September 2014

Glossary for NHS finance and governance

Briefing

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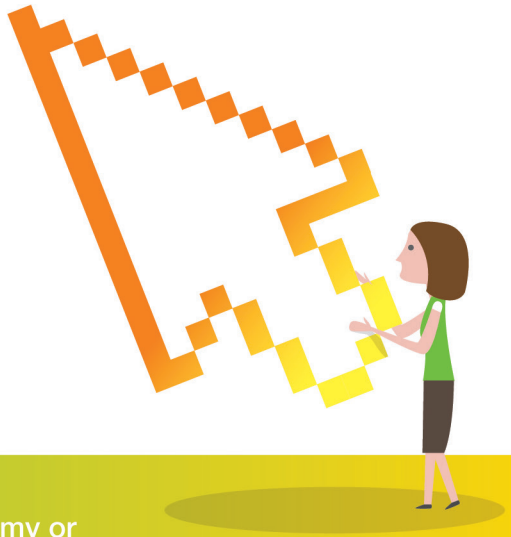

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Index

Introduction

This briefing provides a glossary of terms used frequently in relation to finance and governance in the NHS. The terms are grouped into relevant sections covering:

1. Who does what?

2. Budget setting and monitoring

3. Commissioning

4. Contracts

5. Costing

6. Financial performance

7. Financial planning

8. Governance

9. Payment systems

10. Statutory and departmental duties.

It is not intended to be exhaustive in its coverage – instead it focuses on key terms that HFMA members may find helpful and relevant when discussing different aspects of finance and governance in the NHS or explaining terms to other colleagues.

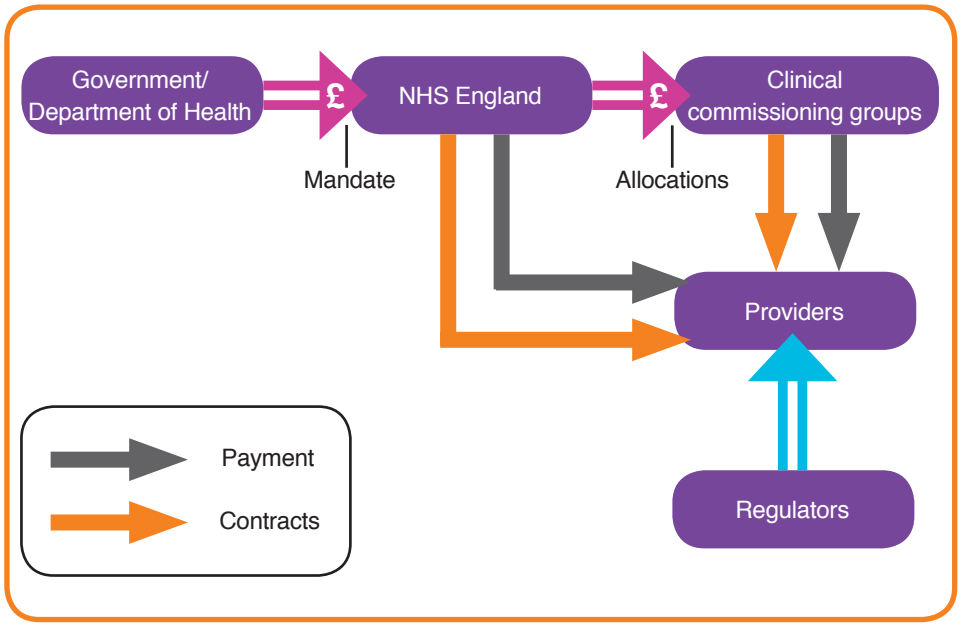
1. WHO DOES WHAT?

Before looking at some specific areas of NHS finance and governance in more detail, it may be helpful to understand who does what in the NHS in England and how their roles relate to each other in finance and governance terms.

The diagram below shows the key organisations and the way that funds flow between them. This section of the briefing will provide an overview of each element.

The Department of Health's purpose is to help people live better for longer. It is responsible for ensuring the provision of a comprehensive health service through the NHS.

It supports the secretary of state and ministers in carrying out their responsibilities for health and social care services by setting national standards, policy and priorities for the NHS.



Providers of healthcare

NHS healthcare can be provided by a range of organisations both within and outside of the NHS. Providers form the other half of the commissioning equation as the organisations that provide the care bought by commissioners. Commissioners can place contracts for the delivery of healthcare with any qualified provider – one able to meet the standards of NHS care and quality and likely to be one of the following types of organisation:

Foundation trusts are public benefit corporations that remain part of the NHS providing healthcare (acute, community, mental health or ambulance services) free at the point of need. They possess three key characteristics that distinguish them from non-foundation trusts:

- Freedom to decide locally how to meet their obligations
- Accountability to local people, who can become members and governors of the foundation trust
- Authorisation and ongoing regulation by the sector regulator for healthcare – Monitor

Non-foundation NHS trusts providing mainly hospital-based services. The most common type is an acute hospital trust. Others include mental health and ambulance trusts. Their performance is overseen by the NHS Trust Development Authority.

Other qualified providers (private and voluntary) providing care in terms of:

- The provision of a specific service
- The provision of additional capacity for an NHS hospital based on an agreed contract and payment arrangement
- A franchising arrangement as in the case of Hinchingbrooke Healthcare NHS Trust where the entire hospital is run by a private sector provider but remains in the NHS.

The Department sponsors stand-alone organisations or arm's length bodies to undertake specific activities to help deliver its agenda

Other commissioners of healthcare

As well as NHS England (see below), healthcare is also commissioned by clinical commissioning groups (CCGs). These are statutory bodies created by the Health and Social Care Act 2012, made up of members that are the GP practices within each one's area. They are responsible for agreeing what care the patients registered with their constituent practices need, negotiating contracts with healthcare providers and monitoring their implementation. They commission the majority of NHS services for their patients.

