How the money goes round

Understanding NHS Finances

Royal Society of Medicine
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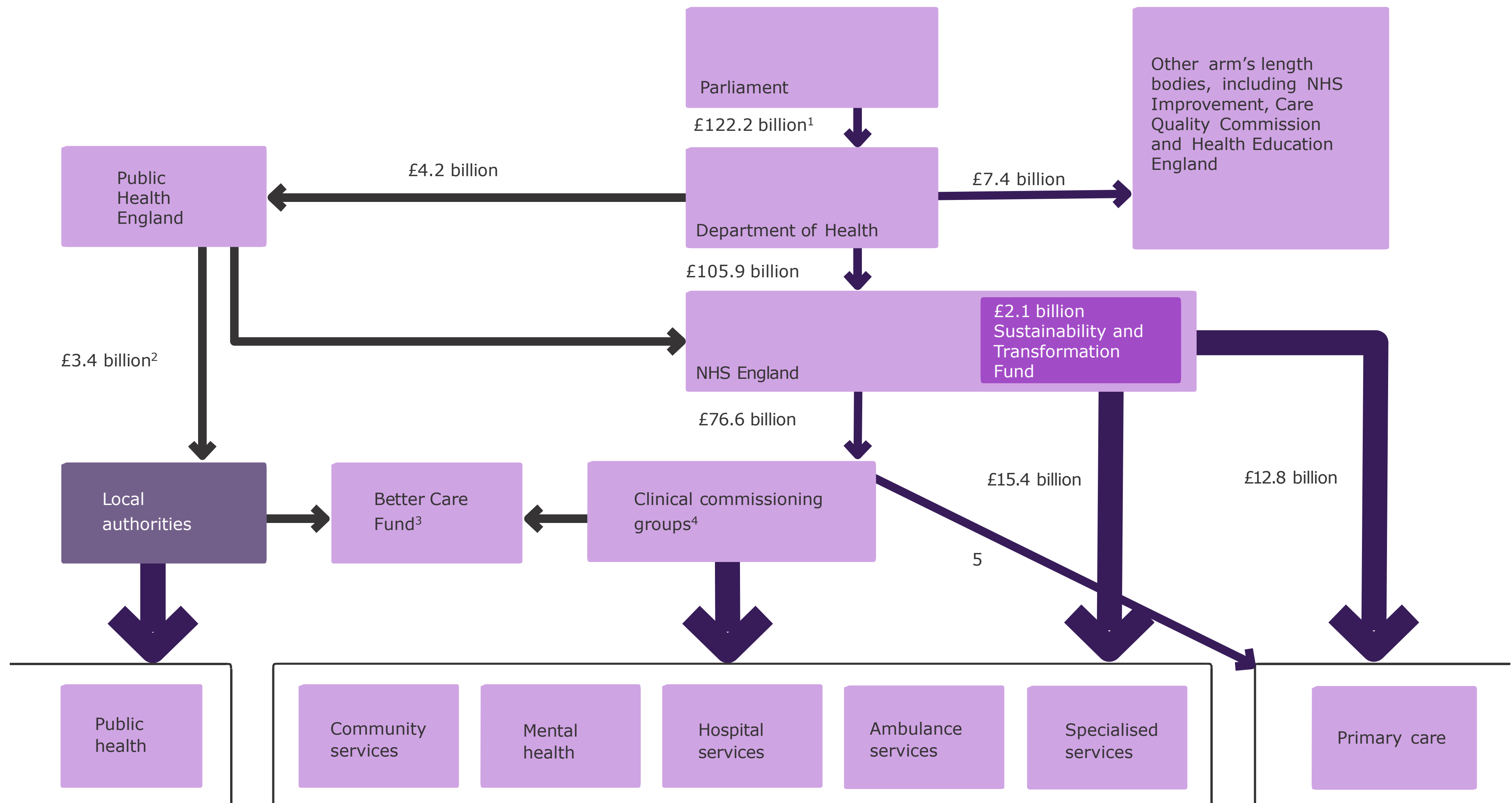
How the NHS uses
financial resources

The NHS: How the money flows



1 All figures are for 2016/17

2 Public health grant

3 With the aim of integrating health and social care services, NHS commissioners and local authorities pool some of their annual budgets (around £5.8 billion in 2016/17) to create the Better Care Fund.

