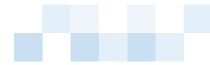

NHS
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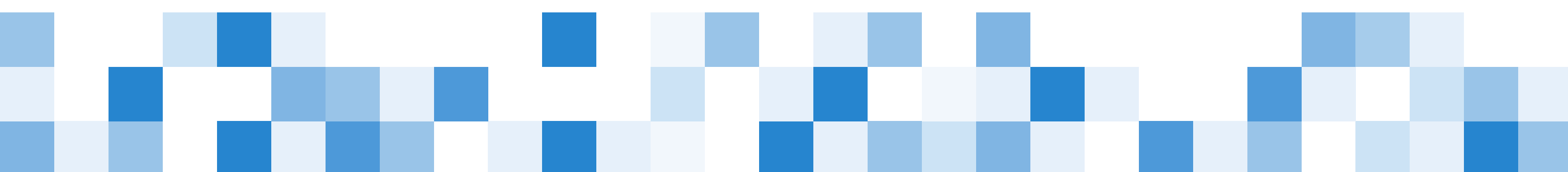
National Primary and Care Trust
Development Programme

The Finance FRIEND for PCTs

Supporting PCT financial management

Revised March 2004



Preface

NatPaCT is charged with supporting the development of PCTs as effective organisations, and enabling them to deliver improvements in health and services. The purpose of the Friend series of publications is to bring together the practical implications of implementing new, complex and interlocking areas of policy in a form that is accessible for busy people in PCTs.

We aim to empower you and your organisation to deliver improvement. We seek to support, explain and explore, not to direct. Where policy implications, sound organisational practice, or good governance require PCTs to address an issue then we will point this out and suggest how you may do this. The experience of some PCTs is already reflected in the content of this publication. However these Friends do not demand unquestioning compliance, and there is no penalty for PCTs who do not follow their counsels. NatPaCT brings no weight of inspection or performance management to bear. If you have found another way, another route that works then - please share it with us and other PCTs.

Making system reform a reality presents new and complex challenges. This Friend, and the others in the series emphatically do not have all the answers. But we believe they offer you a solid and useful starting point.

Important note on extending the role of Primary care

The new contractual approaches in primary care offer PCTs opportunities to modernise primary care services, support choice and access to local services and redesign the patient pathway. The vision for service redesign available through the new GMS and PMS contracts, and in particular the development of Enhanced services, and Specialist PMS services will need to be factored into the processes described on these pages.

This edition of the Finance friend includes an expanded section on the Financial Management implications of new GMS and PMS.

NatPaCT thanks Neil Wilson, Ruth Derrett and colleagues, and Mark Wilson for their contributions to this publication.

March 2004

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1 - The Policy Context

Patient Choice and the increasing diversity of providers

The introduction of choice for elective care and the expansion of choice beyond elective care as the eight national expert committees complete their reviews and the consultation exercise concludes (see www.doh.gov.uk/choiceconsultation) will have a significant impact on financial management:

1. The range of agreements and contracts for care will increase and make commissioning, monitoring, forecasting and reporting more complex.

2. There will be more variations on agreements because it will be more difficult to predict the numbers of people who will go to each provider.

3. There will be significant differences between types of agreement:
    a. agreements with the independent sector and Foundation Trusts will be legally enforceable but those with NHS Trusts will not.

    b. agreements with Independent Sector Treatment Centres will have "floors" where the care will still be funded even if the PCT cannot send the planned number of patients

    c. agreements with Foundation Trusts and NHS Trusts will not have floors

4. These changes will increase the complexity of financial management, particularly managing variations and forecasting their potential impact on the PCT. There will be increased volatility and robust sensitivity testing will be required on forecasts. Finance directors will want to ensure they have robust IT systems to record, analyse, present and manage this complex portfolio of commissioning expenditure. The risks will be higher and require active management.

Financial Flows, Delivering Payment by Results with national tariffs for the majority of care

The introduction of national tariffs for acute care complements the Choice agenda, incentivises providers to increase elective capacity and by setting prices nationally enables commissioners to concentrate on needs and on quality issues rather than price. Until tariff coverage is comprehensive (2005) there will still be a need for local price negotiations and validation of cost pressures.

1. Tariffs initially cover 15 HRGs and require 6 specialties to be commissioned on a cost and volume basis. That extends to 48 HRGs and most specialties from 2004 and will become comprehensive from 2005.

2. The introduction of tariffs requires finance departments to establish robust IT systems to model the cost of variations in volumes of care in a more sophisticated way.

3. The DoH Financial Flows Team provide a spreadsheet model on the web (updated mid Nov 2003) to assist PCTs with the logic.

4. Communicating the impact, risks and volatilities of the new financial environment to Boards, stakeholders and decision makers in a clear and succinct format is a challenge for PCT finance professionals. Collaboration across local networks of PCT and Trust finance directors can be an effective way to design excellent reporting mechanisms.