Arm's length bodies (ALBs)

The Department sponsors a number of stand-alone organisations or arm's length bodies to undertake specific activities to help deliver its agenda. These can be categorised by function:

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

NHS England, an executive non-departmental body working at arm's length from the Department. Its legal name is the NHS Commissioning Board. It is accountable to the secretary of state for health for meeting its legal duties and fulfilling its mandate. NHS England is accountable for staying within its allocated resources and delivering a wide range of improvements in healthcare. It is responsible for some commissioning activities including:

- Primary medical services (dental, pharmacy and ophthalmic services)
- National and regional specialised services and other prescribed services
- Offender health services
- Health services for serving personnel and families in the armed forces
- Four public health services: screening, immunisation, public health services within prisons and public health services for children up to five years.

It is also responsible for managing the commissioning system for the NHS, primarily through the authorisation and monitoring of clinical commissioning groups (CCGs).

Monitor is the sector regulator for healthcare. It has a core duty to 'protect and promote patients' interests' and has responsibility for licensing healthcare providers, setting and regulating prices (with NHS England) and ensuring continuity of services – to maintain patient services deemed essential for which no viable alternative exists. It is also required to 'enable integrated care and prevent anti-competitive behaviour'.

The Care Quality Commission (CQC) is an independent body that is responsible for registering and regulating all providers of health and adult social care in England (including private providers).

The NHS Trust Development Authority (NHS TDA) is a special health authority with responsibility for overseeing all remaining NHS trusts and for supporting them as they move towards foundation status.

Standards ALBs focus on establishing national standards and best practice:

The National Institute for Health and Care Excellence (NICE) is responsible for providing national guidance and quality standards to improve the outcomes of people using the NHS, other public health and social care services.

Providing cost-effective services to the whole of the NHS, some ALBs focus expertise including:

The NHS Business Services Authority (NHS BSA), which provides many central services to NHS organisations and directly to patients and the general public. These include NHS Supply Chain (provides patient-focused

healthcare products and supply chain services to the NHS); making payments to dentists and pharmacists; issuing European Health Insurance Cards; managing the NHS pension scheme and the provision of NHS Protect services in England and Wales.

Health Education England (HEE) provides leadership and oversight on strategic planning and development of the health and public health workforce and allocates education and training resources, including:

- The medical and dental education levy (MADEL) – funding received by NHS bodies for the cost of providing the education element to junior medical staff. This is now being replaced by a system of education tariffs
- Non-medical education and training monies (NMET) - funding that supports the education and training of nurses, allied health professionals and healthcare scientists. This is being replaced by a system of education tariffs
- Service increment for teaching (SIFT) – a payment made from central resources to recognise the additional costs incurred by hospitals in providing undergraduate medical training. This is now being replaced by a system of education tariffs.

The Health and Social Care Information Centre (HSCIC) is the source of data and information relating to health and care. It also supports the delivery of IT infrastructure, information systems and standards to ensure information flows efficiently and securely across the health and social care system to improve patient outcomes.

The NHS Litigation Authority (NHSLA) is a special health authority that handles negligence claims and works to improve risk management practices in the NHS. It operates the clinical negligence scheme for trusts (CNST) - a risk pooling scheme that covers all liability arising from medical negligence for employees while operating under their contract of employment with an NHS organisation. The scheme is also available to private providers.

ALBs that focus on safety and the protection of patients and the public:

Public Health England (PHE) leads on health protection and harnessing efforts to improve the public's health. It works closely with local authorities that have primary responsibility at local level for health improvement and reducing health inequalities.

The Health Research Authority (HRA) was established to protect and promote the interests of patients and the public in health research, and to streamline the regulation of research.

NHS funded research is overseen by the National Institute for Health Research (NIHR), a 'virtual body' funded by the Department to improve the health and wealth of the nation through research that is headed by the chief medical officer.

The accounts of the Department and its ALBs are audited by the National Audit Office (NAO). The NAO audits all government departments as well as a large number of public sector organisations. The NAO reports to the government on how well these departments and organisations have used their resources in relation to economy, efficiency and effectiveness.

The Department is also involved in three more commercial arrangements to deliver services to the wider NHS:

NHS Professionals is a private limited company wholly owned by the Department to provide temporary staff to NHS organisations in England.

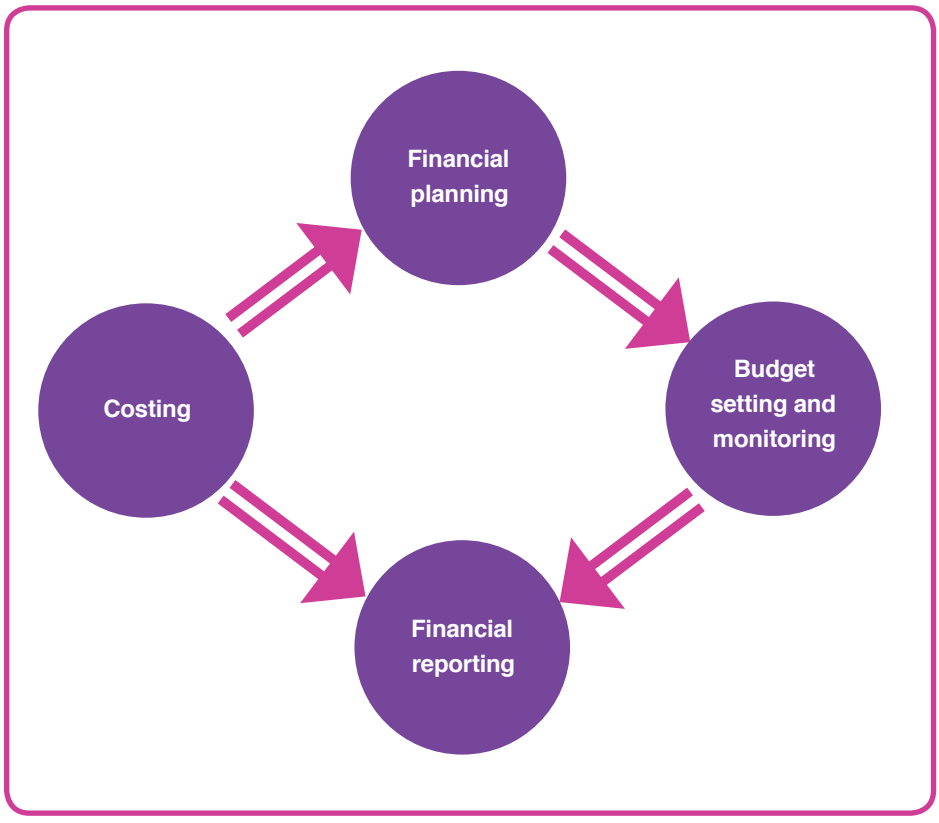
NHS Property Services Ltd is a private limited company wholly owned by the secretary of state for health, whose role is to maintain, manage and develop NHS facilities.

