission for England and Wales,* 2022
[293] The Charity Commission, *Prepare a charity annual return,* updated March 2020

Office of Scottish Charity Regulator

The Office of the Scottish Charity Regulator (OSCR)[294] is the statutory independent body that grants charitable status to and regulates charities operating in Scotland. It has a statutory duty under the *Charities and Trustee Investment (Scotland) Act 2005* to encourage and assist charities to meet their legal requirements.

All charities in Scotland are required to register with OSCR. This may include charities registered with the Charity Commission for England and Wales where those charities also work in Scotland[295].

All charities in Scotland must submit the following to OSCR within 9 months of the financial year-end[296]:

- the annual return
- annual report and accounts
- the independent examiner or audit report.

Charity Commission for Northern Ireland

Charities operating in Northern Ireland must register with the Charity Commission for Northern Ireland (the NI Commission)[297] to be recognised as a charity for tax purposes. The NI Commission is an independent regulator and a non-departmental public body sponsored by the Department for Communities. It was established in March 2009, to deliver the legislative requirements of the *Charities Act (Northern Ireland) 2008*.

The NI Commission's vision is to deliver 'a dynamic and well governed charities sector in which the public has confidence, underpinned by the Commission's effective delivery of its regulatory and advisory role.'

All organisations that meet the following conditions must apply for registration as a charity in Northern Ireland:

- the organisation has exclusively charitable purposes
- it is governed by Northern Ireland law
- it is an organisation that is an independent body – it has control and direction over its governance and resources.

The NI Commission is currently running a staged process for the registration of charities with charities will be called for registration. Newly formed charities must file an expression of intent so that the NI Commission is aware of their existence.

In Northern Ireland, charities registered with the NI Commission must submit the following[298]:

- the annual return
- annual report and accounts
- the independent examiner or audit report.

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[294] OSCR, *About us,* April 2022
[295] OSCR, *Registration,* April 2018
[296] OSCR, *Annual monitoring*, 2021
[297] The Charity Commission for Northern Ireland, *About us,* 2022
[298] The Charity Commission for Northern Ireland, *Annual reporting*, 2021

20.3 The nature and purpose of charitable funds

A charitable fund is created when funds are accepted by a trustee to be held and used for the benefit of a beneficiary or beneficiaries. The arrangement is usually governed by a legal instrument that sets out the terms of the fund and the purpose to which monies are to be applied by the trustee.

Charitable funds held on trust must provide public benefit, be exclusively charitable and be used to further the funds' objectives. There are thirteen acceptable charitable purposes set down in legislation[299]. The categories are subject to the overriding requirement of demonstrable public benefit.

The thirteen charitable purposes in England and Wales

1. The prevention or relief of poverty
2. The advancement of education
3. The advancement of religion
4. The advancement of health or saving lives
5. The advancement of citizenship or community development
6. The advancement of the arts, culture, heritage or science
7. The advancement of amateur sport
8. The advancement of human rights, conflict resolution or reconciliation or the promotion of religious or racial harmony or equality or diversity
9. The advancement of environmental protection or improvement
10. The relief of those in need by reason of youth, age, ill-health, disability, financial hardship or other disadvantages
11. The advancement of animal welfare
12. The promotion of the efficiency of the armed forces of the Crown, or of the efficiency of the police, fire and rescue service or ambulance services
13. Other purposes beneficial to the community not falling under any of the other headings.

There are three classes of charitable funds recognised in law:

- unrestricted funds – that may be spent at the discretion of the trustees in line with the charity's objectives

[299] *For England and Wales, these purposes are s*et out in the *Charities Act 2011*. The charitable purposes in Scotland and Northern Ireland are set out in the *Charities and Trustee Investment (Scotland) Act 2005* and *Charities Act (Northern Ireland) 2008*. The charitable purposes in all four nations are similar but there are some differences.

- restricted funds – that can only be spent in accordance with, usually, written restrictions imposed when the funds were donated or granted or in accordance with the specific terms of an appeal raised for the charity
- endowment funds – where capital funds are made available to a charity and trustees are legally required to invest or retain them.

Endowment funds can be 'permanent' (trustees have no automatic power to spend the capital, only the income generated through its investment), or 'expendable' (trustees can convert capital to income and spend it on the fund's purpose). The law does allow charities to spend permanent endowment in certain circumstances but permission (except in some limited circumstances) would need to be sought from the Commission.

Funds may also be 'designated' or 'earmarked' which means that trustees can set aside unrestricted funds for a specific purpose or more typically for an area of the hospital's operations - for example, cardiology, urology or nursing staff benefits.

Designating funds can be a useful way of building up funds through periodic transfers from unrestricted funds over time for a significant project or where funds are needed to meet on-going costs to which formal, on-going commitments have been made. It may also be a useful way to recognise the apparent wishes of donors which do not create a restricted fund. Funds can be undesignated if the original need is no longer relevant.

Donations are given to be spent on charitable purposes, so trustees are expected to spend them as soon as possible rather than simply accumulating them 'for a rainy day' or 'just in case'. Trustees are therefore required to develop and regularly review their reserves policy that sets out the level of unspent, unrestricted funds the charity indents to hold.

Charities can accumulate funds for specific long-term projects but if trustees want to accumulate funds generally, they must request a 'power of accumulation' from the appropriate regulator (unless the governing document already allows them to do so).

20.4 Charitable income

There are five main sources of new money for charitable funds:

- donations
- fundraising
- legacies
- investment income and interest
- grants.

In some circumstances, income can also be generated through:

- trading – but only if it is in pursuance of the fund's primary purpose - for example, at a training course for NHS staff there may be an ancillary trade in refreshments
- charging for part or all of a service provided by the fund (but only if it is for public benefit, and charging must not restrict access).

It is important to note that trustees are not obliged to accept funds on trust and should refuse income where the conditions imposed by the donor are too onerous, inappropriate or where the trustees are

unlikely to be able to use funds as directed. To avoid criticism and safeguard their own position, trustees are advised to seek advice from the appropriate regulator before refusing a donation.

Acceptance of all donations should be tested against the general principle that it does not, nor appear to, place an NHS charity or the trustee NHS body under an inappropriate obligation. Consideration should also be given where the values of the donor are not consistent with those of the NHS.

Donations

Donations can be:

- solicited - for example, through posters, leaflets or other appeals
- unsolicited - for example, where, at the end of a hospital stay, a patient asks how they can donate to the ward or hospital charity.

Donations of both types can be unrestricted or restricted - for example, an unrestricted donation would arise when a patient or relative gives money 'for the hospital charity' or 'for the ward funds' without specifying how it should be used. Even if there is a particular use suggested, it will only be a 'restriction' if the terms are strictly limited - for example, 'it must be used' or 'must only be used' – and it is formalised in writing. A donation made in response to a fundraising leaflet soliciting donations for a general fund would also be unrestricted.

Ideally, the proportion of donations received as restricted funds is minimised to avoid limiting spending flexibilities. One way to do this is to use a standard form of receipt that invites donors to record how they 'wish' their donation to be used 'without imposing any trust'. The wishes expressed can be reflected through the designation of donations, but donations on these terms are unrestricted. Such a receipting system can also assist with accountability and the receipt can incorporate an invitation to donate under Gift Aid arrangements.

It is important that staff who receive unsolicited donations know how to deal with them as a matter of good financial management as well as to ensure that restricted funds are not unwittingly established.

Fundraising

Fundraising income results from events (anything from coffee mornings and sponsored swims through to high profile celebrity events) and targeted appeals. If the money is sought for an explicit purpose - for example, if tickets or a poster for a charity dinner state 'all proceeds from this event will be used to buy monitors for the special care baby unit', then it must be used for that and nothing else.

Fundraising is now regulated by two non-statutory bodies:

- for England, Wales and Northern Ireland - the Fundraising Regulator[300]. Charities that register with the regulator are listed in their publicly available directory and are allowed to use the fundraising badge on their website and fundraising materials. There is a fee for registering
- in Scotland - the Scottish Fundraising Adjudication Panel[301].

Applicable from October 2019, the *Code of Fundraising Practice*[302]covers the whole of the UK.

The power of NHS trustees to raise funds is set out in legislation:

- section 222 of the NHS Act 2006

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[300] Fundraising Regulator, *About us,* 2022
[301] Scottish Fundraising Adjudication Panel, *About us,* 2022
[302] Fundraising Regulator, *Code of fundraising practice,* updated June 2021

- section 169 of the NHS (Wales) Act 2006
- section 84A of the NHS (Scotland) Act 1978
- schedule 14 of the Health and Personal Services (Northern Ireland) Order 1972.

These Acts permit funds to be used more flexibly where there is an insufficient response (a failed appeal) or an excess of funds over and above the appeal target, provided certain safeguards are met. However, attention should be paid to the wording of all promotional literature and tickets to ensure they do not remove the flexibility the Act provides in applying excess funds, or the funds of failed appeals, for general purposes.

Legacies

Legacies can be restricted or unrestricted depending on the terms on which the bequest is made. The wishes or desires of a donor are normally non-binding designations; however, reference should be made to the terms of the gift to ensure that a binding restriction does not mean that the legacy is restricted funds.

NHS charities which are the beneficiary of any will should, as a matter of best practice, ensure that they have a copy of the will and that it is kept for as long as the charity has the bequest. This will ensure that the charity can meet any terms attached to the donation.

If the legacy cannot be fulfilled - for example, if the function it was intended for no longer exists, or has been transferred to another body, the NHS trustee(s) concerned should consider whether they received the legacy under section 218 of the *NHS Act 2006*, which may provide a power to redirect the funds, but advice should be sought from the Charity Commission for England and Wales.

If it appears that section 218 does not apply, then an application must be made to the Charity Commission for England and Wales for a scheme that allows the legacy to be used in another way. Scottish and Northern Irish charities should apply to their regulator for a scheme.

Investment income and interest

Where charitable funds have surplus monies not needed to fund immediate charitable activities, trustees may invest to generate additional income. However, they must do so in line with legislation and the relevant regulator's guidance and having considered all aspects when making their decision.

In England and Wales, the relevant legislation is the *Trustee Act 2000* which includes a general power of investment that can be used in relation to any charity property held on trust (except property of charitable companies) subject to any 'restriction or exclusion' affecting the charity.

Investment income and interest (and any gains or investment losses) must be apportioned to the individual fund that generates it. Where the trustee(s) administer(s) more than one charity, the income and investment gains and losses must also be apportioned to the respective charities. In the case of designated unrestricted funds of a charity the trustee(s) is permitted to apply investment gains for any of the objects of the charity concerned.

Where investments are made in stocks and shares, trustees should consider the appropriateness of the investment; either as regards the company or industry sector – for example, the trustees may not consider it appropriate in a tobacco company, or one involved in the arms trade.

Trustees' responsibilities when making investments

When making investments, trustees must ensure they further the purposes of the trust; this is normally achieved by securing the best possible returns on investments. However, following Butler-Sloss case[303] further investment guidance has been issued.

The high court judgement[304] ruled that where an investment, or a class of investment, could be in potential conflict with the charitable purposes, trustees can decide to exclude such investments from their portfolio. For example, a charity can exclude investments in tobacco companies if this is deemed to conflict with the purposes of the charity.

The Charity Commission is currently updating Charities and investment matters: a guide for trustees (CC14)[305]; this will include further information on social investments.

Grants

Grants are usually restricted income given for a specific purpose. As well as the general principles that apply to the use of (and accounting for) restricted funds, grants often have additional requirements attached - for example, how an acknowledgement is made in the accounts or other public documents.

As well as the general principles that apply to the use of and accounting for restricted funds, grants often have additional requirements attached including - for example:

- how an acknowledgement, if any, is made in the accounts and other public documents
- how any asset purchased, facility built, or service provided with grant monies is named or branded
- the nature and frequency of monitoring and evaluation reports.

It is important that these additional requirements are met.

20.5 Spending charitable funds

A charitable fund can only spend money in line with its charitable purpose. In other words, in the interests of the fund's beneficiaries (i.e. NHS patients) and not the NHS organisation to which it is linked. Charitable funds cannot be used to fund services; they are for areas that are not covered by national funding.

This does not mean that the charitable fund must itself purchase items of equipment etc. for use in its linked NHS organisation. Most NHS charities are grant making – this means that they provide the funding for the NHS body to purchase goods or services. This ensures that ownership (and any related liabilities) of assets rest with the NHS trust.

Grant making charities should have clear policies and procedures in relation to how grant applications should be made and what types of grant the charity will fund. This guidance should make it clear that grants can only be made to fund schemes that have a charitable purpose and what this means in practice. It should also be well advertised to all possible beneficiaries to ensure that funding is not restricted to those who understand the system.

There are some areas of charitable spending that may need additional consideration:

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[303] UK government, *Update on investment guidance following Butler-Sloss case,* November 2022
[304] England and Wales high court (chancery division), *Butler-Sloss & Ors v The Charity Commission for England And Wales & Anor [2022]* EWHC 974 (Ch) (29 April 2022) bailii.org)
[305] The Charity Commission, *Charities and investment matters: a guide for trustees (CC14),* 2016

- spending on staff – trustees need to be satisfied that the expenditure will have the result of making staff more effective in their roles. Expenditure in staff is not in itself charitable but it can be conducive to the furtherance of the charitable purposes of the employer on the basis that happy staff result in happy patients. Different charities will reach different conclusions in relation to such items of expenditure – this is not necessarily an issue as long as the reasons for the conclusions are well documented.
- spending on research – trustees need to be satisfied that the outcome will be publicly available and is within the scope of the charity's objectives.

  delivery of public services - generally, most NHS charitable funds have been set up to enhance statutory provision rather than to provide what might be regarded as basic public services. If funds are to be used to deliver services, then the trustees will need to ensure that they follow the appropriate processes to approve the expenditure.

Many NHS charities hold lots of small funds and this can impact on the effective use of charitable monies; values may be low, and it can be difficult to spend the monies effectively. It is good practice to regularly review the volume and the purpose of funds. The HFMA briefing *Streamlining NHS charitable funds, Lessons learned from experience*[306] provides some additional detail in this area

20.6 Trustees - the different types

NHS bodies are not themselves charities. Only the property they hold on trust exclusively for charitable purposes constitutes a charity.

The charitable fund's governing documents set out who or what controls, manages and administers the charity; these are the trustees. There are two types of trustee in the NHS, corporate and independent.

Corporate trustees

Most charitable funds in the NHS are managed by a corporate trustee; it is the NHS corporate body (the NHS organisation as an entity) that is the trustee. The governing body of the NHS body acts on behalf of the corporate trustee in the administration of the charitable funds but the members of the governing body are not themselves individual trustees.

This means that the regulator will have a relationship with the corporate body rather than the individuals on the board of the NHS body. Should regulatory action need to be taken, it will be with the NHS body rather than the members of the board. Other than this difference in accountability, the way that members of the board need to act towards the NHS charity is very similar to an individual trustee.

Members of the board must be aware of the requirements of being part of the corporate trustee, and guidance is issued by the relevant bodies that detail requirements as follows:

- in England and Wales, *CC3 The essential trustee: what you need to know*[307]
- in Scotland, *Guidance and good practice for charity trustees*[308]
- in Northern Ireland, *CCNI EG024 Running your charity guidance*[309].