Foundation Trusts with increased independence from central control and legally binding long term contracts for care

The advent of Foundation Trusts from 2004 raises three issues for PCT finances:

1. Contracts with FTs will be for three year periods and are legally binding so the risk management measures to handle financial variations should be included in those agreements rather developed afterwards.

2. FTs will run ahead of the national implementation programme for tariffs so a greater proportion of expenditure will be governed by tariffs and the uplift for inflation/cost pressures will be determined by the DoH rather than by local negotiation.

3. The PCT financial management arrangements need to map to the national model contract on the DoH web site (mid Nov 2003).

Modernisation - Value for Money

The NHS Plan depends upon achieving significant extra capacity and quality improvements by modernisation as well as by applying growth resources. It is a duty of all NHS Trusts to seek to improve value for money.

PCT finance staff should get involved in service modernisation planning and projects from the earliest stage to ensure they are developed on a sound financial basis and take account of all the other policy changes that are changing the financial environment such as tariffs.

Costing existing and new patterns of service delivery is a critical skill that PCT finance teams will need to develop. Collaboration with local PCT and Trust finance colleagues to develop skills and tackle larger projects will make best use of scarce professional time.

2 - Financial Strategy

Introduction

The complexity of the new financial environment for PCTs with Choice, national tariffs, Foundation Trusts, partnership working, modernisation and significant pressures on resources require a long term financial strategy to ensure the desired future pattern of care can be delivered within available resources. National guidance recommends that financial strategies should look 5 to 10 years ahead.

The purpose of producing a long term financial strategy is to give the PCT and its stakeholders a broad brush view of the resource impact of existing arrangements and practice as a context for making decisions on future patterns of care shaped within realistic resource prospects.

The key decisions in a Financial Strategy are a PCT Board matter (with stakeholders). The role of the finance function is to develop the necessary information, options, risk, and sensitivity analyses in a clear, summarised, way to assist the Board in its deliberations. This will include developing real time "what if" models to help the Board explore different options and show the potential financial impact of those alternatives.

Service strategies should be developed in the context of a realistic financial strategy. The purpose of the financial strategy is to ensure that service strategies are affordable against a range of resource prospects and to ensure that all the available resources are disclosed and made available for strategic service planning.

Openness should be a core principal in developing strategies and PCT finance colleagues should work with fellow PCTs, stakeholders and local Trusts on the financial strategy just as they will on the service strategies.

It is essential that recurring and non recurring resources and expenditure be separately identified to minimise the danger of developing unaffordable strategies where recurring deficits are masked by non recurring resources.

The key end product of the strategy is a high level summary which should show total expenditure (and percentage of total resources) by care group reconciled to available resources. It should compare the present position to the forecast future position highlighting the proposed shifts between care groups. It should also be analysed by provider to illustrate the proposed changes in commissioning patterns.

It is useful to analyse where future growth is going (by care group and by provider). This will highlight areas of disinvestment and the care groups attracting the highest priority for new resources.

Strategies should be led by needs and the drive towards quality but will plainly need to be contained within realistic resource prospects.

Resource guidelines can be produced for each client group to influence the strategy makers' thinking. One way to do that is to make a high level judgement, using the principles in the vision, about the future share of total resources for each care group. For example a PCT may decide that primary care should grow more quickly than the average rate of growth over the next decade. If so its share of future resources may increase from say 23% now to say 25% in the future. Other care groups would need to have lower growth targets. This can be a powerful tool to concentrate minds on achieving the preferred future pattern of care. It should be treated with caution because those proposed resource shares are based on value judgements.

The main elements of a financial strategy are:

1. **Resource Prospects**
2. **Current expenditure**
3. **Current deficits (and recovery arrangements to balance them)**
4. **Future expenditure forecasts from service strategies**
5. **Efficiency and inflation**
6. **Non recurrent resources and expenditure, including capital and trust funds**
7. **Risks**

Resource Prospects

A realistic range of resource prospects should be produced.

The present allocation, adjusted for non recurring items, is an important foundation for the forecast and this should be reconciled to the PCT's present budgets with an audit trail of non recurring and other adjustments so that the Board can be confident that all the resources are included.

The information published by the Department of Health on the weighted capitation resource allocation formula provides a sound starting point. It includes population forecasts and funding rates for the different age bands.

The Government's three yearly comprehensive spending reviews and the matching Department of Health guidance are a good guideline for the immediate period ahead.

PCTs should take advice from their Strategic Health Authorities about longer term resource prospects.

A pragmatic approach is to use two or three scenarios, for example high, medium and low growth prospects and to test proposed service strategies against that range in order to select robust and sustainable options.

Current expenditure

The current expenditure budgets adjusted for non recurring items should be matched to the current resource allocation (see above) to demonstrate the PCT is starting in financial balance.

The analysis of spending by care group to support the service strategies will probably differ from the usual financial reporting and budgets so it is important to produce a clear reconciliation between expenditure budgets and the service strategy care group baselines.