NHS Shared Business Services (NHS SBS) is a joint venture between the

The accounts of the Department and its ALBs are audited by the National Audit Office

Department and Steria. It provides back-office finance and accounting services to a variety of public and private sector clients, including all commissioning organisations in the NHS in England. This includes the provision and operation of the financial ledger used by all clinical commissioning groups (CCGs) and commissioning support units (CSUs), as well as NHS England, including area teams. The ledger is known as the Integrated Single Financial Environment (ISFE).

All organisations in the NHS are involved in the financial activities outlined in the diagram below. The briefing will cover terms commonly used when discussing each area.



2. BUDGET SETTING AND MONITORING

A budget is a financial and/or quantitative statement that is prepared and agreed for a specific future period. It usually covers a year but to help with planning, budgets can cover longer periods – three to five years is common. It translates aims into a statement of the resources needed to fulfil them and has either a monetary or non-monetary value. Below are terms commonly used when discussing budgets in the NHS:

Activity-based budgeting produces a budget for a defined activity level – the budgeted costs and income change as activity levels change.

Agenda for change is the NHS-wide grading and pay system for all NHS staff, with the exception of medical and dental staff and some senior managers. Each relevant job role in the NHS is matched to a band on the agenda for change pay scale.

Budgetary control involves comparing actual income, expenditure, activity and workforce results with the budget - what was originally planned - and taking action when differences emerge.

The budget manager is the single named individual responsible for a budget. They are responsible for agreeing, reviewing and monitoring their allocated budgets and taking the action necessary to ensure income and expenditure do not exceed that planned.

Budget monitoring is a continuous process of reviewing actual income and expenditure or non-financial data – for example, patient activity against the budget. A monthly budget monitoring report is often produced to help budget managers to do this.

The budget profile is the likely spending or activity pattern during the time period covered by the budget – for example, the number of patients attending accident and emergency departments will be subject to seasonal variations

and so the resources planned to be spent will fluctuate accordingly.

Rather than record every cost incurred separately, costs are categorised into a number of distinct headings referred to as cost centres. Usually they are in line with an organisation's organisational or management structure – for example, the human resources department or drugs advisory team. Other codes are routinely used for analytical purposes – for example, account codes and activity codes.

Account codes are given to specific types of expenditure and make analysis of the same type of spending across different cost centres possible, such as spending on training throughout an organisation. Activity codes are used when more detailed analysis is required.

A staffing establishment is the number of full-time or whole-time equivalents for each grade of staff budgeted for a ward, department or service. If the budget manager keeps to the agreed staffing establishment, the amount spent against the budget should stay on track throughout the year.

Full-time equivalent (FTE)/whole-time equivalent (WTE) is a measure of staffing numbers, based on the maximum contracted hours. One FTE is one person contracted to work the maximum number of hours per week for a whole year. These measures are not the same as headcount or the actual number of people employed. For example, a part-time receptionist working 22.5 hours out of the standard 37.5 hours per week has an FTE of 22.5 hours divided by 37.5 hours or 0.60 FTE, but a headcount of one.

Incremental budgeting is the most common approach to budgeting in the NHS. Also known as historical budgeting, it starts with the previous year's budget, which is adjusted for known changes and developments. Income, expenditure, savings and activity can be recurrent (ongoing) or non-recurrent (one-off).

Reserves are monies set aside for a specific purpose, often on receipt of specific or ring-fenced income. For example, a contingency reserve allows an organisation to meet unforeseen expenditure during the year.

Revenue costs are the day-to-day costs of running an organisation that might include:

- Contracts for the provision of healthcare
- Maintenance and service costs
- Consumables
- Accommodation
- Staff costs.

The running cost allowance is the money allocated to clinical commissioning groups (CCGs) to pay for clinical and non-clinical management and administrative support, including commissioning support services.

A variance is the difference between what was budgeted and what actually happens. It is used to identify and analyse the cause of overspends or underspends, with a view to proposing rectifying action.

A virement is the process of transferring money from one budget heading/line to another.

Zero based budgeting (ZBB) is 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.