[306] HFMA, *Streamlining NHS charitable funds, Lessons learned from experience,* 2022
[307] The Charity Commission, *The essential trustee*, updated May 2018
[308] OSCR, *Guidance and good practice for charity trustees*, updated December 2017
[309] The Charity Commission of Northern Ireland, *Running your charity guidance,* 2021

Corporate trustee meetings should be held separately from other business, and relevant directions for the establishment, functions and operations of the committee be included in trust standing orders.

Independent trustees

In England, there is a second type of trustee for NHS charities.

Under the *NHS Charitable Trusts (Etc) Act 2016*, English NHS charities can decide to apply to transfer their charitable property to another specifically established independent charity[310].

Where this route is followed, the new charity is regulated solely by the Charity Commission for England and Wales and is 'free to set its own constitution including objects, legal form and trustees' appointments appropriate to its needs'[311]. Independent charities have no relationship with the DHSC and are not classified as public bodies by the ONS.

The transfer of assets to the new charity cannot be reversed but there are several safeguards to protect the interests of patients and the linked NHS organisation. In particular, all assets retain the same designation and the objects of the original charity continue (although they could be expanded to support wider health provision).

The independent trustee model does not currently apply in the devolved nations, where all NHS charities have a corporate trustee. However, work is underway to change the governance arrangements for NHS charities in Scotland following an independent review[312]. The review recommended that an independent trustee board should be established for each of the 16 NHS charities in Scotland[313].

20.7 Trustees – roles and responsibilities

Whether trustees are individually appointed to independent charities or are board members of the corporate trustee, it is important to read the appropriate guidance issued by the charity regulator about trustees' roles and responsibilities.

They should also familiarise themselves with the:

- terms of the charity's governing document
- procedures that have been prescribed in legislation and regulations
- standing orders and standing financial instructions
- relevant guidance on public benefit, decision-making and managing conflicts of interest.

In broad terms, trustees have a duty to ensure compliance, a duty of prudence and a duty of care.

Compliance

Trustees must ensure that:

- the charity complies with charity law and with the requirements of the appropriate regulator. As part of this, they must ensure that the charity prepares its annual report, returns and accounts as required by law
- the charity does not breach any of the requirements or rules in its governing document

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310 DHSC and NHS Charities Together, *NHS charities - conversion to independent status*, updated February 2020
311 DHSC, *Regulation of NHS Charities*, updated March 2014
312 Health Secretary, *Statement on the independent review of governance of NHS endowments*, October 2021
313 Julie Hutchinson LLB TEP WS, *Review of governance of NHS endowment funds*, October 2021

- any fundraising activity undertaken by or on behalf of the charity is properly undertaken and that funds are properly accounted for – this will usually include issuing detailed guidance to staff and volunteers.

Duty of prudence

Trustees must:

- ensure the charity is and will remain solvent
- ensure the charity's income and property is applied solely for the purposes set out in its governing document and for no other purpose
- use charitable funds and assets wisely and only in furtherance of the charity's objects
- avoid activities that might place the charity, its assets or reputation at risk
- take special care when investing the charity's funds
- ensure adequate financial management and control arrangements are in place
- ensure the charity's expenditure is applied fairly amongst those who are qualified to benefit from it
- not allow the charity's income to accumulate unless there is a specific power of accumulation and a future use for it in mind
- have an agreed reserves policy that is reviewed regularly.

Duty of care

Trustees must:

- exercise such care and skill as is reasonable in the circumstances having particular regard to:
  - any special knowledge or experience that he or she has or professes to have
  - where he or she acts as a trustee in the course of a business or profession, to any special knowledge or experience that it is reasonable to expect of a person acting in the course of that kind of business or profession
- act with integrity and avoid any personal or organisational conflicts of interest
- ensure they have appropriate risk management plans in place. Trustees of charities with gross annual income over £500,000 must make a statement about risk management in their annual report
- consider using external professional advice where there may be a material risk to the charity.

20.8 The management of charitable funds

Day-to-day management

Trustees have ultimate responsibility for the running of their charity and can only delegate authority that is specified in the trust's governing document or legislation.

When acting on behalf of corporate trustees, governing bodies of NHS organisations must recognise that:

- the charitable funds they are managing are distinct from their exchequer (NHS) monies

- they have separate and distinct responsibilities for the administration of the charitable funds.

Meeting these responsibilities is best achieved by:

- holding board meetings separately to deal with charitable funds business
- establishing a separate committee to deal with matters relating to the charitable funds – this committee then reports to the board of the NHS organisation acting as corporate trustee.

The frequency of trustee meetings will vary depending upon the size of the charitable funds being administered and the volume and complexity of its transactions. Meetings need to be frequent enough to avoid any delays to the charity's administration that might lead to a failure to meet legal and regulatory requirements or to poor management of its resources.

Whenever they delegate responsibility, trustees must ensure that:

- they have the power to delegate the proposed responsibilities and the arrangements are documented in a scheme of delegation
- the scope of delegated authority is clearly written down – in the form of standing orders, standing financial instructions, policies, procedures and guidance notes
- the person(s) to whom they delegate specific responsibilities has the necessary skills and experience to discharge them competently
- proper reporting procedures and clear lines of accountability are in place
- they are properly informed of all matters that affect their ability to fulfil their responsibilities.

NHS charities often use the financial services facilities used by the corporate trustee NHS body. However, its responsibilities as trustee cannot be delegated and it remains liable for the quality of the services it receives.

A recent inquiry by OSCR, *Inquiry report made under section 33 of the Charities and Trustee Investment (Scotland) Act – Tayside NHS Board Endowment Funds (SC011042)*[314] illustrates some of the issues that need to be considered when making grants to an NHS body, particularly in a corporate trustee situation:

- the corporate trustee was effectively acting to meet a deficit incurred by NHS Tayside in its provision of NHS services by retrospectively agreeing grant applications
- the charity trustee did not sufficiently recognise its duty to consider separately and distinctly the interests of the charity
- despite poor governance and decision-making, charitable assets were only used for charitable purposes and the projects to which grants were awarded were advancing the health of the people of Tayside and therefore in pursuit of the charity's purposes
- charity trustee's board members did not at the time of the key decision see legal advice provided to the charity
- the legal advice the charity received came from the NHS in-house solicitors; it would have been good practice for the charity to have obtained independent legal advice to ensure it was acting, and seen to be acting, independently.

[314] OSCR, *Inquiry report made under section 33 of the Charities and Trustee Investment (Scotland) Act – Tayside NHS Board Endowment Funds*, February 2019

Governance best practice

All of the regulators have produced guidance on best practice in governance:

- Charity Commission for England and Wales, *Charity governance, finance and resilience: 15 questions trustees should ask*[315]
- OSCR, *Guidance and good practice for charity trustees*[316]
- Charity Commission for Northern Ireland, *Manage your charity*[317].

Charities in England and Wales are encouraged to follow the advice set out in the *Charity governance code*[318] which is not a legal or regulatory requirement but sets out the principles and recommended practice for good governance.

Seven principles of charity governance

1. Organisational purpose - the charity's aims are clear so trustees can ensure that they are being delivered effectively and sustainably.
2. Leadership - every charity is led by an effective board that provides strategic leadership in line with the charity's aims and values.
3. Integrity - the board acts with integrity, adopting values and creating a culture that help achieve the organisation's charitable purposes. This includes being aware of the importance of the public's confidence and trust in charities and undertaking duties accordingly.
4. Decision-making, risk and control – making sure that decision-making processes are informed, rigorous and timely and that effective delegation, control and risk assessment and management systems are set up and monitored.
5. Board effectiveness - the board works as an effective team, using the appropriate balance of skills, experience, backgrounds and knowledge to make informed decisions.
6. Equality, diversity and inclusion - the board's approach to diversity supports its effectiveness, leadership and decision-making.
7. Openness and accountability – the board leads the organisation in being transparent and accountable.

To be able to discharge their responsibilities effectively, trustees need management information to inform their decision-making. As well as the more usual financial information relating to budget and spend to date, trustees will need:

- to be informed of significant donations
- a list of large or significant transactions

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[315] Charity Commission for England and Wales, *Charity governance, finance and resilience: 15 questions trustees should ask,* March 2017
[316] OSCR, *Guidance and good practice for charity trustees,* December 2017
[317] Charity Commission for Northern Ireland, *Manage your charity,* June 2019
[318] Charity Governance Code, *Good governance*, 2020

- a summary investment report
- a report on slow moving or overdrawn funds
- a report on the use of the chairperson's discretionary powers.

Risk management

Trustees should maintain a risk register and review it on a regular basis to ensure the effectiveness of actions taken to mitigate identified risks.

20.9 Accounting requirements

The detailed requirements for the preparation and submission of annual accounts of individual charities that are not charitable companies depend upon their level of income or expenditure and where they are based in the UK.

All charities with a gross annual income of over £250,000[319] in the financial year (and all charitable companies) must prepare their accounts on an accruals basis (i.e. all income and expenditure relating to the financial year is included in the accounts regardless of whether cash has actually been received or paid) and follow the *Statement of Recommended Practice (SORP)*[320]. Below this threshold, eligible charities may elect to prepare their accounts on a receipts and payments or accruals basis.

Trustees are also required to ensure that the charity keeps proper books and records. As a minimum, all charities must:

- prepare and maintain accounting records that must be retained for at least 6 years
- prepare annual accounts and make these available to the public on request
- prepare a trustees' annual report and make it available to the public on request.

What charity accruals accounts comprise

- a statement of financial activities (SOFA) for the year that shows all incoming and outgoing resources and reconciles all changes in its funds
- a balance sheet, showing the recognised assets, liabilities and different categories of fund of the charity
- for larger charities[321] only, a cash flow statement
- notes explaining the accounting policies adopted.

Independent assurance

In England and Wales, NHS charities' accounts must be audited if either the charity's gross income exceeds £1m, or its gross assets exceed £3.26m and gross income exceeds £250,000.

NHS charities below the audit threshold must be independently examined in accordance with the guidance issued by the Charity Commission for England and Wales.

In Wales, Scotland and Northern Ireland, NHS charities are consolidated into their corporate trustee's annual accounts and therefore fall under the audit arrangements for those organisations.

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[319] These thresholds are subject to change. The current thresholds are available on the relevant regulator's website.
[320] Charities SORP, *About the SORP-making body,* 2022
[321] Larger charities are those with a gross income exceeding £500,000.

20.10 The annual report

The trustees' annual report is one of the key tools available to charities to help them communicate with stakeholders including donors, beneficiaries and the wider public. It is normally presented with the accounts but is legally a separate document. The SORP sets out in detail the minimum data requirements. These include[322]:

- objectives and activities
- achievements and performance
- financial review
- structure, governance and management
- reference and administrative details.

The amount of detail required depends on whether the charity is a larger charity or not.

Key learning points

- To be charitable, funds must exist to provide public benefit.
- There are 13 acceptable charitable purposes, they differ slightly depending on the nation that the charity works in.
- There are three main types of charitable fund – restricted, unrestricted and endowment.
- Charitable funds income comes from five main sources – donations, fundraising, legacies, investment income and interest and grants.
- All charitable funds spending must be in line with its charitable purpose.
- There are two types of trustee in the NHS in England – corporate and independent.
- Only corporate trustees currently exist in Wales, Scotland and Northern Ireland.
- Trustees have a duty to ensure compliance, a duty of prudence and a duty of care.
- The Charity Commission for England and Wales, the Office of the Scottish Charity Regulator (OSCR) and the Charity Commission for Northern Ireland are the statutory organisations that regulate all charities not just NHS charitable funds.
- Trustees cannot delegate their statutory duties and responsibilities.
- Charitable funds have written rules and procedures governing the formal conduct of their business including standing orders, standing financial instructions and schemes of delegation.
- Charities with a gross annual income of more than £250,000 must prepare accruals accounts and follow the Charities SORP.
- Charitable funds must produce an annual report which is normally presented with the annual accounts.

[322] This is not an exhaustive list. Full details, including exemptions for smaller charities, are set out in the published SORPs which are available via the Charity Commission's website.

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, including a section dedicated to NHS charitable funds. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 21: Health and Social Care in Northern Ireland

Chapter 21. Health and Social Care in Northern Ireland

Overview

This chapter describes the structure and governance of the Health and Social Care (HSC) service in Northern Ireland.

In addition, the chapter outlines the significant structural changes that are being introduced. The HSC is currently developing new arrangements and processes to deliver an integrated approach to health and care delivery, one that empowers healthcare partners to work in partnership across organisational boundaries.

21.1 Introduction

The primary difference between the NHS in England and services in Northern Ireland is that in Northern Ireland health services and social care are fully integrated. The Department of Health (DoH) is one of the nine government departments that administers the responsibilities devolved to the Northern Ireland Assembly (NIA).

Currently, the specific elements of the health and care system for Northern Ireland consist of the Strategic Planning and Performance Group (SPPG) within the DoH, a multi-professional Public Health Agency (PHA), five local commissioning groups (LCGs) to cover the same geographical area as five health and social care trusts (HSC trusts) and seventeen integrated care partnerships (across the five local commissioning group (LCG) areas to ensure coverage of all GP practices).

The Northern Ireland Ambulance Service is the sixth trust in Northern Ireland and provides a regional emergency and non-emergency ambulance service. A regional Business Services Organisation (BSO) provides a range of business and administrative support functions for the health and social care service.

In recent years the DoH has published several documents and consultations as part of a long-term strategy to develop and enhance healthcare services across the region. In 2019, the DoH published *Quality 2020*[323] that set out a 10-year plan to protect and improve the quality of health and social care. The strategy identifies several design principles that should continue to inform planners and practitioners over the next 10 years. The strategy states that a high-quality service should:

- be holistic in nature
- focus on the needs of individuals, families and communities
- be accessible, responsive, integrated, flexible and innovative
- surmount real and perceived boundaries
- promote wellbeing and disease prevention and safeguard the vulnerable
- operate to high standards of safety, professionalism and accountability
- be informed by the active involvement of individuals, families and communities, HSC staff and voluntary and community sectors
- deliver value for money ensuring that all services are affordable, efficient and cost-effective.

[323] DoH, *Quality 2020 - a ten year strategy to protect and improve quality in health and social care in Northern Ireland,* October 2019

In 2021 the Health and Social Care Bill was introduced to address identified weaknesses in the system, particularly around complex and bureaucratic structures, and to provide greater clarity and transparency on accountability and decision-making. The bill became law in 2022 (*Health and Social Care Act (Northern Ireland)*[324] *2022* (the Act)).