4 From April 2017, all CCGs have assumed some responsibility for commissioning primary medical care services. Sixty-three have taken on full delegated responsibility; the rest have joint responsibility with NHS England.

5 NHS England transfers money to those CCGs that have taken on full delegated commissioning of primary medical care services.

What funds do Trusts receive? Capital v Revenue

Capital

- For an asset that will give benefits on a continuing basis – e.g. a car
- Tends to be a “one off” payment
- Over £5k, singly or in a group, such as PCs on a network
- Funded firstly from Trust’s own cash flow
- Limited central capital funds for national initiatives
- Trusts can borrow from the DH for their priorities
- Other sources of funds, e.g. grants, charitable funds, private investor

What funds do Trusts receive? Capital v Revenue

Revenue

- Day to day running costs and minor capital spend
- Will give benefits immediately e.g. the petrol
- Largest element in NHS is staff pay

Where do Trusts get their Revenue from?

- Commissioning process: from CCGs, NHS England, Local Authorities and other NHS Trusts, mostly via contracts to provide services
- Earmarked funds for training medical, non-medical and nursing staff
- Specific funds for research and development
- Private patients and overseas visitors charging
- Other charges to staff, patients and visitors such as catering, car parking, etc.
- Grants from local authorities and charities

Types of funding & costs:

- Revenue v capital
- Recurrent v non-recurrent, e.g.:

	Recurrent	Non-recurrent
Income	CCG contract income	Donation from charitable funds
Expenditure	Paying staff	New ultrasound machine

- Make sure you match non-recurrent income with non-recurrent costs!

What budget statements are used for:

- What you have spent this year (YTD) compared to the budget/plan
- The financial effect of changes you make
- Getting financial forecasts right

- Don’t get reports?... ASK!
- Don’t understand them?... ASK LOUDER!!
- Make sure your Finance Director gives you a named contact you can talk to

Standard business case format – adapt as necessary!

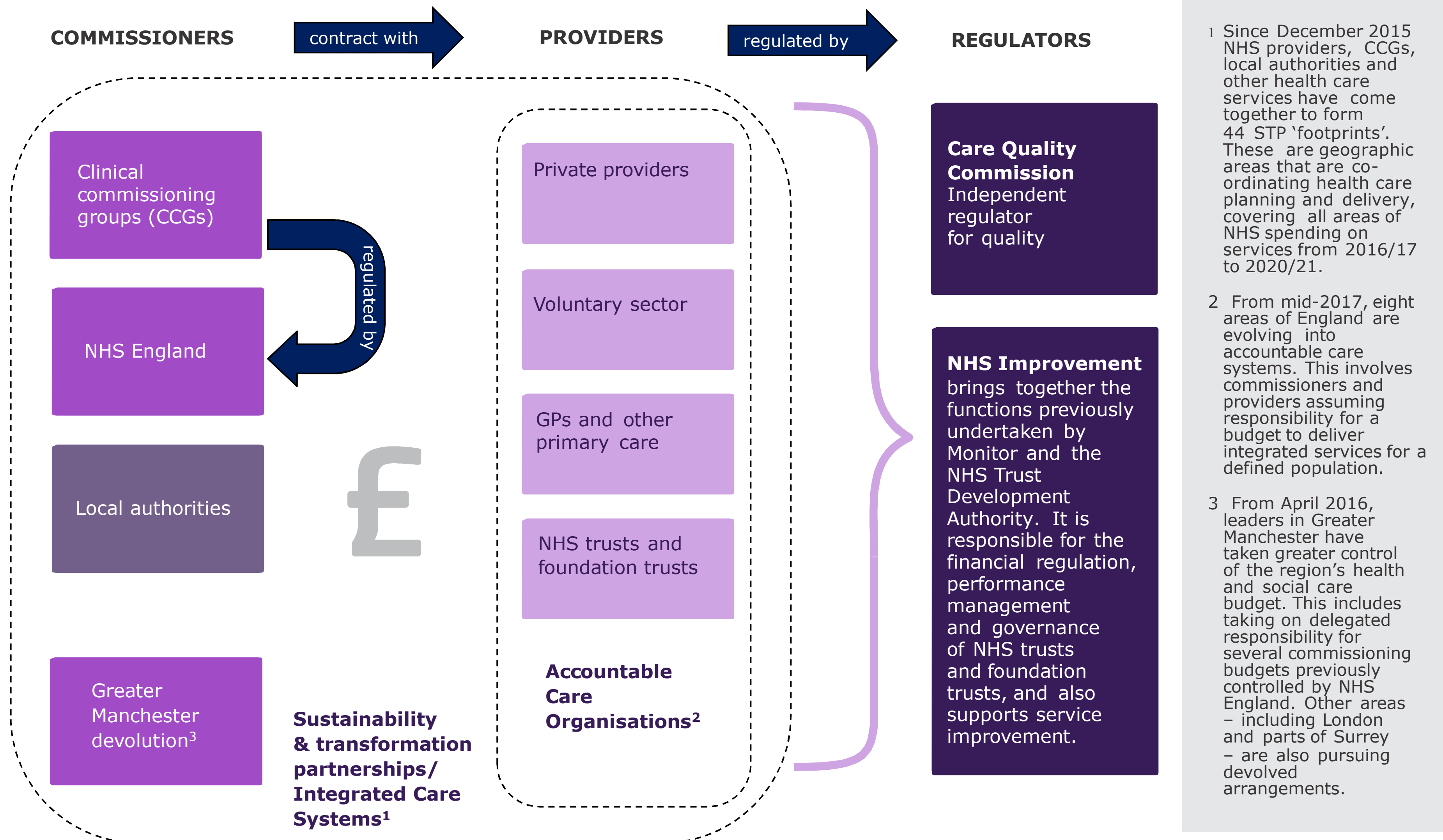
Case	Answers the question…
Strategic	Why are we doing this?
Economic	Which option is best value?
Financial	Can we afford it?
Commercial	How will it be done?
Management	Who will make sure it's done?