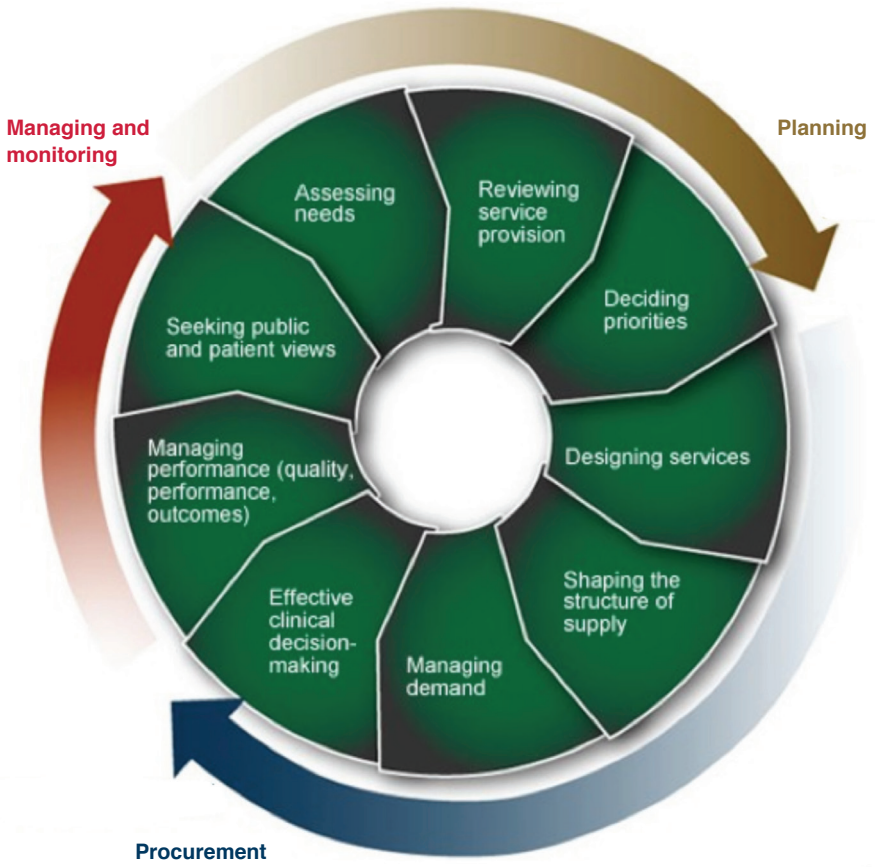
A budget translates aims into a statement of the resources needed to fulfil them and has either a monetary or non-monetary value

3. COMMISSIONING

Commissioning involves making the best use of allocated resources to:

- Improve health and well-being and reduce health inequalities
- Secure access for patients to a comprehensive range of services
- Improve the quality, effectiveness and efficiency of healthcare services
- Increase patient choice

Below you will find terms commonly used in relation to commissioning in the NHS.



Launched through the Spending Round in June 2013, the better care fund (BCF) – formerly known as the integration transformation fund – will be set up as a pooled budget from 1 April 2015. CCGs and local authorities contribute an agreed level of resource into a single pot that is then used to commission health and social care services, enabling patients to experience a seamless service with a single point of access for their health and social care needs.

The BCF is intended to achieve a number of specific objectives:

- To deliver better services to older and disabled people who have multiple and complex needs
- To keep people out of hospital
- To avoid people staying in hospital for long periods.

Hosted by NHS England, clinical networks advise on specific priority service areas of care and are able to offer 'condition-specific advice' to health and well-being boards (HWBs).

Hosted by NHS England, clinical senates are multi-professional advisory groups comprising doctors, nurses and other professionals, as well as patients and volunteers. They provide expert advice on 'strategic clinical decision-making to support commissioners' to improve the quality of patient care for the populations they represent.

A commissioning or operating plan is intended to show how a CCG will use its budget to improve outcomes for patients. Every CCG produces a commissioning plan as part of the annual planning process.

The term co-commissioning is used to describe commissioning arrangements where two or more commissioning organisations align their commissioning systems and priorities for the purpose of achieving shared outcomes while retaining separate responsibility for managing their own

resources to support this. It can take one of the following forms:

- Greater CCG involvement in influencing commissioning decisions made by NHS England area teams
- Joint commissioning arrangements, whereby CCGs and area teams make decisions together, potentially supported by pooled funding arrangements
- Delegated commissioning arrangements, whereby CCGs carry out defined functions on behalf of NHS England and area teams hold CCGs to account for how effectively they carry out these functions [1].

The commissioning cycle illustrates that commissioning is a continuous process as is shown in the diagram on page 9.

Commissioning support units (CSUs) aim to bring specialist skills and knowledge to support CCGs to deliver their commissioning roles. They provide services that benefit from being operated at scale or across a wider geographical or population area that could not be provided by individual CCGs. This may be in the form of back-office functions – for example, finance and human resources, the provision of data analysis and storage, developing the health needs assessment or handling press and media enquiries.

The co-ordinating or lead commissioner model is where CCGs work together so that a single contract is negotiated by the co-ordinating or lead commissioner with the local service provider. The contract is 'performance managed' across all member/associate CCGs.

Demand management is a key part of the commissioning cycle and involves using planning and forecasting skills to ensure patients receive the most appropriate care in the right setting. It is not about managing the number and type of referrals.

The Health and Social Care Act 2012 introduced health and well-being boards (HWBs) to every upper tier local authority. Established as forums of key leaders from the health and care system, their role is to join up commissioning across the NHS, social care, public health and other services that are directly related to health and well-being in the local area.

Joint health and well-being strategies (JHWSs) set out the issues needing greatest attention by key commissioners (CCGs, local authorities and NHS England) and how they will work together to deliver the priorities.

A joint strategic needs assessment (JSNA) is drawn up by local authorities and CCGs and is designed to identify the current and future health and well-being needs of the local population.

Partnership working with local authorities (LAs) for particular services and client groups is increasingly common and is vital with the advent of the better care fund. It allows services to be pulled together on a 'whole system' basis from the perspective of the service user rather than the organisation delivering the service. In this context, lead responsibility for commissioning may sit with the local authority and not the health organisation.

Pooled budgets exist where 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.

Prescribed specialised services or specialised services are healthcare services that are very expensive to provide or very rare or can only be provided by a few specialised providers. They are commissioned nationally by NHS England through its local area teams and are determined by four factors set out in the Health and Social Care Act 2012:

- The number of individuals who require the service or facility

Partnership working with local authorities for particular services and client groups is increasingly common and is vital with the advent of the better care fund

1. Publications Gateway Ref. Number 01599, NHS England, May 2014

- The cost of providing the service or facility
- The number of people able to provide the service or facility
- The financial implications for clinical commissioning groups if they were required to arrange for the provision of the service or facility.