Current deficits

Any recurring or non recurring deficits and the associated recovery plans need to be taken into account in the financial strategy. The degree of risk will determine whether a PCT should make part or all of such deficits a first call on future resources. Recovery plans should be carried through to ensure the PCT gives consistent messages about the need to maintain financial balance and achieve better value for money. There are dangers of distorting priorities if deficits automatically get funded and it will prove hard to meet national targets and local ambitions for better care if growth is pre-empted to meet existing commitments. A careful balance has to be struck by the PCT Board on these decisions.

Expenditure forecasts

The service strategies need to be costed in outline.

Given that one is looking ten years ahead it can be just as robust to take a long term judgemental share of future resources (see final paragraph of the introduction above) and apply commonsense to consider whether the new pattern of care is likely to be able to be achieved within that sum as to attempt to forecast the cost.

Efficiency and inflation

Assessments of the future impact of inflation and efficiency gains need to be made. If substantial (1%+) cash releasing efficiency gains are likely to be necessary to meet excess NHS inflation costs (i.e. those above funded levels) the caution must be exercised about relying on further cash releasing gains.

There is evidence within and outside the NHS that productivity gains and quality gains can be achieved at far higher rates than cash releasing efficiency gains. The NHS Plan is reliant on achieving significant productivity gains as well as spending the growth wisely. New technologies combined with new investment and advances in clinical staff training (for example enabling the wider role of the nurse) give opportunities to achieve very significant improvements in quality, effectiveness and productivity. PCTs should pursue ambitious gains as part of future service strategies.

Non Recurrent Resources

The availability of non recurrent resources can be critical for enabling change.

Long term planning and maintaining financial balance should all deal strictly within the envelope of a recurring equilibrium.

The availability of part year effect savings while developments come on stream can be a useful source of pump priming funding to enable change.

The dependence of service strategies on accessing capital (or public private partnership, private finance initiative or trust funding) should be carefully assessed. PCTs are advised to work with their Strategic Health Authorities to ensure capital assumptions (including permission to spend) are realistic. NHS Trusts will often be the lead organisations when looking at major capital but PCTs need to have a good understanding of the constraints and opportunities.

Risk management

Long term planning carries a high degree of risk and all the components of the financial strategy should be assessed for risk looking at the probability of risks materialising and the potential impact if they do. It is useful to do this in by way of a matrix and to work on a multi disciplinary basis to improve completeness and minimise double counting.

The risk assessment should include a brief description of how one would measure and identify a risk at an early stage as it first materialises what are the early indicators/symptoms and which organisation will monitor them. Counter measures should be set out as part of the matrix, including which organisation will lead the action.

Ultimately a risk matrix will determine which organisation meets the cost but the prime aim should be early identification and action to obviate or minimise the impact.

Conclusion

The development of a vision, associated service strategies and an underpinning financial strategy will provide a PCT with a clear direction to inform all the smaller decisions it must take.

The documents representing that vision will have to serve widely different audiences and it is critical that they be kept at high level and be written in an accessible way.

They do rely on lots of detailed professional work but those technical professionals must find simple ways to communicate the import of their technical work. A separate technical exposition booklet should be produced for people who want to access the underlying work.

The vision and strategies depend on being understood if they are to happen and be sustained in turbulent times. A few clear words and some simple graphics in a short overview publication are most likely to succeed and capture people's imaginations.

3 - Financial Planning

Finance input to planning

Under current NHS planning arrangements, each PCT has produced a service and financial plan, covering the period 2003-06. These three year Local Delivery Plans will have to be updated each year. PCT financial planning to underpin the LDP will include forecasting the future resource prospects in the light of the DoH allocations guidance and the advice of the Strategic Health Authority. PCT's expenditure forecasts need to take a view on future inflation/cost pressures and trends of demand in addition to service plans and objectives.

PCT Plans should create and articulate the vision of the future pattern of local services, supported by financial assumptions setting out the use of resources, set within a realistic policy and growth context. Plans should be developed in partnership with stakeholders and be consistent with other plans within the local health economy including Trust and Foundation Trust service development plans.

One of the most challenging aspects of LDPs is the requirement to identify modernisation and efficiency gains that are necessary to achieve the national Planning & Priority Framework Targets within available resources. Savings and modernisation objectives should be identified in the context of reviewing comparative cost and service utilisation and information on best practice (e.g. from Modernisation Agency).

The PCT should subject its own services to the same rigorous assessment as those applied to services of other providers.

Service and financial plans should cover:-

- The Local Delivery Plan - a national document covering 3 years, identifying how national service standards and targets will be met
- Local priorities
- The financial underpinning plan to support development

The following sections outline the financial input to planning activities through:-

A Understanding the current local position

B Developing medium term plans

C Implementing system reform

A - Understanding the current position

Current pattern of expenditure

There should be a clear financial baseline reflecting the current pattern of expenditure, matched to service programmes, identifying current programme budgets, and the inputs/outcomes delivered by those services. It is important to separate recurring from non recurring issues in creating the baseline for the planning period because the risks and implications of recurring over commitments masked by non recurring resources pose a serious threat to long term financial balance.