https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190609/Green_Book_guidance_short_plain_English_guide_to_assessing_business_cases.pdf

What is the commissioning process?

- Mainly CCGs and NHS England, plus Local Authorities for some ‘public health’ services
- Provide, plan and fund health services for local population
- Work with patients to influence and develop the shape of services they receive
- Commission primary care and other health services from GPs, NHS providers and other providers

How providers are regulated and commissioned



1 Since December 2015 NHS providers, CCGs, local authorities and other health care services have come together to form 44 STP 'footprints'. These are geographic areas that are co-ordinating health care planning and delivery, covering all areas of NHS spending on services from 2016/17 to 2020/21.

2 From mid-2017, eight areas of England are evolving into accountable care systems. This involves commissioners and providers assuming responsibility for a budget to deliver integrated services for a defined population.

3 From April 2016, leaders in Greater Manchester have taken greater control of the region's health and social care budget. This includes taking on delegated responsibility for several commissioning budgets previously controlled by NHS England. Other areas – including London and parts of Surrey – are also pursuing devolved arrangements.

- Determining the health needs of the population
- Assessing the current provision – how far does it meet those needs?
- Identifying where changes are needed or where service is not provided
- Prioritising
- Negotiating the required provision
- Monitoring the services provided

- NHS Constitution commitments, e.g.:
  - Patient Choice – "plurality" of provision
  - Waiting Times – mainly RTT (elective waits), A&E 4-hour standard…
- Other specific Government targets
  - e.g. MRSA rates, cancer waits
- Standards set locally by commissioners:
  - Service specs
  - Commissioning policies, e.g. prior approval
  - Local quality standards
  - Reporting requirements

And by using the NHS Standard Contract…

- Contract mandated for use by NHS commissioners for all their healthcare commissioning contracts other than core primary care
- 3 sections:
  - ***General Conditions:*** national terms that apply in all contracts
  - ***Service Conditions:*** national terms that apply where specific services are being commissioned
  - ***Particulars:*** who the contracting parties are and many, many schedules containing all locally-agreed requirements

http://www.england.nhs.uk/nhs-standard-contract/

2018/19 Policy and Planning

- Main provisions of 2012 Act increasingly ignored – new environment emerging
- Commissioners and providers encouraged to work together in ICS model
- Effective merger of 3 main regulators
- 2.4% real terms £ growth
- PM commitment to another 10 yr NHS plan
- A&E: ‘majority’ to 95% by March 2019
- Major relaxation of waiting times targets – halve the number of >52 week waiters