In 2021, the DoH also published a consultation entitled *Future planning model – integrated care system NI, draft framework*[325] (the framework). This identified the purpose of the integrated care system (ICS) as:

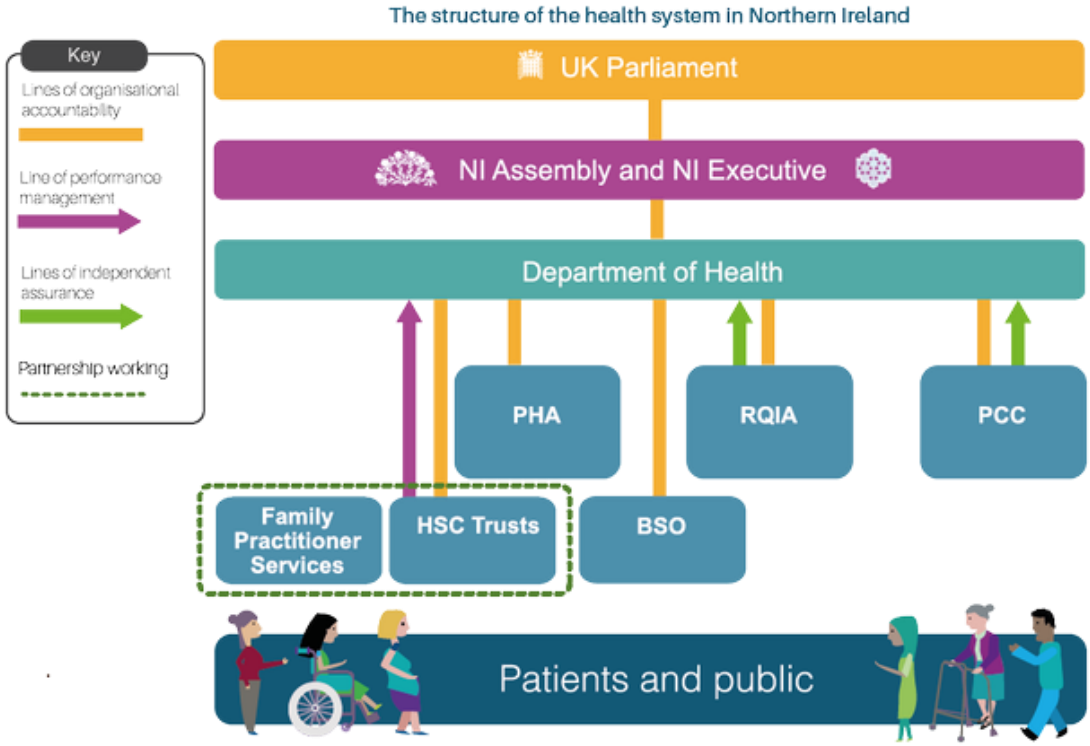
> 'A collaborative partnership between organisations and individuals with a responsibility for planning, managing, and delivering sustainable care, services and interventions to meet the health and wellbeing needs of the local population. Through taking collective action, partnerships will deliver improved outcomes for individuals and communities, and reduce inequalities.'

Work continues to establish the associated organisational structures and working arrangements[326].

21.2 The structure of the HSC

The diagram below shows the current structure of health and social care in Northern Ireland.

Structure of the HSC



Each of these areas has specific responsibilities, outlined in the sections below. Where structural changes are planned as part of the development of an ICS system, these are identified.

[324] Northern Ireland Assembly, *Health and Social Care Act (Northern Ireland) 2022*
[325] DoH, *Future Planning Model – Integrated Care System NI, Draft Framework*, September 2021
[326] HSC, *Integrated care system Northern Ireland,* 2022

Statutory bodies

UK Parliament

The funds for running all public services in the UK ultimately come from Parliament and the public sector in Northern Ireland is expected to operate within the broad framework established by HM Treasury.

Northern Ireland Assembly

The Northern Ireland Assembly (NIA) is the devolved legislature of Northern Ireland. It has power to legislate in a wide range of areas that are not explicitly reserved to the UK Parliament, and to appoint the Northern Ireland Executive. It consists of 90 democratically elected members of the legislative assembly (MLAs). There are five MLAs elected to each of the 18 constituencies across Northern Ireland.

Northern Ireland Executive

The Northern Ireland Executive is the executive arm of the NIA. It is answerable to the Assembly and consists of a First Minster, Deputy First Minister and ministers with individual portfolios and remits. Each minister oversees a department and is responsible for its policy and business.

Power sharing

The NIA operates under a power sharing arrangement and the government must have representatives from both the nationalist and unionist communities.

The first minister is chosen by the largest party in the assembly. If the largest party is 'unionist' then the deputy first minister would be from the largest 'nationalist' party, and vice versa.

At present, no agreement exists between the main parties on formalising the power sharing arrangements and as such it has not been possible to fully establish the executive, nor to appoint a new Speaker to the assembly since May 2022.

Without an executive office, there is no new legislative programme, and until a speaker is appointed it is not possible to hold debates or for ministers to be scrutinised.

Discussions continue with the UK government to resolve this issue, but if this is not possible, further elections will be called.

Department of Health

In Northern Ireland, both health and social care are the responsibility of the Minister for Health. The Department of Health's (DoH) remit covers policy and legislation relating to:

- health and social care - this includes hospitals, family practitioner services, community health and personal social services
- public health - to promote and protect the health and wellbeing of the population of Northern Ireland
- public safety - this covers fire and rescue services.

The DoH's mission is to improve the health and social wellbeing of the people of Northern Ireland. It endeavours to do this by:

- leading a major programme of cross-government action to improve the health and wellbeing of the population and reduce health inequalities. This includes interventions involving health promotion and education to encourage people to adopt activities, behaviours and attitudes

that lead to better health and wellbeing. The aim is a population that is much more engaged in ensuring its own health and wellbeing.
- ensuring the provision of appropriate health and social care services, both in clinical settings such as hospitals and GP surgeries, and in the community through nursing, social work and other professional services.

The Permanent Secretary of the DoH is also chief executive of the HSC, as well as principal accounting officer for the DoH.

Within the DoH, the key business groups are the:

- Strategic Planning and Performance Group
- Healthcare Policy Group
- Social Services Policy Group
- Office of the Chief Medical Officer.

Established under the 2022 Act, the Strategic Planning and Performance Group (SPPG) is part of the DoH and replaces the Health and Social Care Board (HSCB).

Together with local commissioning groups and integrated care partnership committees (see below), it is accountable to the Minister for Health. Its role is to translate the vision for health and social care into a range of services that deliver effective outcomes for users, good value for the taxpayer and compliance with statutory obligations.

To achieve this, the SPPG plans and oversees the delivery of health and social care services for the population of Northern Ireland and takes responsibility for planning, improving and overseeing the delivery of effective, high quality, safe health and social care services within available resources.

One of its key tasks is to ensure effective commissioning of a full range of health and social care services. In addition, the SPPG performance manages HSC bodies against agreed objectives and targets, including the effective use of resources.

There are five professional groups within the department, each led by a chief professional officer. These are the:

- chief medical officer group
- office of social services
- nursing, midwifery and allied health professionals (AHP) directorate
- dental services
- pharmaceutical advice and services.

The DoH reviews any guidance issued by the National Institute for Health and Care Excellence (NICE) and decides if it is relevant for Northern Ireland. If guidance is not considered relevant, or if the DoH decides that it is only partly relevant, it advises on any changes that need to be made. The DoH is likely to approve most NICE guidance and usually decides shortly after NICE has made its decision.

Existing local arrangements

Local commissioning groups (LCGs)

There are currently five local commissioning groups[327] (LCGs). Each LCG is a subcommittee of the SPPG and is co-terminus with its respective HSC trust area. The five LCGs are:

[327] HSC, *Local commissioning groups*, 2022

- Belfast
- Northern
- Southern
- South Eastern
- Western.

LCGs are responsible for assessing health and social care needs; planning health and social care to meet current and emerging needs; and securing the delivery of health and social care to meet those needs.

Under the new ICS arrangements, LCGs will be replaced with area integrated partnership boards (AIPBs). Their key responsibilities cover the strategic planning for their areas, and the local delivery of services that meet local population needs.

Integrated care partnerships (ICPs)

Established in May 2013, integrated care partnerships[328] (ICPs) operate within each LCG area. There are 17 ICPs across the five LCG areas. Each ICP is based around natural geographies of approximately 100,000 people and 25 – 30 practices. ICPs bring together a range of providers from across the health and social care system to review how care is being provided and to consider how services could be improved and better coordinated. ICPs focus on services for frail elderly people and those with some long-term conditions: respiratory conditions, diabetes and stroke. They support the overall vision of making home and the community the hub of care.

The new ICS framework looks to further enhance local and community partnership working. It is expected that local level structures will be based around existing GP federations and integrated care partnership areas and will align and integrate with local council structures (community planning partnerships) and boundaries. The aim is to involve individuals and community leaders, and to ensure there is access and engagement in the provision of services.

Health and social care trusts

The five HSC trusts provide the full range of local acute, mental health and community services. Regional and specialist services may also be provided by individual trusts. As integrated organisations, trusts also provide social care services including nursing home and domiciliary care, learning disability and children's community services. Trusts fulfil the role of 'corporate parent' to children in care, the majority in foster care.

HSC trusts, as corporate entities, are responsible in law for the discharge of statutory social care functions delegated to them by virtue of authorisations made under the *Health and Personal Social Services (Northern Ireland) Order 1994*. Trusts are accountable for the discharge of such functions and are obliged to establish sound organisational and related assurance arrangements to ensure their effective discharge.

New local arrangements

Developing an integrated care system (ICS)

The rationale behind the development of an ICS across Northern Ireland is set out in the *future planning framework*.

The new approach is described on page 8 of the framework as:

[328] HSC, Integrated care partnerships (ICPs), 2022

- the way we design and deliver services must be focused on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration
- local providers and communities must be empowered to work in partnership, including health and social care (HSC) trusts, independent practitioners, and the voluntary and community sectors.

It identifies the overarching roles and responsibilities of the bodies that will support this arrangement. This partnership structure is shown in the diagram below:

Proposed partnership structure

Although the exact responsibilities and structural arrangements are to be finalised, the framework lays out the intentions as:

- regional: oversight, co-ordination and support across the economy including overall responsibility for governance and accountability across the system, and for coordinating the planning and delivery of region wide and specialist services

- area: strategic area planning and local delivery. Five AIPBs, one per trust area, will have responsibility for ensuring local populations' needs are met, while guided by the region wide strategy
- locality: operating at GP federation and ICP areas. Local groups will be working to deliver programmes and interventions, agreed by the AIPBs, at that locality level. Alignment will be developed with other key locality partners, for instance, local councils
- community: a focus on individual towns/ communities. Engagement in the provision of healthcare needs at that local community level, linking to GP practices, community pharmacies and other community partnerships. The exact arrangements will be determined on a community-by-community basis.

The programme to establish the ICS model is progressing, and a steering board, chaired by the Permanent Secretary, has been established. Further details about the ICS development and governance arrangements and FAQs have been provided by the HSC[329].

Funding under the ICS model

No changes are proposed to the current funding model; arrangements are, and would be, complex, and it is expected that they would take some time to develop. The framework does lay down the overarching principles that are expected to apply in the future, although no timescale has currently been set.

The intention is that local areas will control central resources, and being responsible for allocating and managing funds, to ensure cost effective delivery of healthcare for their local population. The AIPBs will be responsible for agreeing how resources should be utilised (working with all ICS partners), and there would be no presumptions as to how funding is allocated; funding would not automatically lie with any specific organisation or service.

Other healthcare agencies

Public Health Agency

The Public Health Agency (PHA) has four primary functions:

- improvement in health and social wellbeing – working with partners across different sectors and communities to make the best use of collective resources; focusing on giving children the best start in life, ensuring a decent standard of living for all and making healthy choices easier
- health protection – protecting the population from infection and environmental hazards
- public health support to commissioning and policy development
- HSC research and development – promoting research and development into initiatives designed to improve the health and wellbeing of the population of Northern Ireland.

Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is an independent health and social care regulatory body. Its functions include promoting quality through disseminating best practice; regulating a wide range of health and social care services through registration; monitoring and inspection; reviewing and reporting on clinical and social care governance in health and social care and keeping the DoH informed about the provision, availability and quality of health and social care services.

[329] HSC, *Integrated Care system NI*, 2022

Its role is to ensure that health and social care services in Northern Ireland are accessible, well managed and meet the required standards. The RQIA works to ensure that there is openness, clarity and accountability in the management and delivery of all these services.

Patient and Client Council

The Patient and Client Council (PCC) is a regional body supported by five local offices operating within the same geographical areas as the five regional HSC trusts. The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers and communities on health and social care issues.

Business Services Organisation

The Business Services Organisation (BSO) provides a range of business and administrative support and specialist professional services to health and social care bodies - for example, financial services; human resources; legal services; information technology and procurement of goods and services. BSO hosts the HSC shared services department that delivers accounts payable; accounts receivable; payroll and recruitment services for all HSC bodies.

The regional procurement and logistics service (PALS) is part of BSO and is the sole provider of professional supplies services (logistics and procurement) to all public health and social care organisations in Northern Ireland. It is a recognised centre of procurement expertise established under the Northern Ireland Public Procurement Policy as approved by the Northern Ireland Assembly.

Other HSC agencies and non-departmental public bodies (NDPBs)

A variety of specialist functions are carried out by organisations on a Northern Ireland-wide basis. These include:

- Northern Ireland Blood Transfusion Service
- Northern Ireland Guardian Ad Litem Agency
- Northern Ireland Practice and Education Council
- Northern Ireland Medical and Dental Training Agency
- Northern Ireland Social Care Council
- Northern Ireland Fire Rescue Service.

21.3 How health and social care is financed

Overall public sector funding for Northern Ireland is provided via the Northern Ireland block vote, as part of the national spending reviews. It is based on a population driven mathematical formula known as the Barnett Formula that has been in use since 1979. Changes to the total provision for Northern Ireland are largely determined through the principle of comparability, whereby HM Treasury adjusts the Northern Ireland block vote in line with comparable programmes in England.

The NIA has the discretion to allocate devolved resources within the Northern Ireland block across all departmental spending programmes. The DoH sets its proposed allocations in the context of the Minister's overall priorities and objectives for the DoH's public expenditure programme. Spending on health and social care equates to approximately 46% of the total public expenditure (revenue and capital) within the control of the NIA (2022/25 Draft Budget[330]).

[330] Department of Finance, *2022-2025 Draft Budget*, February 2022

Revenue allocation

The DoH makes direct revenue allocations to the SPPG, PHA, RQIA and PCC in the form of a revenue resource limit (RRL). This is to cover hospital, community health and social care services and equates to approximately 50% of total public expenditure.

The SPPG and PHA use a weighted capitation revenue allocation formula to determine target allocations for hospital, community health and personal social services on a programme of care basis. The formula determines how much each of the five LCGs receives to purchase services for its residents from trusts.

Allocations are also made to the SPPG to commission the four family practitioner services – general medical, pharmacy, dental and ophthalmic services.

Budgets are set for each LCG area based on a weighted capitation formula. Performance against budget for each LCG area is closely monitored particularly in those areas of high expenditure - for example, prescribing.

As well as commissioning income, HSC trusts may also receive income from:

- other government bodies or charitable organisations in the form of grants
- the Northern Ireland Medical and Dental Training Agency (NIMDTA)
- the DoH to fund specific initiatives - for example, funding for professional training and research and development
- contributions from clients in nursing or residential care provided through trusts where clients have been assessed as being able to pay
- charges to staff, visitors or patients - for example, catering, parking or private patient facilities
- recovering the costs incurred if a person treated after being involved in a road traffic collision subsequently makes a successful claim for personal injury compensation
- charitable donations for the benefit of and expenditure on patients and clients. These charitable funds are accounted for separately from the funds that trusts are allocated for providing healthcare to patients and running their organisations
- commercial research activities.

Capital allocation

The DoH also receives a capital allocation from the NIA – in 2022/23 this amounts to approximately 18% of the total public sector capital budget. Capital allocations are made directly to the PHA, trusts and smaller non-departmental bodies in the form of a capital resource limit (CRL).

Strategic capital planning is the responsibility of the DoH. Individual HSC organisations submit business cases for capital requirements that must be supported by the commissioner (SPPG) and submitted to the DoH for formal approval. Trusts are allocated funding for non-specific capital expenditure (general capital) used for replacement equipment, maintenance and minor capital works. The utilisation of this funding is also supported by business cases, samples of which are checked for compliance by the DoH.