Where possible the PCT should work towards identifying programmes across providers (for example CHD should include the costs of services delivered in primary secondary and tertiary care to enable a full understanding of the service costs). Where appropriate costs borne outside the NHS should also be included (for example social services, education, the voluntary sector). These programme baselines provide a start point from which systematic analysis and prioritisation processes can be put in place for planning purposes.

Identifying comparators

The finance function within the PCT should aim to clearly identify both financial opportunities and risks through the use of effective comparative indicators (name sources e.g. Audit Commission) , for example:-

- Variations in access rate
- Variations in cost of services (for those services where Payment By Results is not yet in place)
- Value for money (taking into account, economy efficiency and effectiveness)
- Variations in health outcome

B - Developing medium term plans - an effective Local Delivery Plan

Overview

The 3 year Local Delivery Plan (2003-06) brings together national targets (web reference Improvement, Expansion and Reform) and local service priorities. It should clearly translate local service and financial strategies into a detailed service and financial planning framework. The finance function should ensure that:-

- there is a clear audit trail to support resource and expenditure framework demonstrating links to national allocation information
- Current and future expected use of different providers should be analysed against the current activity and financial baseline (including the implications of the PCT Choice policy see below)
- The plans take account of the implications of Payment By Results (see below)

Assessing risk

Critical appraisal of plans is essential for risk assessment. There are five perspectives:-

- Are the proposals practical (e.g. recruitment)
- Will proposals deliver the targets?
- Are they affordable?
- How sensitive are the plan proposals to variations in the underlying assumptions for example changes in referral rates?
- What counter measures are available to the PCT and partners in the health system to manage adverse variations as they emerge?

The risk and the probability of adverse outcome, together with impact assessment (including financial impact) should be formally assessed and reported to the Board as an integral part of the planning process.

Needs, demand and capacity

Needs assessment should be driven by the public health capacity within the PCT, including (as examples) forecasts of demographic change, changes in medical technology, comparative analysis of access and referral rates. This should include national and local quality (for example National Service

Frameworks and NICE Guidance) and modernisation targets, moving from input and activity based measures towards measurement of health outcomes (although for the foreseeable future healthcare activity will remain the predominant currency for service level agreements/contracts).

Demand modelling should take account of current referral rates and conversion rates. Proposed service volumes to balance forecast demand with capacity should be subjected to sensitivity testing exploring the potential impact of changes in referral rates, conversion rates and the possible impact on waiting times if emergency referrals exceed forecasts. The sensitivity analyses will help PCTs choose robust solutions and develop contingency plans to manage changes.

The finance and commissioning functions within the PCT should ensure that there is a sound methodology, including financial evaluation amongst other criteria for prioritising proposals, taking account of Payment By Results requirements where appropriate (see below) and ensuring that such decisions are appropriately agreed and recorded within effective PCT governance arrangements.

In the context of NHS Plan targets, the PCT can produce and regularly review a costed capacity plan demonstrating use of national tariffs. This plan should be shared and agreed with local stakeholders within the health economy.

Planning for major change

The introduction of Foundation Trusts will change the role of the PCT in agreeing business cases. In many cases, provided that a Trust can demonstrate affordability against tariff, the emphasis from the PCT will be to ensure synergy of proposals with other services (particularly across providers) and to understand and agree the quality gains for local people.

DoH guidance on Payment By Results requires the affordability of new business cases to be judged against national tariffs. It is possible that some cases will need to operate above tariff for a short period while they reach their full output potential.

The DoH is considering whether PCTs should decide on such short run subsidies above tariff (using national criteria) or if the NHS Bank will manage such cases. PCTs should take advice from their Strategic HA before entering into a subsidy arrangement to ensure they do not cut across emerging policy.

In the case of large-scale capital schemes the PCT will clearly retain its role as a partner with local Trusts in the agreement, development and implementation arrangements for such schemes.

Partnership planning

In some instances PCTs may have formal partnership arrangements across the local community (for example pooled budgets). Whether or not there are formal arrangements in place, where patients are served by a range of organisations there should be a clear financial plan which is explicit in its understanding of the service and financial responsibilities and risks faced by each organisation, including the allocation of responsibility in the event of service or financial pressures throughout the planning period. Financial governance arrangements should be coherent with the local arrangements

Engaging practices in commissioning

The PCT should ensure that:-

- practices have practice and practitioner based information on referrals, use of services, the cost of services, trends and access to peer comparison in an easy to use format. These should be used by the PCT to inform planning proposals, and as part of the engagement process with primary care teams.
- There is clear understanding of primary prescribing trends and cost drivers, including NICE decisions on new drugs or new modalities of use. They should devise a coherent strategy to maximise health benefits and minimise costs.