Secondary uses service (SUS) provides anonymised patient-based data for purposes other than direct patient care. These secondary uses include functions such as healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance.

A unit of planning is a grouping of NHS and social care commissioners that work together to produce a strategic plan for their local health economy with the aim of delivering clinical improvements. The size, format and approach of each unit will depend on local arrangements but all relevant parties must be involved. No units of planning should overlap and the whole population must be covered by a unit of planning.

Secondary uses service provides anonymised patient-based data for purposes other than direct patient care

4. CONTRACTS

A standard contract is used in the NHS for agreements between commissioners and providers of NHS-funded care. A standard contract framework produced each year by NHS England is added to locally. They are comprised of three parts: the particulars, the service conditions and the general conditions.

The contract provides a means of determining whether a provider is meeting its obligations in terms of service quality and patient activity. Contracts with foundation trusts and local authorities are legally binding. Below you will find terms commonly used in relation to contracts in the NHS.

A bilateral contract is a contract between a single commissioner and a single healthcare provider.

Largely based on historical patterns of care, a block contract allows a healthcare provider to receive a lump sum payment to provide a service, irrespective of the number of patients treated or type of treatment provided.

Commissioning for quality and innovation (CQUIN) payments ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement. The schemes that qualify for CQUIN payments reflect both national and local priorities.

Cost and volume contracts are those contracts where a fixed sum is paid for access to a defined range and volume of services. But if there is a variation from the planned level of activity, a variation payment is made according to a variation or threshold agreement clause. This determines the marginal or per unit rate of payment for higher or lower than target performance.

Cost per case contracts identify for each episode or unit of care a payment to the service provider. This form of contract is commonplace for individual, expensive and bespoke care package agreements – for example,

the placement of patients in medium secure mental health facilities.

Data quality improvement plans are agreed between commissioners and providers to improve the capture, quality and flow of data between them – data that is essential for the effective management of contracts.

A framework agreement is an agreement with a supplier setting out terms and conditions under which specific purchases can be made during the term of the agreement. It does not, however, commit the purchaser to buy a certain level of activity.

The general conditions form the third part of the NHS standard contract and contain the fixed conditions that apply to all services and all types of provider, including mechanisms for contract management, generic legal requirements and defined terms. General conditions cannot be varied.

A long-term agreement (LTA) is an agreement with a contractor to provide goods or services over a defined period, usually in excess of 12 months.

A multi-lateral contract is a standard contract between a group of commissioners and a single healthcare provider. The contract is negotiated and signed by a co-ordinating commissioner on behalf of all the commissioners involved.

Never events are serious patient safety events that are largely preventable. As a key indicator of quality, they are detailed in schedule 4 of the particulars of the standard contract for 2014/15 and must be recorded in contract monitoring information.

The particulars to the standard contract set out the key parties involved and the dates by which the contract must be agreed and signed. At present commissioners may exercise a contractual right to retain an element of payment – impose financial penalties when a healthcare provider breaches one or more national standards as set out in the NHS standard contract.

The referral to treatment target is a key performance measure for healthcare providers. It requires 90% of patients to be admitted as either an inpatient or a day case and 95% of patients who are not admitted but require treatment to start consultant-led treatment within 18 weeks of referral. Commissioners review the performance of providers with whom they place contracts.

The service conditions form the second part of the NHS standard contract. They contain the generic, system-wide clauses that relate to the delivery of services – for example, the need for the service provider to publish, maintain and operate a consent policy for service users that complies with good practice and the law.

Service delivery and improvement plans are mandated plans that describe changes to services during the contract period. They may contain:

- Productivity and efficiency plans
- Agreed service redesign plans
- Service development plans
- Priorities for quality improvement.

A service level agreement (SLA) may be used by commissioners and providers where national standard contracts do not apply – for example, where a consultant is provided by one hospital to another for a fixed number of sessions each week.

Service specifications are developed to describe the services covered by the standard contract. They can describe services in terms of patient pathways, mental health care clusters, individual service or service user.

Variations to the standard contract must be agreed between both parties to the original contract. Any such variations are normally recorded in a deed of variation agreed by the commissioner(s) and provider. A procedure for agreeing variations must be followed, set out in the documents supporting the national contract.

Never events are serious patient safety events that are largely preventable

5. COSTING

Costing is all to do with quantifying, in financial terms, the value of resources consumed in carrying out a particular activity or producing a certain unit of output. Understanding how costs are built up and the cost of treating individual patients is fundamental to decision-making in the NHS. Below are some of the terms you may find helpful in relation to costing.

Cost drivers or triggers cause changes in the costs incurred. They can be:

- Activity- or volume-based – these tend to be related to homogenous activities. For example, processing an invoice for £50 involves the same actions as one for £500
- Time-based – these are linked to variations in the amount of time taken for different outputs/ outcomes. For example, an appointment will take more time if the patient has a number of complex issues to be addressed
- Resource-based – for example, when there is a direct charge for materials for a particular activity.

Direct costs can be directly attributed to a particular activity or output. For example, the cost of a radiographer is a direct cost to the radiology department and a lens is a direct cost in the treatment of a patient with cataracts.

Variable costs increase/decrease in line with changes in the level of activity – for example, drugs costs

Fixed costs do not increase or decrease with changes in levels of activity for example, the rent paid for a service to occupy a building.

Indirect costs cannot be attributed directly to a particular activity or cost centre – for example, cleaning costs may be spread across a range of departments in proportion to the floor area occupied by each.

The marginal cost is the increase or decrease in cost caused by an increase or decrease in activity by one unit.

Overhead costs contribute to the general running of the organisation but cannot be directly related to an activity or service – for example, human resources or the costs of the members of the governing body.

Patient-level costing involves allocating costs, where possible, to an individual patient. Assigning costs to individual patients provides opportunities for a much greater understanding of how costs are built up. NHS organisations are required to submit a schedule of costs of delivered healthcare resource groups to allow direct comparison of the relative costs of different providers.