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- Introduced to NHS from 2005
- A system where payments to providers are linked to the activity provided
- Doesn't affect the funding allocated to Commissioners BUT…
- Determines the majority of income most Acute Trusts receive
- Doesn't really apply to mental health or community

https://improvement.nhs.uk/resources/national-tariff-1719/

Three main elements:

1. Standard National Tariff
2. Cost and volume contracting
3. Casemix adjusted payments

- Mandated for most acute activity
- Money follows patient…
  - Providers paid for each individual patient treated (if fully recorded!)
- No price competition…
  - Price is fixed, based on the national average cost for Trusts in England, ±adjustments
- Common currencies to measure activity and benchmark your Trust…
  - spells, attendances, bed days, etc.

- Payment based on actual activity performed – funding follows patient
- Incentive for activity growth where needed
- Disincentive for non-delivery
- But is it really “payment by volume” rather than “payment by results” – is it appropriate for all services, e.g. A&E?
- Still very much **not** the norm outside the acute sector, where no national tariff applies and ‘block’ funded contracts persist

3. Casemix adjusted payments

- Inpatient national tariff based on Healthcare Resource Groups (HRGs) – new version introduced in 2017
- Funding reflects complexity -> cost
- Most other developed economies use casemix-weighted reimbursement systems
- Reimburses more fairly those doing complex work… is it sensitive enough?

  (2006: 548 HRGs -> 2017: 2,782 HRGs)

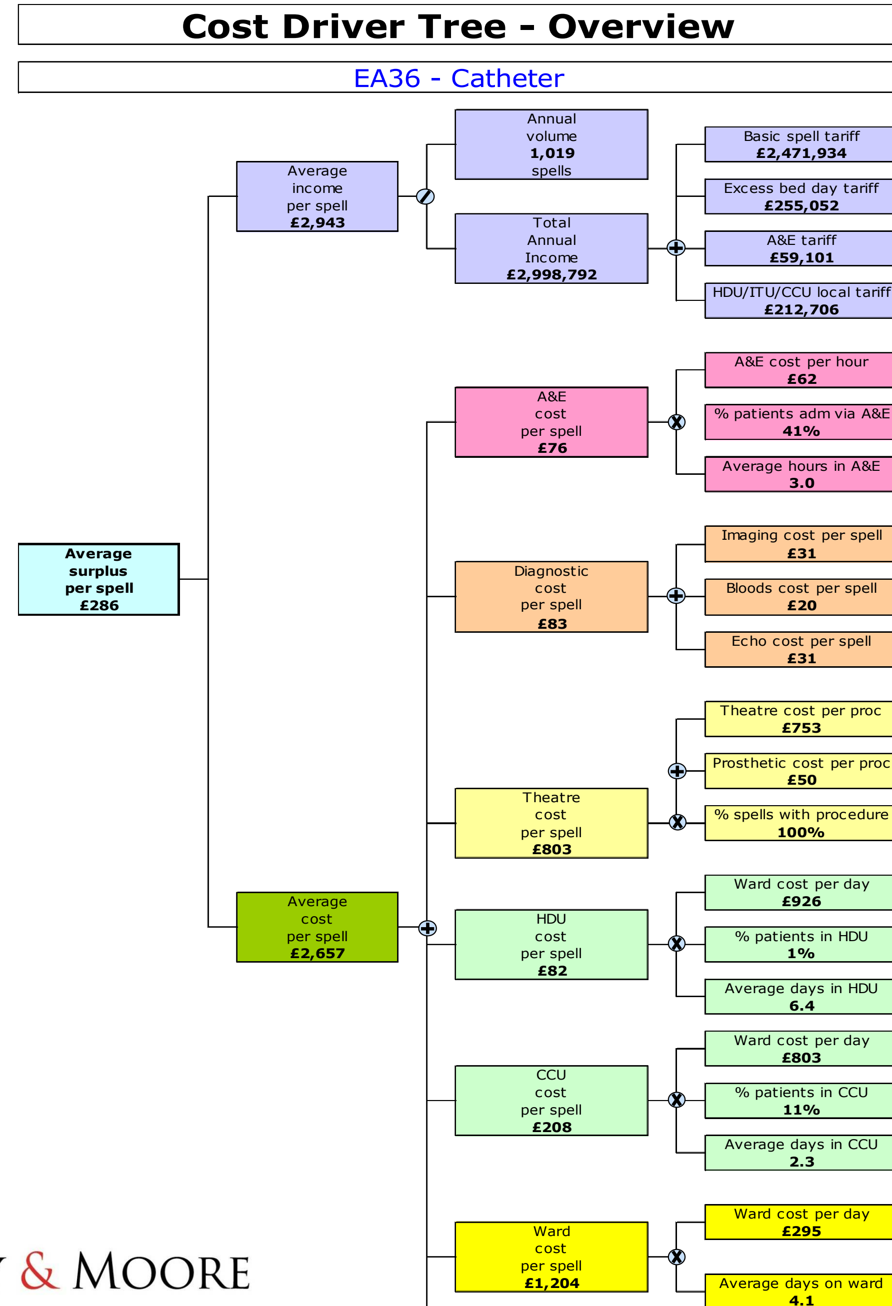
How does this affect clinicians?