C - Implementing System Reform

Payment By Results

Payment By Results sets a standard national tariff for Healthcare Resource Groups (HRGs) - see section 4. In forward planning service delivery PCTs should:-

- understand the position of local providers in relation to tariff and the potential impact on the local health economy
- agree approaches with providers which allow for financial negotiation along the care pathway to ensure that the total care pathway is within the national tariff, but that changes can be made to reflect the modernisation agenda and patient preference
- agree and understand the transition path within the local health economy from current position to full implementation of Payment by results

Section 4 outlines the key impact of the implementation of Payment By Results. The full document including frequently asked questions is at (Http://www.doh.gov.uk/nhsfinancialreforms/index.htm)

Choice

The introduction of Choice at 6 months and choice at point of referral require flexibility in financial and service planning. Following implementation in 2005, patients will have the choice of 4-5 providers at the point of referral. The financial input to plans should take account through sensitivity analysis of changes to patient preferences, and be based on a clear and detailed understanding of choices within the local community. From this analysis PCTs should develop a 'Choice Menu'. The financial implications of this will largely reflect national tariff, however plans should recognise and take account of the infrastructure to support Choice (including e-booking), and associated patient costs (for example transport costs).

PCTs will also need to work closely with local providers to understand the service and financial implications of changes in activity levels through the operation of Choice (for example expansion or contraction of local services).

Foundation Trusts

As part of the application process Foundation Trusts will need to engage with Primary Care Trusts in developing their Strategic Service Direction. The PCT will need to ensure that these 5 year plans are consistent with the local health economy strategies, including income assumptions made by the Trust, and that the financial implications of Foundation Trust status are clear (for example early Foundation Trusts can move directly to national tariff for all applicable activity see web reference Payment By Results - www.doh.gov.uk/nhsfinancialreforms/index.htm)

The transition to Foundation status brings complex issues about convergence toward national tariffs from Payment By Results into play. FT applicants currently below reference cost (2002/03) will benefit from the move to tariff ahead of the national pace of implementation of tariffs. This will not impact on the PCT's purchasing power as the DoH will implement a matching change to the PCT's allocation. The FT applicants that are currently operating above reference cost will have the option of choosing a minimum income guarantee level of prices that can delay their convergence to tariffs. PCT finance directors should work through the risks and opportunities of these changes and explain them to commissioning colleagues and boards. Collaboration with FT finance colleagues is essential to ensure any potential financial gains are maximised for the local health economy and to avoid unpleasant surprises.

PCTs will be represented on the Foundation Trust Board of Governors (local arrangements vary however in most cases one or more PCT representatives will represent the views of PCTs). This represents a further opportunity to ensure coherence in both strategic and 3 year plans.

www.doh.gov.uk/nhsfoundationtrusts/index.htm

4 - Payment by Results

The national policy to introduce standard tariffs for treatment (Financial Flows) is being implemented gradually from 2003 to 2005. It complements the choice policy and is part of the national framework of controls to devolve decisions to local level.

The Department of Health will set tariffs including the uplift for inflation and any deduction for efficiency. When the policy is fully implemented (from April 2005 from a commissioner perspective) it will free PCTs from price negotiations and let them concentrate commissioning efforts on modernising care pathways, quality improvements and purchasing the right quantities of care for their community.

The tariffs use the national Healthcare Resource Group (HRG) classifications of acute care which comprise about 600 headings. HRGs were developed in the UK with substantial clinical involvement to group care (within specialty) into a limited number of headings on an iso-resource basis to assist comparison, planning, costing and analysis.

The initial implementation in April 2003 sets prices for 15 elective HRGs and requires PCTs to commission them on a cost and volume basis. It also requires PCTs to commission 6 elective specialties on a case mix weighted cost and volume basis.

The August 2003 consultation on the next stage will add 33 more HRGs from April 2004. It will require PCTs to commission the majority of specialties on a case mix weighted cost and volume basis from April 05.

The commissioning currency will change from “finished consultant episodes” to spells from April 2004 this should counter “fce inflation” which has occurred partly as a result of modern sub specialised medical practice that can require patients to transfer between consultants during a stay in hospital to access the right care and partly because of the incentive to maximise the count of activity. This change will require some modelling to convert the previous fces to spells and there is likely to be a differential impact from area to area because the ratio of fces to spells varies widely between providers. It is essential the PCTs work closely with their providers to track and manage this change.

Outpatients will be included in tariffs from April 2005.

For commissioning from first wave Foundation Trusts the programme will advance by a year so full coverage will start from April 2004.

A number of health communities are considering adopting a faster pace of change to get the benefits early and avoid the complexities of running two systems, at least with major local providers. That depends on having the information, analysis and staff resources and knowledge available now.

The implementation programme is rapid with a gentle start. PCTs and Trusts need to make good use of the lead in period to be ready to work in the new way as the implementation accelerates. The infrastructure is mainly about information flows and aligning costs with activity and handling more provider agreements with the impact of choice. The most difficult aspect is gaining a sound understanding of the implications and changing dynamics of commissioning amongst the PCT's decision makers and stakeholders. There will undoubtedly be unforeseen/unintended consequences and gaming as all the reforms interact. An effective counter to the potential adverse consequences is close collaboration between PCTs and providers. They should seek win win solutions and so build public confidence in the new, more complex, approach to delivering care.

PCT Boards need to commit time to understanding and thinking through the issues for their patch and ensuring their infrastructure provides them with timely, appropriately structured information to manage the new commissioning environment.