The DoH is informed by, and contributes to, the overall 10-year Investment Strategy for Northern Ireland prepared by the Northern Ireland Executive.

21.4 How HSC organisations demonstrate financial accountability

HSC bodies have two statutory duties: to break even and to stay within their revenue and capital resource limits.

HSC trusts prepare annual accounts in formats prescribed by the DoH. Accounts are produced based on guidance in HM Treasury's *Financial Reporting Manual*[331] (FReM) following international financial reporting standards (IFRS).

The DoH issues a detailed manual of accounts for all health and social care bodies that is updated annually as required to reflect changes in reporting requirements. Where these differ for a DoH body, the manual sets out the procedures that the body must follow.

The accounts must be formally adopted by the DoH, in time to meet the NIA summer recess deadlines (normally June following the financial year-end on 31 March). Following this the accounts must be published on the websites of the HSC bodies and made available to members of the public.

The director of finance is responsible for preparing the accounts.

The annual accounts are audited by the Northern Ireland Audit Office (NIAO), either by its own staff or by contracting out to private sector firms of accountants and auditors. Each set of accounts is then formally laid before the NIA. The Assembly has a Public Accounts Committee (PAC) with a similar role to the committee of the House of Commons of the same name.

HSC bodies are required to have in place suitable internal audit arrangements. At present, this service is provided by BSO Internal Audit Unit. Internal audit must comply with Public Sector Internal Audit Standards (PSIAS). The adequacy of the internal audit arrangements is reviewed and reported on each year by the NIAO as part of their report to those charged with the governance of each body.

The 2021/22 DoH annual report and accounts were laid before the NIA on 8 July 2022[332]

21.5 How HSC organisations are regulated

The key regulatory body in Northern Ireland is the Regulation and Quality Improvement Authority (RQIA), as described earlier.

21.6 How HSC organisations are structured and run

The governance regime for HSC bodies is like that in place throughout the NHS in the rest of the UK making use of codes of conduct and accountability, internal audit, external audit, board reports, annual accounts, annual reports and public board meetings.

As with the NHS in England, the board of each HSC body is the pre-eminent governing body. There are also two mandatory committees of the board – audit and remuneration.

Chief executives of HSC organisations are designated accounting officers. They are accountable to the DoH (and ultimately to the NIA) for the appropriate stewardship of public money and assets and for the organisation's performance. Chief executives are also accountable to their board for meeting its objectives and the day-to-day running of the organisation.

[331] HM Treasury, *The Government Financial Reporting Manual: 2021/22*, December 2021
[332] Department of Health, *Annual report and accounts, for the year ended 31 March 2022*, July 2022

21.7 Commissioning

The SPPG develops an annual commissioning plan in close partnership with the Public Health Agency through a commissioning cycle that covers:

- assessing needs
- strategic planning across the HSC and all programmes of care
- priority setting
- securing resources to address needs
- agreeing with providers the delivery of appropriate services (and subsequent monitoring of that delivery)
- assuring that the safety and quality of services commissioned are improving, that recommendations from the RQIA and other reviews have been implemented and that as a minimum, services meet DoH and other recognised standards
- evaluating the impact of that assessment and feeding learning back into the new baseline position in terms of how needs have changed.

For the most part the SPPG/ PHA commissioning plan reflects the decisions and recommendations of the LCGs as they have devolved responsibility for assessing and ultimately addressing the needs of their local populations, working within regional policy and strategy frameworks, available resources and performance targets.

The geographical basis of LCGs better reflects the needs of natural communities and the organisation of local health and social care economies, including hospitals, community networks and geographically based partners. On the other hand, commissioning around 'communities of interest' or client-groups, or 'programmes of care' can ensure that the needs of service users and carers are addressed holistically, and services are planned in a coordinated way to meet identified needs.

Both approaches operate within the health and social care commissioning landscape in Northern Ireland. While the establishment of LCGs gives prominence to geography, this is balanced by programme of care based planning within LCGs. These teams link across LCG boundaries where necessary, to form regional strategic planning networks relevant to client or 'community of interest' groups. Commissioning of services from independent family practitioner contractors is managed centrally. These arrangements recognise regional priorities, including service framework standards.

21.8 Costing

The five HSC trusts submit annual reference cost returns that capture the cost of services across a prescribed list of health and social care activities. Health resource group (HRGs) based reference costs are calculated for most hospital acute inpatients and day cases, and community and personal social services indicators are calculated for a range of community and social care services.

Organisations use these reference costs to compare their costs with those of similar organisations. This comparison establishes a benchmark that enables organisations to identify areas where they may be able to reduce costs or increase productivity by understanding and implementing best practice methodologies used in other provider organisations. The unit costs are also used to inform the revenue business case process and respond to NIA questions and external information requests.

Further details regarding NHS Costing are provided in chapter 17.

21.9 Charitable funds

Charitable funds accounts are held by HSC trusts in Northern Ireland and are largely comprised of donations by individuals or legacies.

As in England and Wales these funds are used for the purpose for which the original donation was intended, or the bequest was made (where that is known) otherwise the uses to which the funds can be put may be unrestricted. Charitable funds are held and managed by HSC trusts and boards as corporate trustees.

Where a DoH body controls a charitable fund, as well as preparing separate annual accounts for its charitable funds, the body is also required to consolidate these accounts into its annual accounts (as per the DoH *Manual of Accounts*).

The Charity Commission for Northern Ireland was established on 27 March 2009 and regulates charities, including HSC charitable funds.

Further details regarding Charitable Funds in the NHS are provided in chapter 20.

Key learning points

- The primary difference between the NHS in England and services in Northern Ireland is that in Northern Ireland health services and social care are fully integrated.
- The HSC is introducing revised arrangements to develop an effective integrated care system.
- The new arrangements bring together all partner bodies to address and respond to the needs of the individual, while working within a regional wide healthcare strategy.
- Work continues to establish structures and operational arrangements to support and ensure delivery of effective partnership working under the framework.
- Overall public sector funding for Northern Ireland is provided via the Northern Ireland block vote, as part of the national spending reviews. It is based on a population driven mathematical formula known as the Barnett Formula that has been in use since 1979.
- Accounts are produced based on guidance in HM Treasury's *Financial Reporting Manual (FReM)* following international financial reporting standards (IFRS).
- HSC organisations follow governance arrangements like NHS England bodies, with leadership of the organisations being through a board.

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, including a section dedicated to NHS charitable

funds. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 22:
The NHS in Wales

Chapter 22. The NHS in Wales

Overview

This chapter describes the structure and governance as regards the provision of healthcare services in Wales.

Many of the principles underpinning NHS finance in Wales are like those in England – this chapter focuses on the key differences relating to finance and governance.

22.1 Introduction

Responsibility for health and social care services in Wales lies with the Senedd (the Welsh Parliament) and with the Welsh Government.

Devolved responsibility for health was first established in 1999 with the creation of the Senedd Cymru (the Welsh Parliament; formerly known National Assembly for Wales) and Welsh Government. Following a referendum in March 2011, the Assembly was given the power to create laws where policy had been devolved (including for health). Devolved responsibilities include:

- education
- health
- local government
- transport
- planning
- economic development
- social services
- culture
- Welsh language
- environment
- agriculture and rural affairs.

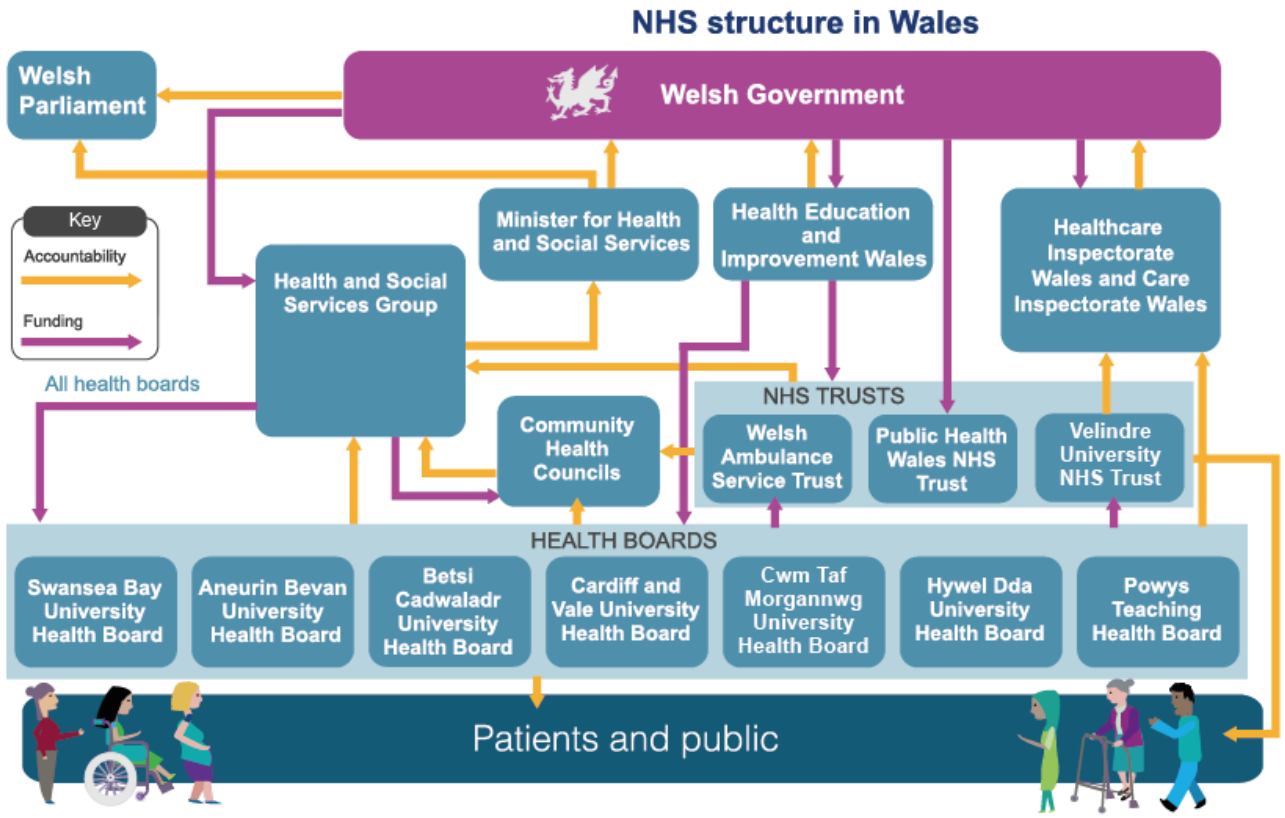
The Welsh Government develops and implements policy in these areas and is accountable to the Senedd; it is led by the First Minister.

The First Minister is nominated by the Senedd, and formally appointed by the Crown. The First Minister will appoint a Cabinet of Welsh ministers for the development and implementation of government policy. Cabinet responsibility for the NHS in Wales rests with the Minister for Health and Social Services.

22.2 The structure

The diagram below shows the current structure of the NHS in Wales. Each of these areas has specific responsibilities, outlined in the sections below.

Structure of the NHS in Wales



Parliamentary and governmental arrangements

The Senedd (the Welsh Parliament)

The Senedd comprises 60 members and is the democratically elected body that represents the interests of Wales and its people. The Senedd makes laws for Wales and holds the Welsh Government to account.

The Welsh Government

The Welsh Government formulates health policy and sets out the strategic planning and delivery framework for NHS Wales and its partner bodies.

The Welsh Government is usually established by the party, or parties, who hold most seats in the Parliament, and consists of Welsh ministers, deputy ministers and the Counsel General. The Welsh Government is headed by the First Minister, and its role is to:

- make decisions regarding the devolved areas for the whole of Wales
- develop and implement policy

- propose Welsh laws and make statutory instruments.

The arrangements provided for in the *Government of Wales Act 2006* created a formal legal separation between the Welsh Government and the Senedd.

Welsh ministers

The Minister for Health and Social Services is a cabinet position in the Welsh Government. The Minister is responsible (and accountable to the Welsh Parliament) for the exercise of all the powers in the health and social services portfolio, including:

- health and social care strategy
- NHS delivery and performance, including financial management
- public health
- general practice management.

Health and Social Services Group

The Health and Social Services Group (HSSG) is the Welsh Government department responsible for the NHS and social care in Wales. The HSSG is headed by the Director General of Health and Social Services, who is also the Chief Executive of NHS Wales. The HSSG supports ministers, and the Director General, in discharging their responsibilities. The Chief Medical Officer for Wales is also a member of the HSSG.

The HSSG advises the Welsh Government on policies and strategies for health and social care in Wales. This includes contributing to relevant legislation and providing funding for the NHS and other related bodies.

National Delivery Group

This group is responsible for overseeing the development and delivery of NHS services across Wales, and for planning and performance management of the NHS on behalf of Welsh ministers. This is enacted in accordance with the directions set by ministers. The group is chaired by the Director General for Health and Social Services/ Chief Executive of NHS Wales (the Director General).

The Director General is responsible for providing ministers with policy advice and exercising strategic leadership and management of NHS Wales.

Local delivery arrangements

NHS Wales

NHS Wales is one service made up of several organisations (described in further detail below). Healthcare in Wales is delivered through a variety of providers, ranging from local health boards (LHBs) and NHS trusts to community pharmacies and opticians.

NHS Wales comprises seven LHBs and three NHS trusts. The LHBs and trusts are accountable to the Director General of Health and Social Services and NHS Wales Chief Executive (the Director General) through their chief executives. The Director General is in turn accountable to Ministers.

Local health boards (LHBs)

The seven LHBs are responsible for planning, commissioning and providing local health services to address local needs. Responsibilities include:

- planning, designing, developing and securing delivery of primary, community and secondary care services
- specialised and tertiary services for their areas, to meet identified local needs within the national policy and standards framework set out by the Minister.

The LHBs must adhere to the standards of good governance set for the NHS in Wales, encapsulated in the governance e-manual[333]. These are based on the Welsh Government's *Citizen centred governance principles*[334].

Under the provisions of the *Social Services and Well-being (Wales) Act 2014*[335], local authorities and LHBs can pool funding to jointly commission care services within their areas. The Welsh ministers have the power to make regulations requiring local authorities and LHBs to pool budgets.

In addition, across the seven LHBs are two joint committees. These cover specialised services and ambulance services.

The Welsh Health Specialised Services Committee (WHSSC)

Specialised services are planned and funded jointly by the LHBs through the Welsh Health Specialised Services Committee (WHSSC). The WHSSC exercises its responsibilities on behalf of the seven LHBs. Established in 2010, it is not a statutory body and is hosted by the Cwm Taf Morgannwg University Health Board. Each LHB is a member of the committee.

The Emergency Ambulance Services Committee (EASC)

The EASC is responsible for planning and ensuring there are sufficient ambulance services for the people of Wales. Each LHB is a member of the committee and they collaboratively commission both emergency and non-emergency services across Wales.

NHS trusts

There are three NHS trusts in Wales:

- the Welsh Ambulance Services NHS Trust provides emergency and non-emergency ambulance services and manages NHS Direct in Wales
- Velindre University NHS Trust provides specialised cancer services for South Wales, as well as hosting the Welsh Blood Service
- Public Health Wales NHS Trust provides all-Wales screening services and a national public health service.