?

How does it affect clinicians?

- What income does your service attract under national tariff?
- How much does it cost to provide? Do you get service line reporting and can you understand it?!
- How does your activity get captured and recorded?
- If new services come on stream or the pathway changes, what is the impact on the above?

One way of capturing these issues…



An inpatient price comprises:

- Price for A&E attendance (if admitted via A&E) **PLUS**
- Price for inpatient spell (elective or non-elective) for length of stay up to the ‘trimpoint’

Plus or minus (if applicable):

- Any ‘unbundled’ services such as complex imaging, critical care or high cost drugs
- Reduction if an emergency short stay (0-1 days) OR
- Excess bed days if they stay past a “trimpoint”
- Uplift for certain specialised services at certain providers
- Uplift for ‘Market Forces Factor’ (geography)

Case Study 1

Minor ear procedure as a day case

Case Study 2

Minor ear procedure as an emergency inpatient

See Handouts

National Tariff: Case Study 1

- Patient, aged 15 years, has self-referred to a hospital minor injury unit with a minor ear problem
- No investigation or treatment is thought to be necessary in the MIU
- A simple procedure is required
- Discharged with advice and procedure is booked as a day case in the following month
- The procedure is carried out and the patient is discharged later that day

- Patient, aged 15 years, has been brought by car to a hospital A&E with a minor ear problem
- After a simple investigation (category 1) in A&E, it is decided that this requires a minor procedure to be carried out immediately
- Patient is immediately admitted to the ENT ward and treated as an inpatient
- Patient is discharged after 6 days

National Tariff for Case Studies

A&E attendance tariff for 2018/19:

HRG code	HRG name	Tariff (£) Type 1 and 2 Departments	Type 3 Departments
VB01Z	Emergency Medicine, Any Investigation with Category 5 Treatment	328	63
VB02Z	Emergency Medicine, Category 3 Investigation with Category 4 Treatment	299	63
VB03Z	Emergency Medicine, Category 3 Investigation with Category 1-3 Treatment	216	63
VB04Z	Emergency Medicine, Category 2 Investigation with Category 4 Treatment	196	63
VB05Z	Emergency Medicine, Category 2 Investigation with Category 3 Treatment	164	63
VB06Z	Emergency Medicine, Category 1 Investigation with Category 3-4 Treatment	115	63
VB07Z	Emergency Medicine, Category 2 Investigation with Category 2 Treatment	144	63
VB08Z	Emergency Medicine, Category 2 Investigation with Category 1 Treatment	133	63
VB09Z	Emergency Medicine, Category 1 Investigation with Category 1-2 Treatment	93	63
VB10Z	Emergency Medicine, Dental Care	82	63
VB11Z	Emergency Medicine, No Investigation with No Significant Treatment	63	63
VB99Z	Emergency Medicine, Patient Dead On Arrival	93	63