The Department web site gives the details including the August consultation paper and the background papers together with an executive summary at www.doh.gov.uk/nhsfinancialreforms

The critical change is the move to cost & volume commissioning where the reimbursement of trusts will vary according to the number of patients they treat. PCTs will be able to set ceilings for the quantum of care they wish to buy. There will not be floors because choice at the point of referral by patients from December 2005 could make it impossible for a PCT to take up its planned volume from a provider.

The tariffs bring a new measure of affordability for business cases. The previous test was whether the PCTs could afford the case. The new test is can the business case operate within the tariff price of the extra care it will deliver in the medium/longer term. A second issue arises about who would fund the start up cost for the first year or two before a project reaches its longer term equilibrium within tariff. The DoH Finance Directorate is considering whether PCTs or the NHS Bank should fund the start up. It is likely that guidance will be issued on assessing business cases but it is not yet available (at Sept 2003).

This policy places the risks of increasing demand with commissioners and the cost risks with providers. PCTs need to consider their risk management arrangements as an integral part of planning and developing service level agreements. Establishing risk sharing consortia with other PCTs is an effective measure provided that the arrangements are well managed. Consortia are likely to unravel if members are allowed to dump known problems into the risk pool, or if arrangements are not seen to be fair, or are used to avoid dealing with difficult issues. Actively planning and modelling demand, agreeing thresholds for referral and intervention and redesigning care pathways with providers and stakeholders will deliver sustainable solutions.

5 - Finance input to commissioning

Strategic and medium term planning (see sections 2 and 3.) will have provided a service and financial framework to inform the commissioning of care in the medium and longer term. Commissioning population requirements translates these priorities and decisions into Service Level Agreements/contracts with NHS and non-NHS providers of care. The following sections suggest how the finance input to commissioning should be focused towards ensuring robust financial information to support the commissioning process and ensuring that through scenario planning, modernisation and comparative analysis commissioners ensure value for money through the commissioning process. PCTs should ensure that services provided directly by the PCT are subject to the same rigorous assessment where appropriate.

Baselines

Under Payment By Results, locally negotiated prices will be replaced by standard national HRG-based tariffs for care in acute hospital settings. Over time the tariff will be extended and is ultimately intended to cover all hospital and community health services. This significant reform removes local NHS organisations from the need for complex (and often protracted) price negotiations, however:-

- There may be significant financial risk for commissioners or providers during the transition period to 2008.
- At present non-acute services are not covered by the tariff, although it is hoped to include some non-acute services in 2005/06.

In the short and medium term, therefore, commissioners will need to maintain a clear understanding of the finance and activity baseline, using Healthcare Resource Groups (HRGs) as the key activity measure for acute activity, ensuring the following key tasks as a minimum to agree baselines with providers of care:-

- Where activity is not currently included within the Service Level Agreement (SLA) at HRG level, commissioners and providers will need to review actual activity levels and agree a costed activity base by provider, and by individual PCT within each provider. A substantial part of this information will be provided by Trust reference cost information, however, given the potential financial risk to both providers and commissioners, an open book approach is fundamental to ensure that local agreement is reached to handle anomalies within reference cost information. There needs to be a clear auditable activity trail reconciling data from the validated patient minimum data sets to the SLA to ensure a complete and accurate HRG based baseline.
- The baseline should analyse activity, and associated cost, into recurrent and non-recurrent activity to take account (for example) of additional activity to meet waiting time targets, or predicted changes to activity levels to reflect the impact of patient choice. The recurrent baseline will enable providers to develop appropriate income assumptions. At commissioner level, the full implementation of Payment by Results will mean that in theory there is no financial impact resulting from a change in provider, however maintaining the financial stability of the local health economy will be supported by a shared baseline and provide a robust basis for service planning.
- Providers and commissioners should agree the impact of movement towards full implementation of payment by results. If efficiency savings are required, an agreed savings programme will be necessary, linked back to strategic service objectives and supported by a communications plan.
- Modernisation and innovation will rely on a shared understanding of baseline financial costs and assumptions and an agreed process for implementation of modernisation plans within SLAs. For example, where part of the current care pathway is commissioned from an alternative provider (for example rehabilitation for some conditions), both provider and commissioner will need to agree the proportion of the tariff which transfers to the new provider. In some ways, this reintroduces the complexity of local price negotiation, and both parties will need to ensure a clear process for understanding the baseline costs of the tariff.

- For those non-acute services where Payment By Results does not apply, providers and commissioners will need to continue to agree financial and activity baselines, taking account of inflationary and other cost pressures, service pressures and developments and the impact of agreed business cases.
- Commissioners and providers will need to develop joint work to understand and develop information to support commissioning and service decisions, for which a shared and agreed baseline is necessary, for example:-
    - Information to support programme budgeting, or managed clinical networks.
    - Practice-based information, including practice-based finance and activity data.
    - Comparative information to support commissioning.