The results are published each year in the national schedule of reference costs. At present, this information is used to inform the calculation of national prices for reimbursing providers of NHS healthcare in England.

Semi-fixed or step costs tend to remain fixed for a given level of activity but change in steps when activity levels exceed or fall below given levels. For example, substance misuse staff numbers may remain fixed within a given range of referral levels but vary if the number of referrals significantly drops or increases.

Variable costs increase/decrease in line with changes in the level of activity – for example, drugs costs.

6. FINANCIAL PERFORMANCE (IN YEAR)

All NHS organisations are required to deliver a satisfactory level of financial performance and demonstrate financial stewardship of public monies (see section on statutory duties).

To ensure that NHS organisations remain on track in financial terms, a number of tools are used to measure performance. Below are terms that are commonly used in relation to the financial performance of NHS organisations.

Benchmarking is the process of measuring and comparing performance against other similar organisations to obtain information that helps to identify areas for potential improvement.

The capital servicing capacity ratio is one of the metrics incorporated within the continuity of services risk rating. It measures the number of times the costs of a foundation trust's annual debt can be covered by the money available.

The continuity of services risk rating is used by healthcare regulator Monitor, to assess the ability of a licensed provider to continue to provide commissioner requested services (those services specified and deemed essential by commissioners that will be considered for protection should the provider fail). It has two parts: a liquidity ratio and a capital servicing capacity ratio.

Earnings before interest, taxation, depreciation and amortisation (EBITDA) is a measure of a trust's surplus from normal operations, providing an indication of the organisation's ability to reinvest and meet any interest associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation.

- Depreciation is a non-cash expense that recognises that assets are 'used up' during their useful life. The term relates to tangible assets such as property, plant and equipment, as well as some intangible assets such as software development.
- Amortisation follows the same underlying principle as depreciation but is the term used in relation to intangible assets such as patents, intellectual property and software licences.

A forecast is a prediction of the future performance of a budget. To produce a forecast, the following is needed:

- The total underspend or overspend for the year to date
- Non recurrent costs or benefits within the year to date position
- The number of months left in the financial year
- The likely change to income and expenditure before the year end.

Free cash flow (FCF) is the revenue available to pay back debt.

Key performance indicators (KPIs) enable an organisation to define and assess progress towards its goals. KPIs enable performance to be examined across a range of areas and compared over time – providing regular and consistently measured feedback.

Liquidity is a measure of how long an organisation could continue if it collected no more cash from debtors. In Monitor's *Risk assessment framework*, it is measured by the number of days' worth of operating costs held in cash or cash-equivalent forms and is a key component of the continuity of services risk rating.

Sensitivity analysis is financial modelling used by NHS organisations to identify what happens to the financial position as variables change – for example, in the event that adverse risks are realised.

KPIs enable performance to be examined across a range of areas and compared over time – providing regular and consistently measured feedback

The term value for money (VFM) is used when assessing whether or not the maximum benefit has been obtained from the goods or services bought or investment made. Specifically it involves looking at:

- Economy – sourcing resources as cheaply as possible
- Effectiveness – ensuring desired goals/ targets are achieved
- Efficiency – ensuring outputs/ outcomes are maximised for the resources (inputs) used.

Working capital is the money and assets (owned resources) that an organisation can call upon to finance its day-to-day operations. If working capital dips too low, organisations risk running out of cash and may need a loan to smooth cash flows.

A business plan is 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

7. FINANCIAL PLANNING

All NHS organisations are required to undertake financial planning. The plan must cover all expected sources of income and expenditure and the full range of responsibilities under the management of the organisation over the short, medium and longer term.

Below are some key terms in relation to financial planning and funding sources that you may find helpful.

An allocation is the amount of money made available to a CCG to purchase healthcare for the patients registered with its constituent practices. Allocations are made available annually by NHS England. The allocation will be split into two elements: the programme allocation for all the services provided to manage and improve the health of the local population and running costs, the resource available to manage and administer the services.

The development of a business case is a formal process for identifying the financial and qualitative implications of options for changing services and/or making investments.

A business plan is 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. Generally business plans cover the forthcoming year(s) in greater detail than those periods further in the future. The business plan should be consistent with the strategic objectives of the organisation and provide the basis for the annual budget.

In most businesses, capital refers either to shareholder investment funds or buildings, land and equipment owned by a business that has the potential to earn income in the future. The NHS uses this second definition, but adds a further condition: that the cost of the building/equipment exceeds a minimum threshold, normally £5,000. Capital is thus an asset (or group of functionally interdependent assets), with a useful life expectancy of greater

than one year, whose cost exceeds the threshold.

A cost improvement plan/programme (CIP) sets out the savings that an NHS organisation plans to make to reduce its expenditure/ increase efficiency. It is used to close the gap between the level of income received and the expenditure incurred in any one year.

Cost pressures must be taken into account when producing a financial plan. A generic cost pressure is an increase in cost that is generally beyond the control of individual health organisations. They may also be referred to as national cost pressures and include items such as national changes to the rate of employers' contributions in relation to the NHS pension scheme. A local cost pressure is an increase in cost that may or may not be geographically widespread but is considered to be within the control of individual elements of the NHS.

Distance from target (DFT) is the difference between a CCG's baseline (historic) allocation and its share of available resources based on the health needs of its population or target allocation. The target allocation of each CCG is determined by a formula that takes account of the number of patients registered with each GP practice; the age and recent diagnostic history of those patients; the relative level of deprivation and unmet health needs.

The efficiency factor is the percentage amount by which prices are adjusted downwards to reflect Monitor's assumption about the savings the NHS can make each year.

A financial model is used to illustrate what the income and costs for different scenarios will be, when they will be received and incurred and what tolerances there are for each.

A full business case (FBC) is 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 budget and time scale.

Operational plans (OPs) outline how an NHS organisation plans to meet national and local priorities within the financial resources available to it.