A&E department type is defined as:

01	Emergency departments are a CONSULTANT led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency PATIENTS
02	Consultant led mono specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of PATIENTS
03	Other type of A&E/minor injury ACTIVITY with designated accommodation for the reception of accident and emergency PATIENTS. The department may be doctor led or NURSE led and treats at least minor injuries and illnesses and can be routinely accessed without APPOINTMENT.
04	NHS walk in centres

(http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp)

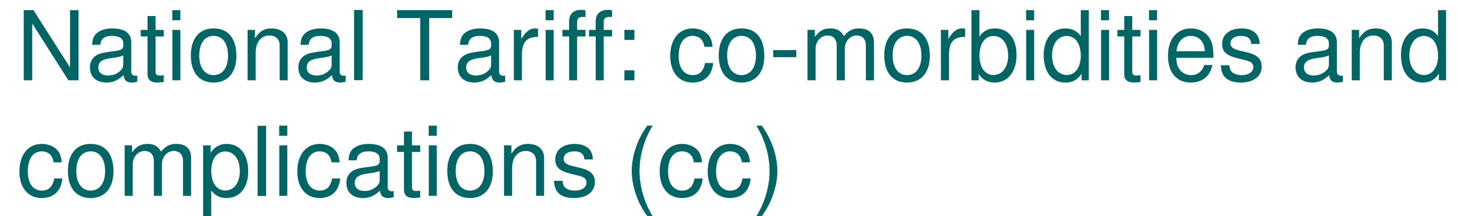
National Tariff for Case Studies

Excerpt from the Admitted Patient Care tariff for 2018/19:

HRG code	HRG name	Outpatient procedure tariff (£)	Combined day case / ordinary elective spell tariff (£)	Ordinary elective long stay trim point (days)	Non-elective spell tariff (£)	Non-elective long stay trim point (days)	Per day long stay payment (for days exceeding trim point) (£)
CA50Z	Complex Ear Procedures	-	2,971	5	5,636	16	241
CA51A	Very Major Ear Procedures, 19 years and over	-	2,438	5	2,438	5	241
CA51B	Very Major Ear Procedures, 18 years and under	-	2,677	5	5,137	17	418
CA52A	Major Ear Procedures, 19 years and over	-	1,403	5	2,117	25	241
CA52B	Major Ear Procedures, 18 years and under	-	1,520	5	2,432	15	418
CA53A	Intermediate Ear Procedures, 19 years and over	91	987	5	987	5	241
CA53B	Intermediate Ear Procedures, 18 years and under	165	1,091	5	1,091	5	418
CA54A	Minor Ear Procedures, 19 years and over	91	684	5	684	5	241
CA54B	Minor Ear Procedures, 18 years and under	82	738	5	778	5	418
CA55A	Minimal Ear Procedures, 19 years and over	90	654	5	654	5	241

The answer (probably):

	Case study 1	Case study 2
MIU/A&E attendance	£63	£93
Day case/inpatient admission	£738	£778
Excess bed days	-	£418
Total income:	**£801**	**£1,289**



National Tariff: co-morbidities and complications (cc)

- Of the 2,782 HRGs in 2018/19: 1,780 are ‘splits’ of a common ‘root’ HRG e.g.:

HRG code	HRG name	Non-elective spell tariff (£)
AA35A	Stroke with CC Score 16+	11,526
AA35B	Stroke with CC Score 13-15	7,129
AA35C	Stroke with CC Score 10-12	5,096
AA35D	Stroke with CC Score 7-9	3,328
AA35E	Stroke with CC Score 4-6	2,042
AA35F	Stroke with CC Score 0-3	1,128

- There is a significant attribute such as cc (secondary diagnoses), age or length of stay that result in the spell being paid a different price
- Full and accurate recording is key to £!

All NHS organisations have to do it…

Understanding the difference between

INNOVATION
and
IMPROVEMENT

The RULES are:

1. Stand in a circle. You must pass the ball between you so that each of you touch the ball

2. This must be done in the same order each time

Thanks for listening

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Presentation available at:

http://baileyandmoore.com/wp-content/uploads/2018/06/RSM-NHS-Finance-2018.pdf