Community Health Councils

Community Health Councils (CHCs) are statutory, lay bodies responsible for representing the local community. They provide an independent voice regarding the local NHS and the services it provides; they are a link between those who run the NHS and those who use it. CHCs will:

- consider health issues from the public's viewpoint

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[333] NHS Wales, *Governance e-manual*, June 2022
[334] NHS Wales, *Citizen Centred Governance principles*, August 2010
[335] UK Government, *Social Services and Well-being (Wales) Act 2014*

- visit local services to hear from patients and those who care for and about them about their experiences
- look at local and national NHS plans and proposals to make sure they meet the needs of local communities
- meet regularly with NHS managers
- speak to people in their communities about their views and experiences of NHS services
- provide a free, confidential and independent complaints advocacy service for people who want help raising concerns about NHS care and treatment.

CHCs have a statutory right to visit hospitals, clinics and primary care establishments where NHS services are delivered. This includes GP practices, dental surgeries, opticians, pharmacists and nursing homes.

There are seven CHCs that are co-terminus with the seven local health boards (LHBs).

The board of community health councils is a separate statutory body responsible for monitoring the performance of the CHCs in Wales as well as operating a complaints procedure for those who wish to make a complaint about NHS services in Wales.

Other health agencies

Shared services

The NHS Wales Shared Services Partnership (NWSSP) is an independent organisation, owned and directed by NHS Wales. It supports NHS Wales through the provision of a range of back-office functions and services including internal audit, procurement, counter-fraud services, employment services (including payroll and payment of expenses).

The Healthcare Inspectorate Wales (HIW) and the Care Inspectorate Wales (CIW)

The HIW is responsible for the inspection and regulation of Welsh NHS services (including Welsh NHS funded care) and independent healthcare services in Wales. The CIW is responsible for the inspection and regulation of social and non-health care for adults and children in Wales.

To maintain their independence, both organisations are managed within the Welsh Government but outside the HSSG.

As part of their overall responsibility to improve the safety and quality of health and care services across Wales, and to ensure the sharing of good practice, the HIW and CIW have agreed several protocols, concordats and memoranda setting out how they will work together where there is a cross-over in their work.

Health Education and Improvement Wales (HEIW)

HEIW leads on education, training and development for the healthcare workforce across Wales. Its defined strategic objectives are:

- to lead the planning, development and well-being of a competent, sustainable and flexible workforce to support the delivery of *A Healthier Wales: our plan for health and social care*[336]
- to improve the quality and accessibility of education and training for all healthcare staff ensuring that it meets future needs
- to work with partners to improve collective leadership capacity in the NHS
- to develop the workforce to support the delivery of safety and quality

[336] Welsh Government, *A Healthier Wales: our Plan for Health and Social Care,* 2021

- to be an exemplar employer and a great place to work
- to be recognised as an excellent partner, influencer and leader.

Digital Health and Care Wales (DHCW)

DHCW was established in April 2021 and replaced the NHS Wales Informatics Service. It is established as a special health authority within NHS Wales. Its role is to:

- support frontline staff with modern systems and secure access to information about their patients, available wherever they want to work
- deliver new digital solutions to support care for cancer patients, to help nurses, to modernise critical care units, to update hospital pharmacy, prescribing and community care
- use data to provide insight and improve how health and care services are delivered and accessed by patients
- help Welsh people manage their own health and recovery from illness by putting health services in their pocket. Give people access to their own digital health record and apps from any device making it easier to connect with health and care services
- combat cyber-crime through a dedicated cyber resilience unit
- use digital standards to allow for faster development and delivery of digital services
- protect valuable data assets by modernising data storage and adopting a 'cloud-first' policy.

Public Service Boards (PSBs)

Public service boards are partnerships across public service agencies working together to improve local services. The members of each PSB are the local authority, the LHB, the local fire and rescue authority and the Natural Resources Body for Wales, but they can involve other organisations that would have an interest in the well-being for that area.

Every local council area in Wales is required to have a PSB (established under the *Well-being of Future Generations (Wales) Act 2015*[337]). The Act is about improving the social, economic, environmental and cultural well-being of Wales and established seven well-being goals:

- a prosperous Wales
- a resilient Wales
- a healthier Wales
- a more equal Wales
- a Wales of cohesive communities
- a Wales of vibrant culture and thriving Welsh language
- a globally responsible Wales.

The aim is to improve the economic, social, environmental and cultural well-being for the Welsh population. Each PSB has responsibility for:

- assessing the state of economic, social, environmental and cultural well-being in its area
- setting objectives that are designed to maximise the PSB's contribution to the well-being goals.

Each PSB is required to prepare a plan setting out the steps it will take to meet its objectives.

[337] UK Government, *Well-being of Future Generations (Wales) Act 2015*

Regional Partnership Boards (RPBs)

Regional partnership boards (RPBs) were established in April 2016. They operate at a regional level to support the delivery of social services and work in close collaboration with the health sector. RPBs are coterminous with each health board and local authority and implement joint area plans and pool budgets for the benefit of the local population.

PSBs and RPBs are part of the Welsh Government's ambition to develop a 'wellness system'. The aim is to provide a seamless whole system approach to health and social care that is designed around the needs and preferences of individuals.

Future developments

Establishment of an NHS Executive

A decision was made in 2018 and outlined in *A healthier Wales: our plan for health and social care*[338] (document updated 2021*),* to establish a national executive function but development was paused in 2020 due to the Covid-19 pandemic.

Work to establish the NHS Executive continues.

In May 2022 a *Written Statement: Update on setting up an NHS Executive for Wales*[339] was issued by the Minister for Health and Social Services setting out the aims of the NHS Executive. To support and enable the continuing transformation of clinical services, the NHS Executive will:

- strengthen national leadership and support quality improvement
- provide more central direction, ensuring a consistent and equitable approach to national and regional planning based on outcomes
- enable stronger performance management arrangements, including capacity to challenge and support organisations that are not operating as expected.

The citizen voice body

From April 2023 the seven community health councils will be replaced with a single Citizen voice body (CVB)[340]. The CVB will be independent of government, the NHS and local authorities and will:

- listen to the views of the public
- help ensure that the people of Wales are part of the design and improvement of services; that their experiences are built into new models of care and influence policies and plans
- build greater connection between health and social care providers, individuals and communities
- provide support to people considering or making a complaint about their care.

22.3 How the NHS in Wales is financed

NHS Wales is funded by the Welsh Government that itself receives funds voted to it by the UK Parliament. The overall level of funding received is based on a population driven mathematical formula known as the Barnett formula. In addition, the principle of comparability is applied to these monies: any changes to the funding provided for the NHS in England are matched by an increase/ decrease in the Welsh Government's funding.

It is for the Welsh Government to determine how the funding is applied, and this is done through an annual budget planning round that allocates funding to the sectors for which the Welsh Government

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[338] Welsh Government, *A healthier Wales: our plan for health and social care,* October 2021
339 Welsh Government, *Written Statement: Update on setting up an NHS Executive for Wales*, May 2022
340 Community Health Council, *A new voice body for health and social care,* 2022

has responsibility. The budget is formally presented to the Parliament for approval in an annual budget motion. The 2022/23 budget was published in March 2022: *Final Budget 2022-23, A Budget to build a stronger, fairer and greener Wales*[341].

The health and social services budget is the largest expenditure group in the Welsh Parliament's budget and in 2022/23 accounts for approximately 43% of the total Welsh budget.

The allocation for health and social services comprises:

- a revenue budget for current expenditure (i.e., the day-to-day money for salaries and consumables). In 2022/23, this amounts to £9.98bn
- a capital budget for expenditure on larger, long life items such as land and buildings. In 2022/23, this amounts to £339m.

The Welsh Government holds back a 'top slice' for centrally funded initiatives or services (such as the costs of training new doctors and nurses). It then decides how to share the rest of the allocations to NHS organisations.

Revenue allocation

Each LHB has a unified allocation to fund healthcare for its population[342]. The allocation for hospital and community health services is based on resident populations. Allocations for general medical services and prescribing are based on registered populations, and pharmacy and dental contract allocations are based on the provision of services.

The distribution of funding is largely based on historical patterns and follows a needs-based allocation formula that was developed by the late Professor Townsend in 2001. The formula is based on the population covered by the LHB area adjusted to take account of:

- the health needs of the population
- unavoidable geographical variations in the cost of services.

The Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) are funded from LHB allocations.

Velindre University NHS Trust receives its funding through healthcare agreements with the LHBs and via WHSSC.

The Public Health Wales NHS Trust receives most of its funding directly from the Welsh Government.

As well as the Welsh Government revenue allocation, healthcare agreements with other LHBs and cross border income, LHBs may also receive funding from:

- the leasing of buildings
- charges to staff, visitors or patients - for example, catering or private patient facilities
- the Welsh Government for specific initiatives, teaching and research and development
- grants from government bodies.

Treatment for some Welsh residents, particularly for specialised services and patients living in North Wales and Powys, is provided by English NHS providers. These treatments are funded through

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[341] Welsh Government, *Final Budget 2022-23, A Budget to build a stronger, fairer and greener Wales,* March 2022
[342] Welsh Government, *Health Board 2022-23 Allocations,* December 2021

contracts with the English provider. Where applicable, payment is made in line with the payment system (see chapter 19).

Capital allocation

In 2022/23 the capital budget for health is £339m[343], which accounts for around 13% of the total budget. The Welsh Government allocates these capital resources to LHBs and NHS trusts. There are 2 types of capital allocations:

- discretionary capital to cover routine equipment replacement, IT developments and small-scale building works
- Wales infrastructure investment plan for specific medium to large scale schemes beyond the scope of discretionary capital.

LHBs and trusts are required to submit business cases for funding for major capital schemes using the five-case model, in line with the *NHS Wales infrastructure investment guidance*[344]. The HSSG has established an infrastructure investment board (IIB) to provide support to LHBs and trusts in the development of business cases, and to scrutinise cases at all stages of their development.

All NHS infrastructure investment proposals must be prioritised at a local level and included in the integrated medium-term plans (IMTP) of NHS organisations.

NHS trusts are allowed to retain sale proceeds from the disposal of assets up to a maximum of £500,000.

As with other parts of the public sector, the Welsh Government and NHS Wales are not able to move (vire) funds between capital and revenue allocations.

The private finance initiative (PFI) is no longer used in Wales although a small number of schemes still exist.

22.4 How the NHS in Wales demonstrates financial accountability

Statutory financial duties

These statutory financial duties encompass both revenue and capital expenditure.

The *National Health Services Finance (Wales) Act 2014*[345] established the statutory financial duties of LHBs as:

- a resource limit (break-even) duty - to ensure, across a three-year rolling period, that aggregate expenditure does not exceed aggregate funding
- a planning duty – to prepare an integrated medium-term plan (IMTP) that complies with the resource limit duty, and for the plan to be submitted to and approved by, Welsh ministers.

The *NHS (Wales) Act 2006*[346], Schedule 4 Paragraph 2 sets down the financial duties for trusts, and these were confirmed under Welsh Health Circular WHC/2016/054 (Statutory Financial Duties of Local Health Boards and NHS Trusts)[347] being:

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[343] Welsh Government, *Final Budget 2022-23, A Budget to build a stronger, fairer and greener Wales,* March 2022
[344] NHS Wales, *NHS Wales infrastructure investment guidance,* 2018
[345] UK Government, *National Health Services Finance (Wales) Act 2014*
[346] UK Government, *National Health Service (Wales) Act 2006*
[347] Welsh Government, *Welsh Health Circular WHC/2016/054 (Statutory Financial Duties of Local Health Boards and NHS Trusts)*, December 2016

- a breakeven duty - to ensure that revenue is not less than sufficient to meet outgoings properly chargeable to the revenue account in respect of each rolling three-year accounting period
- a planning duty – to prepare a plan that is compliant with the breakeven duty, and for that plan to be submitted to and approved by the Welsh Ministers.

In summary, the financial performance of NHS organisations in Wales is assessed using the following targets:

- three-year break-even performance for NHS trusts or resource limit for LHBs - the three-year rolling break-even duty
- external financing limit for NHS trusts: the difference between what a trust plans to spend on capital in a year and the level of funding that it has available internally
- preparation of a three-year IMTP that is approved by Welsh ministers
- capital resource limits for LHBs and NHS trusts.

In 2021/22 three of the seven LHBs failed to meet their revenue financial duty to break-even over a three-year period. None of the NHS trusts were in breach of this duty[348].

As regards the planning duty, this was paused in 2021/22 due to the Covid-19 pandemic; all organisations were deemed to have met this duty.

One NHS body, the Betsi Cadwaladr University Health Board, received a qualified 'true and fair' opinion, because the auditor could not obtain sufficient evidence that certain figures were accurately stated and accounted for in the correct accounting period in 2021/22[349].

In addition, the auditor general issued a qualified regularity opinion for eight NHS bodies as they incurred irregular expenditure during the year.

This expenditure was incurred through complying with a direction by Ministers to fund clinicians' pensions tax liabilities. Ministers directed NHS bodies to proceed with plans to commit to making payments to clinical staff to restore the value of their pension benefits packages, where taking on additional work increased their pension tax liabilities, and it was the auditor general's opinion, that these transactions were irregular and material in nature.

Integrated medium term plans (IMTP)

As indicated above, LHBs and trusts are directed by the Welsh Government to produce three-year IMTPs. Directions and guidance for the completion of IMTPs, *The Planning Framework (2022 – 2025)*[350], was published in November 2021.

The IMTP is a plan that sets out the organisation's strategy for complying with its financial duties while improving:

- the health of the people for whom it is responsible
- the provision of healthcare to such people.

While developing the IMTP, wider statutory duties must be taken into account - for example, the requirement to undertake a joint assessment of the local population's care and support needs under

[348] Audit Wales, *NHS Wales finances data tool, financial duties,* 2022
[349] Audit Wales. *Auditor general qualifies his audit opinion on Betsi Cadwaladr University Health Boards 2021/22 accounts,* August 2022
[350] Welsh Government, *NHS Wales, Planning Framework, 2022 - 2025,* November 2021

the *Social Services and Well-being (Wales) Act 2014*[351] and to plan services jointly with other public bodies under the *Well-being of Future Generations (Wales) Act 2015*[352].

LHBs are also required to submit delivery plans for specific services - for example, stroke and heart disease to outline actions to achieve nationally agreed performance measures and outcomes.

Statutory accounts

The format and presentation of statutory accounts are prescribed by NHS Wales and are based on the guidance in *HM Treasury's Financial Reporting Manual*[353]. The accounts must be adopted formally by the board and presented, as part of the overall annual report of the organisation, at the annual general meeting by 30 September following the financial year end on 31 March.

The director of finance is responsible for preparing the accounts.

The individual accounts of LHBs and NHS trusts are summarised into two consolidated NHS accounts that are then subject to independent audit and scrutiny by the Wales Audit Office.

Monthly financial monitoring

Each NHS organisation is also required to submit monthly monitoring statements reporting on actual financial performance and forecast outturn. This is supplemented by a detailed commentary from the director of finance covering assumptions and risks behind the reported position. The overall position is monitored by the Welsh Government. The Minister will occasionally make a statement to the Parliament on the financial position of the NHS in Wales.

Audit

Each NHS organisation is responsible for providing an effective internal audit service to meet public sector internal audit standards (PSIAS). All NHS bodies are required to submit a governance statement as part of their annual accounts. Accountable officers (i.e., chief executives) are required to sign the statement on behalf of the board.