Scenarios

Planning the financial impact of scenarios enables commissioners and providers to take a proactive approach to risk management, understanding the impact of changes to key drivers, including:-

- changes in demand (usually rising trends)
- changes in threshold for treatment/admission
- changes to the pathway of care
- the impact of patient choice
- the impact of changes external to the commissioner/provider (for example changes to social services arrangements)

Planning for a range of scenarios enables the provider and commissioner to jointly carry out high-level sensitivity analysis and the consequent potential service and financial impact, including risks to meeting key service and financial targets. This analysis should form part of a joint approach to early intervention and risk management of avoidable risks, and resourcing or minimising the impact of particular unavoidable risks.

Modernisation

It is not feasible to recommend one specific approach to the financial evaluation and implementation of modernisation activities since these vary considerably in both scope and financial impact, however commissioners and providers need to agree a common approach and principles which should include as a minimum:-

- Proposals must be subject to rigorous business cases assessment to ensure they represent good value for money and are a robust and sustainable alternative to the current mode of provision
- Where the commissioner plans to commission part of a care pathway within an alternative setting, clear financial principles must be agreed in advance by the local health economy to ensure a balance between releasing resources to support innovative and effective changes to current care pathways, and recognising the impact of such changes on current service provision.
- Open book transparent approach, across the local health economy.
- Many smaller but significant changes to modernise services should be possible in year, and within the tariff
- Where business cases are proposed, there must be clarity to ensure affordability at tariff level in the short/medium term, and how such business cases will be funded in the short term

Comparative Performance/Performance improvement

Comparative performance will include a range of financial and non-financial comparators (outcomes, access rates, etc). The only comprehensive source that draws all the information together to examine performance is produced by the Department of Health. It was initially designed for generating performance ratings but has much wider potential uses and the Department are exploring a wider dissemination with a number of SHAs as part of the new way of measuring efficiency. This brings

together activity, staffing levels, cost and a number of quality measures. Other key sources are outlined below. The list is not exhaustive, and a number of health economies have benefited from bespoke products designed for their specific needs. Commissioners should ensure that sufficient information is available to give a credible and wide-ranging view of the relative efficiency of different parts of the health system.

Sources of Information

Finance sources include:-

- National reference costs - available on the Department of Health website and sent to all Finance Directors on CD.
- Audit Commission Compare software analyses the key features of acute trust performance
- Value for Money studies
- Bespoke products available from the private sector (e.g. CHKS, but there are a number of others)

Activity sources include:

- National HES data from the Department of Health website
- Local commissioning databases
- SHA database
- Primary care prescribing tools

Staffing

- National data DoH website
- Local information in PCTs and Trusts
- Local Workforce Development Confederation data

Quality

- Dr Foster analysis available on http://www.drfoster.co.uk/home/guides.asp
- The DoH performance database has a number of quality indicators
- CHI reports need to be taken into account

Foundation Trusts

The above principles apply to Foundation Trusts as to other Trusts, however in addition PCTs will need to take account of the following added complexities:-

- The Foundation Trust contract, unlike current Service Level Agreements will be legally binding and may include (the Foundation Trust contract is due November 2003) financial penalties for non-delivery of particular clauses (for example information). PCTs will need to ensure that clauses with a potential financial impact are well understood and communicated within the PCT
- Activity requirements for FT contracts are not yet known, but earlier indications were that commissioners would need to confirm with some certainty activity requirements for a 3 year period. Given the potential conflict with patient choice, this is likely to be an indication of commissioner intent rather than contract certainty, however commissioners will need to ensure a clear activity forecast which reconciles to the commissioner's financial strategy (see section 2)

The timetable and process established by the Department will be the best source for commissioners in ensuring that the transition is managed effectively. Commissioners should ensure regular ongoing financial dialogue with providers, and shared understanding of the guidance and transition issues to be managed. The most effective source for this guidance is the Department of Health Foundation Trust team (see also the Foundation Trust weblink at www.doh.gov.uk/nhsfoundationtrusts)

6 - Financial management

Commissioning secondary care

In recent years, maintaining in-year stability in the financial management of Service Level Agreements has relied upon:-

- Agreements which were often block contract arrangements, not legally binding, where changing activity levels did not trigger significant changes to the contract value.
- Control of referrals towards (primarily) local providers for core secondary services

Overall, the level of information to support the service and financial management of agreements has been variable, and focused towards specialty based activity information.

System reforms across the public sector lead the NHS towards a more dynamic commissioning environment, with the potential to lead towards a greater degree of financial risk through:-

- Payment By Results - rewarding providers on a national standard tariff moves financial management predictability in terms of in-year financial management towards an environment where both Trust and commissioner will need to place increased emphasis on risk management (for example a relatively small change in the threshold for referral or for treatment) will trigger additional payment at standard national tariff
- Choice - will require PCTs to work closely with local communities to understand and reflect individual and collective choices within service level agreements/contracts. SLAs will need to respond flexibility to patient choice. PCTs as commissioners are likely to engage with a larger number of providers.
- Diversity and plurality - offer opportunities to PCT and local people through contestability, but increase the complexity of the interface between commissioner and provider (for example Treatment centres, overseas treatment, overseas teams. Independent sector)
- A significant increase in the proportion of resources committed through partnership agreements (see section 7)

In financial management of their arrangements, PCTs will need to ensure that:-

- They have the management resources to engage effectively with a larger number of diverse providers, and to support patient choice
- Effective arrangements are in place to identify and manage service risks and financial consequences in a dynamic environment with a range of providers, including the additional complexities of partnership agreements outlined above.