Quality, innovation, productivity and prevention (QIPP) is a programme designed to identify savings that can be reinvested in the health service and improve quality of care. Responsibility for its achievement lies with CCGs; QIPP plans must therefore be built into planning (and performance management) processes.

Revenue funding is received by an NHS organisation to meet the costs of its day-to-day activities.

Service lines are units from which services are planned and delivered. Each service line has unique characteristics focusing on a particular medical condition – making it clinically different from another service.

Service line management (SLM) is 'an organisation structure and management framework' where specialist clinical areas are identified and managed as distinct operational units. Within these units '…clinicians and managers can plan service activities, set objectives and targets, monitor their service's financial and operational activity and manage performance'[2].

Service line reporting (SLR) involves looking in detail at the income and costs of an organisation's services in much the same way as a private sector company analyses its business units. In practice, this puts the focus on profitability information by specialty or service.

Transformation programmes enable an NHS organisation or number of organisations to fundamentally change the way a service is provided/delivered.

Value is concerned with the delivery of the best quality of care possible within the resources available.

Service line reporting involves looking in detail at the income and costs of an organisation's services in much the same way as a private sector company analyses its business units

2. *Service line management: an overview,* Monitor, 2009

8. GOVERNANCE

Governance (or corporate governance) is 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 should underpin all that an organisation does. In the NHS this means it must encompass clinical, financial and organisational aspects.

Below are a number of key terms that may be helpful when discussing governance in the NHS.

Accountability means demonstrating on an ongoing basis that public money is being used wisely and effectively.

The accountable officer (AO) in an NHS organisation is responsible for ensuring that his or her organisation:

- Operates effectively, economically and with probity
- Makes good use of their resources
- Keeps proper accounts.

For NHS trusts, the accountable officer is the chief executive. He or she is accountable to parliament via the Department of Health accounting officer and the secretary of state for health. For CCGs, the accountable officer is either the chief officer or the chief clinical officer. He or she is accountable to parliament via NHS England's accounting officer (the chief executive, as designated in the Health and Social Care Act 2012) and the secretary of state for health. In NHS foundation trusts, accountable officers are known as accounting officers and are directly responsible to parliament.

For NHS trusts, the accountable officer is the chief executive. He or she is accountable to parliament via the Department of Health

Audit is the process of validating the accuracy, completeness and adequacy of disclosure in financial records.

The audit committee is a statutory committee of the governing body of all NHS organisations. It is best practice for the audit committee to be solely comprised of non-executive directors or lay/independent members. Its role is to review and report on the relevance and rigour of the governance structures in place and the assurances the governing body receives.

The board assurance framework records the key processes used to manage the organisation and the principle risks to meeting its strategic objectives.

Each NHS organisation must have a chief finance officer or finance director who has a key role in governance terms. As members of the governing body or board, they have a range of responsibilities from statutory duties relating to accountability, governance and probity; traditional treasurer activities; corporate strategic management and day-to-day operational management. This also means they have collective responsibility for all the organisation's activities.

Clinical governance is a framework of processes, systems and controls that helps NHS organisations demonstrate accountability for continuously improving the quality of their services and safeguarding high standards of care. Good clinical governance involves establishing an environment in which clinical excellence can flourish.

Originally issued in 1994 and revised in 2004, the code of accountability 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.

Conflicts of interest arise when a person or organisation has a relationship or is involved in something elsewhere that may influence their decision-making. This has increased as an issue with the involvement of GPs in CCGs, where GPs individually or collectively may benefit from particular service models.

Constitutions and/or standing orders translate an organisation's statutory powers into 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.

A declaration of interest occurs when an employee or member of the NHS organisation or its governing body formally acknowledges a potential conflict of interest. This is either made in writing to the governing body or, if it occurs during the course of a meeting, is acknowledged to enable the declaration to be appropriately recorded in the meeting minutes.

External auditors have two key roles for public sector organisations: to review and report on the year-end accounts and to scrutinise arrangements for securing value for money in the use of resources.

The governing body or board is the organisation's pre-eminent group that takes corporate responsibility for the strategies and actions of the organisation and is accountable to the public for the services provided. It sets the strategy and objectives for the organisation, monitors their achievement and looks for potential problems and risks that might prevent them being achieved.

The governance statement (GS) is 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 operating throughout the preceding year.

Internal audit has two aspects – first, providing an independent and objective opinion to the accountable officer, governing body and audit committee on the extent that risk management, control and governance arrangements support the aims of the organisation; second to provide an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance.

A lay member of a CCG or non-executive director (NED) is a member of the governing body but not directly employed by the organisation. They are normally appointed by the organisation's nominations committee and chosen based on their individual skills and what they will bring to the overall composition of the governing body. They are expected to challenge decisions and strategies.

The Nolan principles of public life are the key principles of how individuals and organisations in the public sector should conduct themselves:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership.

Prime financial policies, also known as standing financial instructions, set out the organisation's detailed financial procedures and responsibilities. They are designed to ensure NHS organisations account fully and openly for all that they do.

A register of interests details any potentially conflicting relationships and any business interests held by the members of the governing body and other employees. All NHS organisations maintain a register of interests subject to external audit review to help counter the risk of conflicts of interest arising.

The remuneration committee is a mandatory committee of the governing body. It sets the remuneration and allowances for executive directors and makes recommendations in relation to the level of remuneration received by senior management (usually the first layer of managers below the governing body), including whether or not pay is linked to performance. To ensure people involved in the day-to-day

The Nolan principles of public life are the key principles of how individuals and organisations in the public sector should conduct themselves

running of the organisation do not make sensitive decisions in this area, the committee's membership is solely composed of non-executive or lay members of the governing body or board.

The scheme of reservation and delegation is a detailed listing of who the governing body empowers to take actions or make decisions on its behalf.

First published in 1993, the standards of business conduct are the strict ethical standards to be applied by all staff when conducting NHS business. They include the standards of conduct expected of all NHS staff and the measures NHS organisations need to take to safeguard themselves. For example, they include the requirement for NHS organisations to prevent bribery taking place with the advent of the Bribery Act 2010.