The annual accounts are audited by the Wales Audit Office, and the Auditor General for Wales[354] is the statutory auditor for most of the Welsh public sector.

22.5 Health and social care strategy in Wales

The regulation and performance management of the NHS in Wales is undertaken in the context of the Welsh Government's health and social care strategy, and so is dependent on the political composition of the Welsh Government and the policies in place.

The strategy will develop over time. Key elements of the current overarching health and social care strategies are summarised below.

In February 2016, the Welsh Government and NHS Wales jointly published *Prudent healthcare: securing health and well-being for future generations*[355] to support national action. The stated concept of 'prudent healthcare' is to ensure that the Welsh NHS is always adding value, is

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[351] UK Government, *Social Services and Well-being (Wales) Act, 2014*
[352] UK Government, *Well-being of Future Generations (Wales) Act 2015*
[353] HM Treasury, *The Government Financial Reporting Manual: 2021/22*, December 2021
[354] Audit Wales, *Auditor General for Wales*, 2022
[355] Welsh Government, *Prudent healthcare: securing health and well-being for future generations,* February 2016

contributing to improved outcomes, and provides a sustainable service. To this end, the following principles are to be applied:

- achieve health and well-being with the public, patients, and professionals as equal partners through co-production
- care for those with the greatest health need first, making the most effective use of all skills and resources
- do only what is needed, no more, no less; and do no harm
- reduce inappropriate variation using evidence-based practices consistently and transparently.

In 2018 (updated in 2021) the Welsh Government published *A healthier Wales: our plan for health and social care*[356] setting out how the NHS and social care should work together to:

- support people to stay well
- develop a person-centred approach to care
- provide more services outside of hospitals
- make better use of technology.

22.6 How the NHS in Wales is regulated

The key regulatory bodies in Wales are the Healthcare Inspectorate Wales (HIW) and the Care Inspectorate Wales (CIW), as described earlier.

22.7 Health and care standards

In 2015 NHS Wales published *Health and Care Standards*[357]. This built on previous work form 2013 (*Doing Well; Doing Better: Standards for Health Services in Wales*[358]) and from 2003 and the *Fundamentals of Care, Guidance for Health and Social Care Staff*[359]*)*.

The standards include seven themes that are intended to work together. They collectively describe a service that will provide high quality, safe and reliable care, that has the individual at the centre as shown in the diagram:

[356] Welsh Government, *A healthier Wales: our plan for health and social care, October 2021*
[357] Welsh Government, *Health and care standards,* April 2015
[358] NHS Wales, *Doing Well; Doing Better: Standards for Health Services in Wales,* April 2010
[359] Welsh Assembly, *Fundamentals of Care, Guidance for Health and Social Care Staff, 2003*

Person centred care in Wales

22.8 How NHS organisations in Wales are structured and run

For the NHS in Wales, governance is defined as 'a system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives.'

As in England, all NHS organisations have a board that is the pre-eminent governing body and has some functions 'reserved' to it (including financial stewardship, strategy and appointing senior executives). However, they are also required to establish (as a minimum) several committees to cover the following aspects of board business:

- quality and safety
- audit
- information governance
- charitable funds
- remuneration and terms of service
- Mental Health Act requirements.

As in England, NHS bodies must have an accountable officer (the chief executive) who is accountable to the Welsh Government for the proper stewardship of public money and assets and for the organisation's performance. Chief executives are also accountable to their own board for meeting their objectives and the day-to-day running of the organisation.

22.9 Commissioning

LHBs are responsible for deciding how to use their funding to meet the health needs of their population including hospital, community, GP, and other primary care services. LHBs also fund services provided by the private and independent sectors although the Welsh Government is committed to eliminating the use of private sector hospitals.

Patient flows between LHBs are funded through healthcare agreements between the boards. These are currently based on historic costs.

Although LHBs have significant discretion in relation to how they use their funding, they must meet the priorities set out in the *NHS delivery framework* issued by the Welsh Government, and they must develop their plans together with local authorities.

22.10 Costing

Most of the patient activity in Wales is covered by patient level costing. This requires costs to be classified in a specific way and using a defined process to work out the cost of treating an individual patient.

NHS organisations submit annual cost returns that capture total cost by specialty and total cost by healthcare resource group (HRG). LHBs are also required to analyse costs over the 23 programme budget categories, based on version 10 of the *International classification of diseases*[360].

The development of costing and benchmarking in NHS Wales is overseen by the strategic financial intelligence group, reporting into the efficiency framework - a sub-group of the NHS Wales directors of finance group.

Further details regarding NHS costing are provided in Chapter 17 of the Introductory Guide to NHS Finance.

22.11 Charitable funds

Charitable funds are held by NHS trusts and LHBs in Wales under the same legislative framework as exists in England. All funds are registered with the Charity Commission and accounts must be submitted to the Charity Commission.

Further details regarding Charitable Funds are provided in Chapter 20 of the Introductory Guide to NHS Finance.

[360] World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems (ICD-10),* 2019

Key learning points

- Responsibility for health and social care services in Wales lies with the Senedd (the Welsh Parliament) and with the Welsh Government.
- Commissioning and provision of health services is through local health boards (LHBs). Hospital services are managed by the LHBs.
- A national executive function is being established.
- NHS Wales is funded by the Welsh Government which itself receives funds voted to it by the UK Parliament. It is based on a population driven mathematical formula known as the Barnett Formula that has been in use since 1979.
- Accounts are produced based on guidance in HM Treasury's *Financial Reporting Manual (FReM)* following international financial reporting standards (IFRS).
- NHS Wales bodies follow governance arrangements similar to NHS England organisations, led by a board.

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, including a section dedicated to NHS charitable funds. It also highlights online learning courses that are available. The directory of resources can be found here.

HFMA introductory guide to NHS finance

Chapter 23:
The NHS in Scotland

Chapter 23. The NHS in Scotland

Overview

This chapter describes the structure and governance as regards the provision of healthcare services in Scotland.

Many of the principles underpinning NHS finance in Scotland are like those in England – this chapter focuses on the key differences relating to finance and governance.

23.1 Introduction

Responsibility for health services in Scotland was devolved from Westminster to the Scottish Parliament in 1998. The Scottish Parliament was given the power to create laws where responsibility has been devolved. As well as for the provision for health services, this includes:

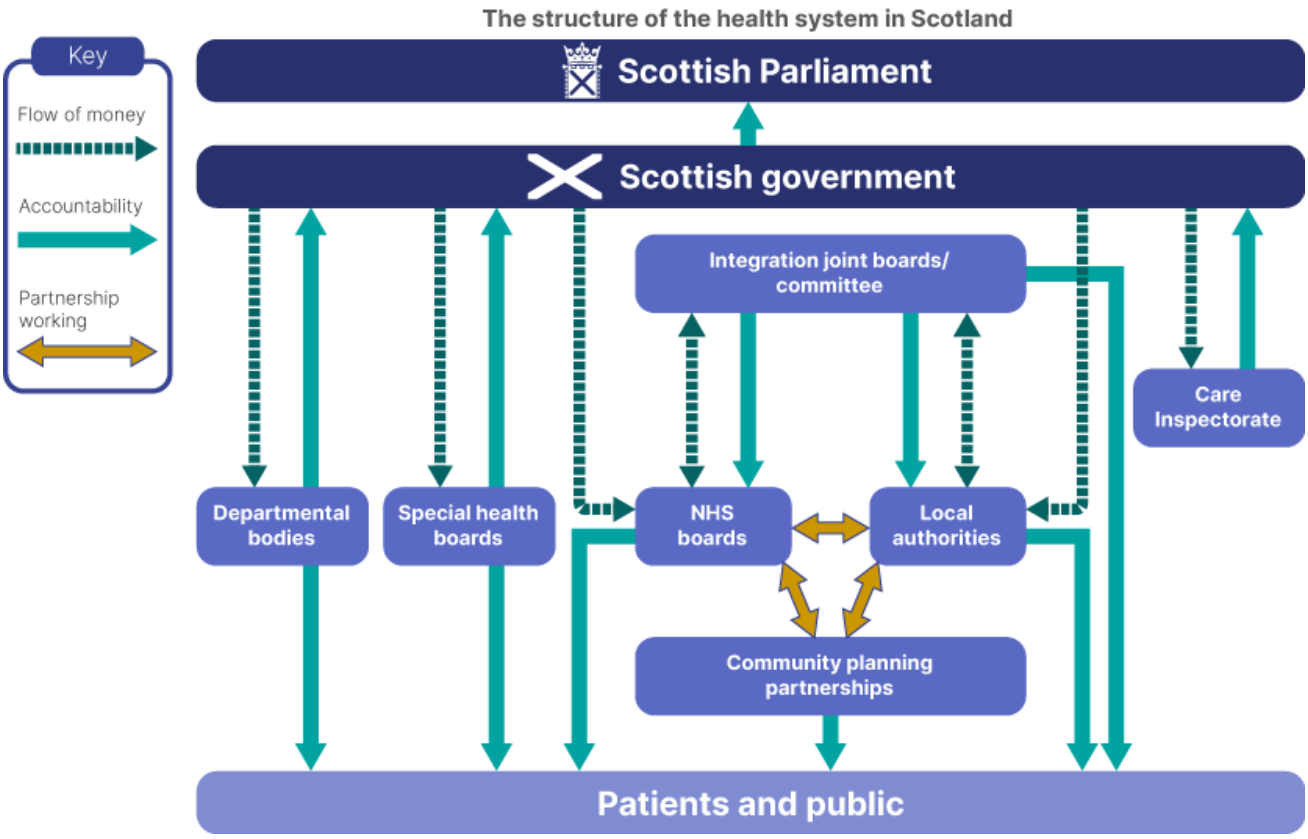
- economic development
- education
- justice
- rural affairs
- housing
- environment
- equal opportunities
- consumer advocacy and advice
- transport
- taxation.

The Scottish government, formed by the party with the majority of Members of the Scottish Parliament, develops and implements policy in these areas, and is accountable to the Scottish government.

The Scottish government is led by the 'First Minister'. The First Minister is nominated by the Scottish Parliament and appointed by the monarch. The First Minister then appoints the Scottish ministers to make up the cabinet with the agreement of the Scottish Parliament and the approval of the monarch.

23.2 Who does what?

The diagram that follows shows the structure of the NHS in Scotland. Each of these areas has specific responsibilities, outlined in the sections below.



Parliamentary and governmental arrangements

The Scottish Parliament

The Scottish Parliament is made up of 129 elected Members of the Scottish Parliament (MSPs). The last election was in May 2021. The Scottish Parliament is responsible for passing laws in respect of those matters that affect most aspects of day-to-day life in Scotland and holds the Scottish government to account.

Scottish government

Immediately after each election, the Scottish Parliament nominates the First Minister who is then appointed by the monarch. The Scottish government is led by the First Minister who is supported by a cabinet formed of Scottish Ministers. It is the Cabinet Secretary for Health and Social Care who has responsibility for the NHS as well as the integration of health and social care[361].

Health and Social Care Group

The Health and social care group (HSCG[362]) is made up of a number of government directorates that have responsibility for their specific areas. The directorates will support Scottish ministers in the development and management of health and social care services by NHS Scotland[363]. Directorates within the HSCG are responsible for:

- providing strategic leadership for the NHS and social care in Scotland as well as public health
- lead the integration of health and social care into wider government policy
- supporting ministers to be accountable to the public and the Scottish Parliament

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[361] Scottish Government, *Cabinet secretary for health and social care,* 2022
[362] Scottish Government, *Health and social care,* 2022
[363] NHS Scotland is the collective noun for all NHS bodies in Scotland

- managing and allocating public money to the various parts of the NHS in Scotland
- ensuring that the highest standards of health and social care are met
- ensuring that high quality health and social care services are delivered to the Scottish population.

Membership of the HSCG is drawn from the following directorates:

- chief medical officer
- chief nurse
- health finance, corporate governance and value
- health workforce
- healthcare quality and improvement
- population health
- primary care
- social care and national care service development.

Local delivery arrangements

NHS boards

There are 14 territorial NHS boards across Scotland. They have responsibility for the protection and improvement of their population's health, and for the delivery of frontline services. They are responsible for planning, commissioning and delivering NHS services to their populations. They also take overall responsibility for the health of their populations. This involves planning and commissioning community and hospital health services including services provided by GPs, dentists, community pharmacists and opticians.

The NHS boards are funded by and report directly to the HSCG. The chief executive of each NHS board is the accountable officer. The role of the accountable officer is a key element in governance terms with a line of accountability for the proper stewardship of public money and assets and for the organisation's performance stretching up to Parliament. The accountable officer is also accountable to the organisation's board for meeting the objectives it sets, for day-to-day management and for ensuring that governance arrangements are effective.

In 2019, the Scottish government issued *A blueprint for good governance*[364] to all NHS boards. The document emphasised the importance of good corporate governance and described how its adoption would help NHS boards to improve their corporate governance systems.

Special NHS boards

National or special NHS boards provide services across the whole of Scotland. They are also funded by and report directly to the HSCG. There are currently six special boards as follows:

- Public Health Scotland – established in April 2020 and Scotland's lead national agency for improving and protecting the health and wellbeing of all the country's people
- NHS Education for Scotland – concerned with developing and delivering quality education and training for NHS staff

[364] Scottish Government, *A blueprint for good governance,* January 2019

- NHS National Waiting Times Centre – responsible for ensuring prompt access to first-class treatment
- NHS 24 – provides health advice and information
- the Scottish Ambulance Service – responds to almost 600,000 accident and emergency calls and takes 1.6 million patients to and from hospital each year
- the State Hospitals Board for Scotland – has responsibility for secure settings for those with mental health disorders who are unable to be cared for in any other setting.

Departmental public bodies

There are two departmental public bodies; these are:

- Healthcare Improvement Scotland – supports the delivery of high-quality, evidence-based care and scrutinises services to provide public assurance about the quality and safety of healthcare
- NHS National Services Scotland – supplies essential services including health protection, blood transfusion and information technology.

As with NHS boards, the chief executive of each special NHS board is the accountable officer.

Other health agencies

Care Inspectorate

The Care Inspectorate[365] regulates and inspects care services in Scotland to ensure that they meet the necessary standards. They also jointly inspect with other regulators, to ascertain how well different organisations in local areas work to support adults and children.

It is a publicly funded executive non departmental public body. This means it operates independently from Scottish ministers but is accountable to them.

Community planning partnerships

Community planning partnerships (CPPs) help public agencies to work together with the community to design and deliver better services to make a real difference to people's lives. There are 32 CPPs across Scotland, one for each council area. Each CPP focuses on where partners' collective efforts and resources can add the most value to their local communities, with particular emphasis on reducing inequality.

The *Community Empowerment (Scotland) Act 2015* strengthened community planning by giving CPPs a statutory footing. It also explicitly states that public bodies including NHS boards will work together with communities to improve outcomes for a local area. While there are no specified lines of accountability, NHS boards and integration authorities are obligated to ensure that there is both direct contribution from and leadership within their local CPP. The CPP should focus on how to improve local priority outcomes relating to health and wellbeing.

Integrated working

In April 2014, the *Public Bodies (Joint Working) (Scotland) Act 2014* was passed. The purpose of the legislation was to provide a framework to improve the quality and consistency of health and social care services in Scotland.

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[365] Care Inspectorate, *About us*, 2022

The Act required NHS boards and local authorities to enter an integration scheme to ensure the effective delivery of the delegated functions. The integration scheme set out the range of functions (or services) covered to meet the minimum requirements set out in the legislation. As a minimum, this was to include adult social care services, adult community health services and a proportion of adult acute services. The inclusion of children's services was at the discretion of the partners in each area.

An integration authority (IA) is an entity that has responsibility for ensuring that health and social care services are planned, managed and delivered in an integrated manner. The Scottish model allows the integration authority to take one of two forms: either an integration joint board or integration joint monitoring committee.

Integration joint boards

The 2014 Act allowed local authorities and NHS boards to create a separate legal entity known as an integration joint board (IJB). IJBs are local government bodies (not NHS organisations) and are therefore subject to the same financial governance framework as local government bodies. The IJB has a chief officer who has a direct line of accountability to the chief executives of the NHS board and the local authority for the delivery of integrated services. In total, there are 31 IJBs across Scotland. IJBs are required to prepare and publish statutory accounts (section 106 of the local government (Scotland) Act).

Voting members of the IJB comprise equal representation from the NHS boards and local authorities involved.

The IJB is responsible for the planning, resourcing and operational delivery of all integrated services delegated to it. The integrated services will be set out in the IJB's strategic plan and integrated scheme.

NHS boards and local authorities make financial budget offers/ payments to the IJB covering social care plus core, hosted and set aside health functions that are delegated under the integration scheme. The IJB then directs and pays for the NHS board and local authority, or other providers, to deliver services in line with its strategic plan for the delivery of local integrated health and social care services. IJBs are required to produce an annual performance report on the extent to which their strategic objectives have been met.

Integration joint monitoring committee

This is the second model that has only been adopted in the Highlands.

In this case, no new entity is established. Instead, the decision is made that either the health board or the local authority will take lead responsibility for the provision of integrated health and social care services. As there is no separate entity, the chief executive of the lead body is accountable for the provision of all integrated services.

An integration joint monitoring committee is established by the health board and local authority. Its role is to scrutinise the delivery of integrated arrangements and report on process. It is effectively an overseeing committee whose job is to make recommendations on how the NHS board and local authorities can best make use of resources to deliver integrated health and social care services to their local population.

To effect integration of health and social care services in this scenario, NHS boards and local authorities can move funding between each other, with the lead body having ultimate responsibility for delivering integrated health and social care services.

NHS Services in Scotland

NHS Services in Scotland (NSS) offers shared services across all of Scotland, with the aim to help save money and free up resources to be re-invested into essential services.

As part of its 2020 Vision, the Scottish government committed to increasing shared services across all organisational 'support' services including finance and HR. This work is being progressed through NSS.

Future developments

In 2020, the First Minister announced an independent review into adult and social care in Scotland. The report on the independent review[366] was published in 2021 and recommended the establishment of a National Care Service (NCS). Following consultation[367], the *National care service (Scotland) bill*[368] was introduced to Parliament in June 2022.

National care service

The introduction of a National care service (NCS) continues with the overall strategy of integrated services building on the working arrangements that have developed through integration joint boards.

The rules for how NHS healthcare services work will not change, but the framework will allow more effective service provision and facilitate greater integrated working across all partners, and within communities. Recommendations included:

- establishment of a National care service, equal to NHS Scotland, with both reporting to Scottish ministers
- the NCS will ensure that all service users, their families and carers get the same level of care and support
- improved support, with decisions based on needs, rights and preferences
- improved safety and quality of care across all care homes
- social care to focus on enabling people to stay in their own homes and communities
- those in charge of services should include people with lived experience, unpaid carers, local communities, care providers and other key stakeholders, when planning and making decisions
- there must be a good system in place to deal with complaints quickly.

The development of a NCS has followed on from two key healthcare strategies.

Published in 2011, the 2020 Vision set out the Scottish Parliament's vision for Scotland. The aim was to develop strategies such that by 2020, everyone would be able to live longer, healthier lives at home, or in a homely setting. Key areas would include integration of services, quality of care, prevention and a focus on the community and care at home environments.

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366 Scottish Government, *Independent review of adult social care*, 2022
367 Scottish Government, *A national care service for Scotland: consultation,* August 2021
368 The Scottish Parliament, *National care service (Scotland) bill*, June 2022

In 2016, a national clinical strategy for Scotland provided further clarity on the government's priorities and reform programme and continued the development of the strategies previously identified.

23.3 How the NHS in Scotland in financed

NHS Scotland funding is provided from the overall Scottish budget, and it is the responsibility of the First Minister for Scotland to identify the allocations to the various services for which they are responsible. This includes health, prisons, education and social services. Health is one of the major areas of expenditure.

The total money that central government has to spend - collectively called the Scottish Consolidated Fund, comes from the following sources:

- a block grant from the UK Government
- EU funds
- Scottish income tax (collected by HM Revenue and Customs)
- non-domestic rates (collected by local authorities)
- devolved taxes (collected by Revenue Scotland)
- borrowing.

Since April 2010, the allocation of resources for hospital and community health services (HCHS) as well as GP prescribing has been based on a funding formula developed by the Technical Advisory Group on Resource Allocation[369] (TAGRA). This formula reflects several factors including population share, the age and sex breakdown of that population and level of deprivation.

For 2022/23, the revenue health and social care allocation[370] totals £17.4bn (over 40% of the total annual Scottish allocation). The capital allocation is £0.5bn (approximately 10% of the total). The results of the resource allocation formula for future years are published by Public Health Scotland (PHS). PHS has published details of the national resource allocation formula (NRAC) for the financial years *2023 to 2024*[371] and *2024 to 2025*[372].

Cash limited/ non-cash limited

Funds allocated to HCHS are distributed via a resource allocation. These are cash limited funds; NHS boards must not overspend against their allocation (resource limit) and are highly restricted in their ability to carry forward surpluses or deficits from one year into another.

Funding for family health services (specifically dental, pharmaceutical and ophthalmic services) forms part of the Scottish government health allocation. This is subject to a national cash limit, but not at NHS board level.

Capital planning process

Capital resources are managed through the Scottish government capital investment group (CIG)[373]. The thresholds for approval are based on a board's size, rather than a threshold as is the case in England. The limits for NHS boards range from £3m to £10m, but specific limits also apply to

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[369] TAGRA, *Home page,* 2022
[370] Scottish government, *Scottish budget 2022-23*, December 2021
[371] Public Health Scotland, *Resource allocation formula (NRAC), results for financial year 2023 to 2024,* March 2021
[372] Public Health Scotland, *Resource allocation formula (NRAC), results for financial year 2024 to 2025,* August 2022
[373] Scottish government, *Capital planning: approval process,* 2022

specific categories of schemes.

The CIG oversees the approval processes, and all schemes in excess of the relevant delegated limit need to be submitted to the CIG for approval.

The Scottish future trust

Established by the Scottish government in 2008, the Scottish future trust (SFT)[374] is a centre of expertise for infrastructure projects, working collaboratively across the private and public sectors.

The SFT manages the hub initiative[375]. This aims to integrate capital projects across the whole public sector, using a mixture of private and public sector funding. All projects put forward for hub funding must be approved by CIG, regardless of value.

23.4 How organisations demonstrate financial accountability

Annual operational plan

All NHS boards are required to publish an annual operational plan covering a three-year period (updated annually). It is aligned to the *Medium Term Financial Framework*[376] for the period. Plans are updated annually. The Scottish government is looking to return to three-year planning cycle for 2022/23 and beyond.

These plans were not formally signed off in 2020/21 due to the impact of Covid, and a one-year plan was submitted for 2021/22, in the form of a remobilisation plan[377], with regular updates to reflect the uncertainty of Covid, and the evolving requirements. Further actions were identified within *The NHS recovery plan*[378], which looks at the actions over the next five years, and recognises the financial sustainability challenges.

Statutory financial duties

NHS boards are required by statute to operate within set limits[379]:

- the revenue resource limit – the resource budget for ongoing activity
- the capital resource limit - the budget for capital investment
- cash requirement – the cash financing requirement to deliver the revenue and capital resource limits.

Monthly financial monitoring

All NHS boards have a responsibility to control their finances throughout the year. Performance is monitored by the HSCG. As a result, NHS boards are required to complete monthly financial performance returns (FPR) to the HSCG.

NHS boards meet regularly with the HSCG to monitor and forecast progress against statutory targets. Where an organisation is forecast to miss a target, remedial action is expected so that the target can be achieved. In cases where an NHS board fails to operate within its revenue resource

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374 Scottish futures trust, *About us,* 2022
375 Scottish future trust, *Hub*, 2022Scottish Government Medium Term Health and Social Care Financial Framework, October 2018
376 Scottish Government, *Medium Term Health and Social Care Financial Framework,* October 2018
377 Scottish Government, *Re-mobilise, Recover, Re-design, the framework for Scotland,* May 2020
378 Scottish Government, *NHS recovery plan,* updated September 2021
379 UK government, *National Health Service (Scotland) Act 1978,* July 1978

limit, it can apply for a loan known as brokerage. Arrangements for the repayment of this loan must be agreed between the NHS board and the HSCG.

Statutory accounts

Audited accounts are produced and published as part of the annual report.

NHS boards are required to prepare their accounts in accordance with the *Scottish Public Finance Manual*[380] which is consistent with HM Treasury's *Financial Reporting Manual (FReM)*[381]. The HSCG determines the format of external reporting by the production of an accounts template that is also used to produce consolidated health accounts for the government in Scotland.

The principles of financial control and internal monitoring are set out in financial directions. It is left to local discretion to determine the exact nature of internal monitoring, but it is sensible that this mirrors external requirements. Internal financial control is ensured through the adoption of standing financial instructions, standard operating procedures and formal schemes of delegation (chapter 13 provides more details on governance principles and arrangements).

Integrated joint boards are also required to produce annual accounts but as a local government body, they must follow section 106 of the *Local Government Act 1973*[382].

23.5 Governance and audit

Audit Scotland and external audit

The audit of NHS Scotland is the responsibility of the Auditor General for Scotland (AGS). The AGS appoints auditors to each NHS board. The AGS is supported by Audit Scotland[383], which commissions audits from its own staff and commercial firms of auditors.

Auditors perform the audits of NHS boards in accordance with the *Code of Audit Practice* issued by Audit Scotland and approved by the AGS. Auditors are responsible for considering:

- financial stewardship and governance through the annual audit of NHS bodies' accounts
- achievement of value for money through a programme of national performance audit reports.

Audit Scotland is responsible for carrying out performance audits (formerly known as value for money audits). The AGS produces an annual overview of the *NHS in Scotland*[384] that provides information on a range of performance measures.

The 2020/21 report of the auditor general for Scotland on the *Scottish Government Consolidated Accounts: year ended 31 March 2021*[385] noted that in all material aspects, expenditure and income was incurred in accordance with applicable guidance and gave a true and fair view.

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380 Scottish *Government, Scottish public finance manual*, 2022
381 HM Treasury, *The government financial reporting manual: 2022/23*, December 2021
382 *Local Government (Scotland) Act 1973*
383 Audit Scotland, *About us,* 2022
384 Audit Scotland, *NHS in Scotland 2021*, February 2022
385 Scottish government*, Scottish government consolidated accounts: year ended 31 March 2021,* December 2021

Internal audit

Each NHS organisation is responsible for providing an effective internal audit service to meet public sector internal audit standards (PSIAS).

NHS boards may provide internal audit themselves, by means of a consortium arrangement with neighbouring boards or contract out this service to private firms. IJBs will utilise the internal audit functions of their partners or purchase this function. IJBs have an IJB audit and risk committee and an appointed IJB chief internal auditor.

All NHS bodies are required to submit a governance statement as part of their annual accounts. Accountable officers (i.e., chief executives) are required to sign the statement on behalf of the board.

Counter fraud services

Counter Fraud Services[386] (CFS) deter, detect and investigate frauds and other irregularities throughout NHS Scotland. CFS is hosted by NHS National Services Scotland and has links with every NHS board through partnership agreements and nominated fraud liaison officers. CFS also undertakes pro-active exercises in areas of high risk.

Clinical negligence and other risks scheme

Launched in 2000, membership of the clinical negligence and other risks indemnity scheme[387] (CNORIS) is mandatory for all health bodies. The scheme has three main objectives:

- providing advice on clinical and non-clinical scheme coverage to members
- supporting members to manage their risks and associated budgets by providing related information and analysis
- ensuring that contributions by members are allocated equitably through regular review of risk profiles and losses.

23.6 Costing and pricing

Costing

Public Health Scotland (PHS) publishes an annual update[388], the *Costs Book*, on health service costs in Scotland. The *Costs Book* provides cost information for NHS Scotland and a detailed analysis of where resources are spent. For 2020/21, a high-level cost summary was published, covering hospital, community and primary care provision. The publication contains NHS board information for hospital and primary care services.

It is used mainly for benchmarking by healthcare providers to assess efficiency. Managers at all levels can use the information as an aid to decision-making, planning and control and it also provides a set of indicators of performance for comparison purposes.

The information contained within the reports is derived from the Scottish financial returns (SFRs) and data collection returns completed by the NHS boards.

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[386] National services Scotland, *Counter fraud services,* 2022
[387] NHS services Scotland, central legal office, *Clinical risks and other risks indemnity scheme,* 2022
[388] Public Health Scotland, *Scottish health service costs, high-level costs summary 2020 to 2021*, February 2022

Pricing

A pricing system is required for cross boundary activity flows for acute hospital in-patients and day cases.

The price or tariff is calculated using healthcare resource groups (HRGs) to reflect the differences in case mix complexity. However, because the Scottish costing data is relatively high-level, English national costs are used to estimate costs at the HRG level. For example, if a hip replacement costs around 4 times as much as an arthroscopy in England, then it is assumed that this is also the case in Scotland.

23.7 Endowment funds

There are sixteen NHS linked charities in Scotland, each of which is registered with the Scottish charity regulator (OSCR). The relevant legislation is the *National Health Service (Scotland) Act 1978* (section 83(1)). This states that:

> 'A health board shall have power to accept, hold and administer any property on trust for purposes relating to any service which it is the function of any NHS trust in the area of the health board to make arrangements for, administer or provide.'

The charity trustee of each NHS-linked charity is the relevant NHS health board. The board acts as a corporate trustee, which means the individuals who are board members of the NHS health board also act as officers of the corporate trustee of the related NHS charity.

Independent review of governance of NHS endowments

During 2019 an independent review was undertaken into the governance arrangements of NHS endowment funds in Scotland, with a remit to provide the Scottish government with recommendations on how to strengthen the governance of these funds.

The *Governance of NHS endowment funds: review*[389] identified that where interest of the health board conflicts with that of the charity, it creates an inherent conflict of interest; board members act as both the corporate trustee, and as members of the NHS board for that host organisation.

The review made 28 recommendations in total. The most significant was to replace the existing corporate trustee with a charitable board comprising an independent chair and with a majority of independent members.

The report was written in 2019, immediately before the Covid pandemic. It was reviewed in 2021 and confirmed that the recommendations remained unchanged.

In October 2021 the Cabinet Secretary for Health and Social Care published the report and updated Parliament on the findings[390] and next steps. All the recommendations were accepted, and it was noted that adoption of the recommendations would require legislative change. A consultation will be undertaken with key stakeholders on the proposed process to change the current arrangements. No timescale has currently been set, but given the nature of the change, it is expected to be a relatively long process.