The system of internal control is established to minimise the risk of an NHS organisation not achieving its objectives. It is based on ongoing risk management processes designed to identify principal risks, evaluate the nature and extent of those risks and manage them.

The care cluster is the currency used for adult mental health and learning disability services, based on the characteristics of a service user

9. PAYMENT SYSTEMS

The NHS in England requires those organisations that buy services on behalf of patients to reimburse all providers of NHS services. The system of financial flows that supports this is known as the payment mechanism. Below are terms that you may find commonly used when discussing the reimbursement of NHS services.

Rather than being set at the national average cost of delivering the procedures concerned, best practice tariffs reflect the costs of delivering treatments in line with NICE guidance – for example, by undertaking cholecystectomies (gall bladder removal) as a day-case procedure or admitting stroke patients directly to a dedicated stroke unit. They financially incentivise the clinically appropriate model against other treatments for the same condition.

The care cluster is the currency used for adult mental health and learning disability services. Based on the characteristics of a service user, care clusters describe the common needs of a group of service users over a given period. Each cluster (numbered 0 to 21) includes different diagnostic codes. Service providers must specify the types of interventions that they will offer service users in each cluster.

A healthcare currency is a defined unit of output activity or healthcare that is paid for by commissioners. For example, the currency used for admitted patient care (covering a spell of care from admission to discharge) is the healthcare resource group (HRG). The currency for outpatient attendances is the attendance itself.

Mainly applicable to patient activity in acute hospitals, HRGs are the currency used to collate the costs of procedures/ diagnoses into common groupings to which prices can be applied. HRGs place these procedures and/ or diagnoses into resource-homogenous bands – clinically similar and consuming similar levels of resource. HRGs enable organisations to compare

costs for delivering services and prices to be set for paying for the delivery of those services.

A local modification is an increase to a national price agreed between a commissioner and provider if local circumstances make it uneconomic to continue to provide a particular service at the national price. A number of specific conditions must be met including that the higher costs incurred cannot be avoided by the provider.

A local price is one that is negotiated and agreed between a commissioner and a healthcare provider for a healthcare activity when a national preset price does not exist. Even if a currency exists – for example, for mental health care clusters – agreement must be reached during the contracting process to determine the price paid by commissioners for each unit of that healthcare activity.

A local variation is an increase or decrease in a national price or a change in currency agreed between a commissioner and a provider if the national price is not appropriate for local circumstances – for example, to support the introduction of an integrated pathway of care. The rules set by Monitor and NHS England must be followed.

The marginal rate emergency tariff (MRET) is an adjustment made to the amount a provider of emergency services is reimbursed. It aims to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid 30% of the national price for each patient admitted as an emergency over and above a set threshold.

The market forces factor (MFF) is a payment index applied to all NHS bodies providing services under the national tariff to account for geographical variations in the cost of providing healthcare in different parts of the country.

A national price is the price set by Monitor for a defined unit of healthcare. It is the amount paid by a commissioner to reimburse a provider of NHS funded healthcare.

The national tariff or payment mechanism is a system of financial flows – a way of moving funds around the health service. It enables healthcare providers in England to be reimbursed for the costs of providing treatment. Introduced in 2003 as payment by results, it is a single payment mechanism applicable to all providers of NHS healthcare services other than primary care and public health. Under payment by results, the term ‘national tariff’ referred to the price paid by commissioners for a clinical procedure.

The national tariff document is the document jointly published each year by Monitor and NHS England outlining the payment mechanism for the NHS in England.

Introduced in 2003, payment by results (PBR) was the system for reimbursing healthcare providers in England for the costs of providing treatment. Based on the linking of a preset price to a defined measure of output or activity, it has been superseded by the national tariff.

A year of care payment is a payment to a healthcare provider that pays for specified treatment and care for one patient during the course of the year. This type of payment currently applies to patients with cystic fibrosis and paediatric diabetes.

The national tariff or payment mechanism is a system of financial flows – a way of moving funds around the health service

The external financing limit is one of the performance targets against which a non-foundation NHS trust is measured

10. STATUTORY AND DEPARTMENTAL DUTIES

NHS bodies are subject to a range of statutory and departmental financial duties depending on the type of organisation concerned. These are outlined below.

Statutory duties

Break even means that income equals expenditure. Although the break even duty is a statutory requirement for non-foundation NHS trusts, all NHS bodies are expected to operate a balanced budget ensuring that total expenditure does not exceed total income.

Capital resource limit (CRL) is an expenditure limit determined annually by the Department for each non-foundation NHS trust and NHS England, and by NHS England for CCGs. It limits the amount that may be spent on capital purchases and takes account of money owed by and to the organisation in relation to capital as well as the sale or disposal of assets. If net capital expenditure is less than the limit, the target has been achieved.

The revenue resource limit (RRL) is one of the financial performance targets against which NHS England and CCGs are measured and is used to determine whether or not operational financial balance has been met. It is set annually and is the total funding allocated for revenue or day-to-day spending.

Departmental duties

The external financing limit (EFL) is one of the performance targets against which a non-foundation NHS trust is measured. The EFL is a control on net cash flows and sets a limit on the level of cash that may be:

- Drawn from either external sources or the trust's own cash reserves (a positive EFL) OR
- Repaid to external sources to increase cash reserves (a negative EFL).

A target EFL is set at the start of the financial year by the Department and the trust is expected to manage its resources to ensure it achieves the target. Trusts must not overshoot it.

The public sector payment policy requires all NHS organisations to achieve a 'public sector payment standard' for valid invoices to be paid within 30 days of their receipt or the receipt of the goods or services. A target (currently 95%) is set at the start of the year by the Department for the value and volume of invoices that must be paid within 30 days. Performance against the target must be reported in the annual report and accounts. It is also known as the better payment practice code.

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About this briefing

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About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

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