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[389] Scottish Government, *Governance of NHS endowment funds: review*, 2022
[390] Scottish government, *Independent review of governance of NHS endowments: Health Secretary statement*, October 2021

Key learning points

- Responsibility for health and social care services in Scotland lies with the Scottish Parliament and with the Scottish government.
- NHS Scotland consists of 14 territorial NHS boards. They have responsibility for the protection and improvement of their population's health, and for the delivery of frontline services.
- NHS Scotland is funded by the Scottish government. The money that the government has to spend on services comes from areas that include Scottish income tax and a UK government grant voted to it by the UK Parliament.
- Annual accounts are produced based on guidance in HM Treasury's *Financial Reporting Manual (FReM)* following international financial reporting standards (IFRS).
- NHS Scotland bodies follow governance arrangements like NHS England organisations, led by a board.
- The arrangements for managing endowment funds are in the process of being revised.

Additional HFMA resources

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HFMA introductory guide to NHS finance

Appendix: Glossary of terms

Appendix: Glossary of terms

This listing includes a brief explanation of some of the terms used in the guide but is not exhaustive. The HFMA has produced several briefings that list key financial and governance terms. These can be downloaded from the publications section of our website – type in 'glossary' to the search function: https://www.hfma.org.uk/publications

Term	
Accountability	Demonstrating on an ongoing basis that public money is being used wisely and effectively and for its intended purpose
Accountable/ Accounting officer	Responsible for ensuring that his or her organisation operates effectively, economically and with probity; makes good use of resources and keeps proper accounts
Accounts directions	In some places, the various Acts of Parliament that establish NHS bodies state that the Secretary for State for Health/ NHS England can 'direct' them to do certain things. As a result, directions have statutory force, have to be followed and cannot be ignored
Accrual	An accounting concept that is designed to ensure that the accounts a show all the income and expenditure that relate to the financial year
Activity-based budgeting	Closely links finances to the costs of delivering healthcare
Administration income/ expenditure	Income/ expenditure that is not for the direct provision of healthcare or healthcare related services
Aligned payment and incentive approach (API)	A type of contract between an NHS commissioner and provider consisting of a fixed element for the provision of a baseline level of services and a smaller variable element to reflect the delivery of specific priorities
Allocation	The annual amount of money made available to a health board or integrated care board to deliver/ purchase healthcare for its local population
Annually Managed Expenditure (AME)	Public expenditure that cannot reasonably be subject to firm, multi-year limits
Amortisation	Amortisation is the process of charging the cost of an intangible asset such as a patent or software licence over its useful life
Any qualified provider	A qualified provider is a healthcare provider which is registered with the Care Quality Commission, licensed by NHS England and meets the terms and conditions of the NHS standard contract

Term	
Arm's length bodies (ALBs)	ALBs are stand-alone national organisations sponsored by the Department of Health and Social Care (DHSC) that work closely with the local NHS, social care services, and other ALBs to regulate the system, improve standards, protect public welfare and support local services
Audit	The process of validating the accuracy, completeness and adequacy of disclosure in financial records
Audit committee	A statutory committee of the governing body of all NHS organisations. Its role is to review and report on the relevance and rigour of the governance structures in place and the assurances the board receives
Balanced budget	A budget that delivers break-even or a surplus
Benchmarking	The process of comparing objective information from similar activities or organisations to help identify the best or most efficient way of providing a service or carrying out an activity
Best practice tariffs	Under the national tariff payment system, providers were reimbursed more money for each patient who followed the nationally determined best practice pathway for certain procedures
Better care fund (BCF)	This is money from the NHS and local government that is 'pooled' through a section 75 agreement to fund improvements in how health and social care services work together in local areas
Block contract	Allows a healthcare provider to receive a lump sum payment to provide a service irrespective of the number of patients treated or the type of treatment provided
Board assurance framework (BAF)	Records the key processes used to manage the organisation and the principal risks to meeting its strategic objectives
Board/ governing body	The organisation's pre-eminent group that takes corporate responsibility for the strategies and actions of the organisation and is accountable to the public and Parliament
Break even	Income equals expenditure. It's important because an organisation can't spend more money than it has coming in and still be financially viable
Budget	A financial and/ or quantitative statement that is prepared and agreed for a specific future period. It translates aims into a statement of the resources needed to fulfil them and has either a monetary or non-monetary value

Term	
Budget holder	The single named individual responsible for or a budget. They are responsible for agreeing, reviewing and monitoring their allocated budgets and taking the action necessary to ensure that income and expenditure do not exceed that planned. In some organisations, this role may be known as a budget manager
Budget monitoring	A continuous process of reviewing actual income and expenditure or non-financial data - for example, patient activity against the budget
Business case	A formal process (in written form) for identifying the financial and qualitative implications of options for changing services and/ or making investments
Business plan	The written end product of a process that identifies the aims, objectives and resource requirements of an organisation over the next three to five-year period
Capital	An asset (or group of functionally interdependent assets) with a useful life expectancy of greater than one year, whose cost exceeds a minimum threshold, normally £5,000
Capital resource limit (CRL)	An expenditure limit for an NHS organisation limiting the amount that may be expended on capital purchases. It takes account of money owed by and to the organisation in relation to capital and the sale or disposal of assets
Capital departmental expenditure limit (CDEL)	A limit on the amount of capital expenditure in an accounting year that can be incurred by all the bodies in the Department of Health and Social Care (DHSC) group
Code of accountability	This defines the public service values that must underpin the work of NHS governing bodies, sets out accountability regimes and describes the basis on which NHS organisations should fulfil their statutory duties
Commissioning for quality and innovation (CQUIN)	Payments designed to ensure that a proportion of a healthcare providers' income is conditional on delivering quality and innovation. The schemes that qualify for the payments reflect both national and local priorities
Consolidation	The requirement for individual NHS bodies' accounts to be included in a consolidated set of accounts with other bodies under common control
Constitution and/ or standing orders	Translate an organisation's statutory powers into a series of practical rules designed to protect the interests of the organisation, its staff and 'customers'. They specify how functions will be carried out and how decisions will be made

Term	
Cost improvement plan/ programme (CIP)	Sets out the savings that an NHS organisation is going to save money whilst maintaining the quality of the services it provides. They are used to close the gap between the level of revenue received and the expenditure incurred in any one year
Cost pressures	A generic cost pressure is an increase in cost that is generally beyond the control of an individual organisation. A local cost pressure is an increase in cost that, although it may or may not be geographically widespread, is considered to be within the control of an individual organisation
Cost per case contracts	Commonplace for individual, expensive and bespoke care package agreements, these contracts identify for each episode or unit of care a payment to the service provider
Costing	Quantifying, in financial terms, the value of resources consumed in carrying out a particular activity/ service or producing a certain unit of output
Currency	A unit of healthcare that commissioners buy on behalf of patients - for example, an outpatient attendance or an ambulance journey
Deferred income	Income received in advance for goods or services that have not yet been delivered or provided
Depreciation	An accounting charge (not involving a cash outlay) that recognises that the value of a capital asset is used up or consumed over its useful life
Direct costs	Costs that can be directly attributed to a particular activity or output
Discretionary capital	The element of Welsh NHS organisations' capital resource allocations that is intended for meeting statutory obligations
Drawdown	The amount of cash that an integrated care board (ICB) can access. Cash cannot be accessed in advance of when it is needed
External financing limit (EFL)	External financing limit (EFL) is one of the performance targets against which the financial performance of a non-foundation NHS trust is measured. It is a control on net cash flows and trusts must not overshoot their EFL
Financial model	A mechanism used for illustrating what the income and costs for different scenarios will be, when they will be received and incurred and what tolerances there are for each
Five case model	The HM Treasury approach used to develop public sector business cases for spending proposals. It requires consideration of five 'cases': strategic, economic, commercial, financial and management
Fixed costs	Costs that do not increase or decrease with changes in levels of activity

Term	
Forecast	A prediction of future financial performance
Full business case (FBC)	A written document that brings together the arguments for a preferred planned investment including current and future service requirements, affordability, the organisation's competitive service position and the ability to complete the project within the specified budget and time scale
Going concern	All accounts prepared in accordance with international financial reporting standards (IFRS) are prepared on a going concern basis unless management either intends to liquidate the entity or to cease trading, or has no realistic alternative but to do so. For public sector bodies, such as NHS bodies and local authorities, this means focusing on whether the services provided by the entity are going to be continued rather than whether the entity providing the service will continue to exist
Governance	The system by which organisations are directed and controlled. It is concerned with how an organisation is run - how it structures itself and how it is led
Governance statement (GS)	A key component of the annual report and accounts and is signed by the accountable officer (on behalf of the governing body). It is designed to provide assurance in relation to the system of internal control that has been operating throughout the preceding year
Group accounting manual (GAM)	Mandatory accounting guidance for all DHSC group bodies including integrated care boards, NHS trusts, NHS foundation trusts and arm's length bodies (ALBs)
Green paper	Green papers are government consultation documents, allowing interested parties (both inside and outside parliament), the opportunity to provide feedback on policies and legislative proposals.
Healthcare agreements	Contracts agreed between two local health boards or a local health board and an NHS trust
Healthcare resource groups (HRGs)	The currency used to collate the costs of procedures/ diagnoses into common groupings
Incremental/ historical budget/ base budget	The previous year's budget adjusted for all known changes and developments
Integrated care	Healthcare organised with the patient as the central focus. It is frequently provided by more than one organisation – be they from the public, private or voluntary sector
Indirect costs	Costs that cannot be attributed directly to a particular activity or cost centre

Term	
Integrated care board (ICB)	The lead statutory NHS organisations within each of the 42 integrated care systems in England. They are allocated funding from NHS England and work with integrated care partnerships (ICPs) to plan how to use it. They commission NHS services via contracts with providers
Integrated care partnership (ICP)	Bring together the ICBs, their partner local authorities and other locally determined representatives and are tasked with developing a strategy to address the health, social care and public health needs of their system
Integrated care system (ICS)	Geographically based partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live in their area
Liquidity	A measure of how much cash an organisation has to ensure it can meet its financial obligations
Local price	A price for a healthcare activity that is negotiated and agreed between a commissioner and a healthcare provider for a healthcare activity
Local variation	Under the national tariff payment system a local variation was an adjustment to a national price or currency or a payment approach agreed by a provider and commissioner. The proposed variation had to meet documented criteria and be notified to NHS England
National price	Under the national tariff payment system a national price is the price set for a defined unit of healthcare. Currently, national prices are only set for diagnostic imaging services. It is the amount paid by a commissioner to reimburse a provider of NHS funded healthcare for these services
National tariff document (NTD)	The document published each year by NHS England outlining the payment mechanism for the NHS in England
Nolan principles	The key principles of how individuals and organisations in the public sector should conduct themselves
Non-executive director/ non-officer member/ lay member	They are key members of the organisation's governing body. Appointed based on their individual skills and what they will bring to the overall composition of the board, they are expected to challenge decisions and strategies
Non-recurrent	One-off income, expenditure or savings
Outline business case (OBC)	A written document that evaluates different investment options using economic appraisals to identify the preferred option in financial terms
Overhead costs	Those costs that contribute to the general running of the organisation but cannot be directly related to an activity or service
Patient level costing	Allocating costs, wherever possible, to an individual patient

Term	
Patient level costing and information system (PLICS)	Computer software that enables an organisation to determine and analyse patient-level costs
Payment by results (PbR)	Between 2003 and 2013 this was the system for reimbursing healthcare providers in England for the costs of providing treatment, based around the use of a national tariff payment system that linked a preset price to a defined measure of output or activity
Payment mechanism	A system of financial flows that moves funds around the NHS between commissioners and providers applicable to all providers of NHS healthcare services other than primary care and public health
Personal health budget (PHB)	An allocation of NHS resources that individuals can use to meet their health and wellbeing goals
Pooled budget	A local authority and an NHS body combine resources and jointly commission or manage an integrated service under section 75 of the NHS Act 2006
Primary care network (PCN)	A group of local GP practices in England for sharing staff and collaborating while maintaining the independence of individual practices. PCNs receive additional funding to deliver commitments made in the NHS long term plan
Programme income or expenditure	Any income spent or expenditure incurred on the direct provision of healthcare or healthcare related services
Public dividend capital (PDC)	Equivalent to taxpayers' share capital in an NHS trust or foundation trust. NHS trusts and foundation trusts pay an annual PDC dividend based on the value of their assets
Quality, innovation, productivity and prevention (QIPP)	A programme designed to identify savings that can be reinvested in the health service and improve the quality of care. Responsibility for achievement lies with ICBs
Recurrent	On-going income, expenditure or savings
Reserves	Monies that are set aside for a specific purpose, often on receipt of specific or ring-fenced income
Resource limit (RL) or revenue resource limit (RRL)	One of the financial performance targets used to determine whether or not operational financial balance has been met by health boards (RL), NHS England and ICBs (RRL)
Revenue costs	The day-to-day costs of running an organisation

Term	
Resource/ revenue departmental expenditure limit (RDEL)	A limit on the amount of expenditure in an accounting year on revenue items. It is set by HM Treasury for the DHSC based on the amount of resource voted to the DHSC by Parliament.
Revenue funding	The funding received by an NHS organisation to meet the costs of its day-to-day activities
Running costs	Incurred by NHS England and integrated care boards (ICBs), the costs of non-clinical management and administrative support including commissioning support services
Scheme of reservation and delegation	A detailed listing of who the board of an organisation empowers to take actions or make decisions on its behalf
Semi fixed/ step costs	Costs that tend to remain fixed for a given level of activity but change in steps when activity levels exceed or fall below given levels
Service line management (SLM)	A way to identify and then manage autonomous and accountable business units within a healthcare provider usually based on individual clinical specialties
Service line reporting (SLR)	Looking in detail at the income and costs of services in much the same way as a private sector company analyses its business units
Standards of business conduct	The strict ethical standards to be applied by all staff when conducting NHS business
Standing financial instructions (SFIs)	Set out the organisation's detailed financial procedures and responsibilities. They are designed to ensure that NHS organisations account fully and openly for all that they do
Sustainability and transformation partnership (STP)	Precursor to ICSs, bringing health and care partners together across a geographical area
Sustainability and transformation plan (STP)	A five-year strategic plan, designed to ensure that organisations within the partnership were working towards the same priorities
Transformation programmes	Enable an NHS organisation or number of organisations to fundamentally change the way that a service is provided/ delivered
Underlying deficit	A recurrent, ongoing mismatch between an organisation’s revenue and expenditure
Value for money (VFM)	The term is used when assessing whether the maximum benefit has been obtained from the goods or services bought or an investment made

Term	
Variable costs	Those costs that increase/ decrease in line with changes in the level of activity
Variance	The difference between budgeted and actual income and/ or expenditure. Variances are used to identify and analyse the cause of over or under spends with a view to taking action to rectify the position
Virement	The process of transferring money from one budget heading/ line to another
Working capital	The money and assets (owned resources) that an organisation can call upon to finance its day-to-day operations
Zero based budgeting (ZBB)	An approach to budgeting that involves starting with a blank sheet of paper and building up the budget, working out all figures based on the agreed objectives and what it will cost to meet them
White paper	White papers are policy documents produced by the government. They set out proposals for future legislation and may include a draft version of the planned bill. There is the opportunity for further consultation with interested parties before the bill is formally presented to parliament.

HFMA
HFMA House, 4 Broad Plain, Bristol, BS2 0JP
T 0117 929 4789
E info@hfma.org.uk
W hfma.org.uk

ISBN 978-1-910127-01-8