The following section identifies the financial management objectives of the PCT and the key deliverables to ensure effective in year management of the resources of the organisation. The PCT should ensure that:-

A sound financial plan is agreed and endorsed by the Board which meets the organisation's financial duties

Budgets are set which reflect the secondary commissioning requirements of the Local Delivery Plan (LDP), supported by Service Level Agreements (Foundation Trust/other contracts) and are approved by the Board ensuring that the financial duties are met. This process should include annual forecasts of cash flow. SLAs should be based on the national model SLA or Foundation Trust contract as applicable and should meet the following requirements:-

a. Contracts/SLAs should be agreed and signed before the start of the financial year to which they relate, and should have been agreed by the Board as part of the budget-setting process of the organisation.

b. The agreement should include all information (and arrangements for timely receipt of information) to monitor the agreement and to identify risks to delivery for example activity information at HRG level, profiling of activity to take account of seasonal trends, referral rates (by source of referral), access rates (by specialty and by key HRG where appropriate, age and sex adjusted). Where a joint agreement is made between a provider and several PCTs with one PCT acting as lead commissioner, the commissioners require explicit agreement about the management of contract performance between commissioners.

c. The agreement should be structured to reflect the national model SLA (or Foundation Trust contract) including case-mix weighted specialty information and standard tariff activity where appropriate to meet requirements of Payment By Results, arrangements for the implementation of Choice (and identification of Choice patients where appropriate).

d. Budgets are profiled to ensure appropriate monitoring of actual expenditure to budget. In the context of secondary care commissioning, this implies a clear understanding and profiling of activity trends, agreed with key providers of care. Effective risk management will need to identify key drivers (for example, early identification of changes to referral rates or treatment thresholds) to ensure early engagement with clinicians, agreement of management action where appropriate.

e. A clear risk management agreement which identified how risks will be identified and managed throughout the agreement, including financial consequences of changes to service delivery.

PCT commissioning budgets should be profiled against the SLAs to ensure appropriate monitoring of actual expenditure/income to budget.

Variations from plan are identified and reported promptly to trigger appropriate management action

a. There is a clear system of internal controls to control expenditure (including for example training and responsibilities of budget holders).

b. Budget holders should receive timely, clear and accurate financial and non-financial information to support appropriate management action.

c. Management accounts should be regularly reconciled to financial accounts and treasury management

d. The Board should receive effective advice on the financial position and agreed management action where appropriate.

e. Effective communication should be established across the organisation to ensure that knock-on effects of variations (for example increased activity levels) are communicated across the organisation, and the potential impact assessed promptly.

Risks are clearly identified and managed to minimise financial consequences

a. The PCT will have agreed a risk management process and plan as part of the Service Level Agreement/Contract. The effectiveness of risk management will rely on timely and accurate information and collaboration and engagement between commissioner and provider to ensure that the risk agreement is sufficiently comprehensive and that (excluding exceptional circumstances) risks are allocated according to the ability of each part to identify and to manage risks. Shared unspecific risks should be avoided where possible since they tend to imply a re-opening of the agreement during the year. The renegotiation which follows not only leads to delay and uncertainty for both commissioner and provider, but is likely to be incompatible with key elements of current reforms (legally binding agreements with Foundation Trusts and with the independent sector, the national model SLA, and implications of Payment By Results). It is in the interests of both parties to agree the allocation of risk including allocation of risk between commissioners where a joint agreement exists.

b. Additional risks exist in the management of partnership agreements. It will be helpful to take separate advice from auditors and legal advisors prior to establishment of significant partnership agreements to ensure that financial duties are met and risks are managed.

In conclusion, the changing environment within the NHS calls for a much more dynamic and flexible approach to the development of agreements, and to financial management processes to support the PCT in commissioning effective secondary care services. Where possible PCTs should be looking towards longer-term agreements (see Foundation Trust contracts), building on the more flexible and dynamic agreements required to implement patient choice and Payment By Results. PCTs will also want to see strong clinical engagement in the performance management of agreements, and consider whether for some services, practice-based monitoring of secondary services could be helpful.

Further links

Foundation Trust link - FT contract when available

Model SLA

Payment By Results

Primary Care Contracting

www.doh.gov.uk/gmscontract/implementation

Introduction

The new GMS contract arrangements and matching changes to PMS from April 2004 radically reform the role, scope and funding of primary care.

The new arrangements are supported by substantial growth resources (a 33% increase by 2005/06) dedicated to enhancing the range and quality of primary care services and enhancing the working lives of primary care staff.

The changes bring all the primary care funding streams into the NHS resource limit system for the first time. That will enable PCTs to integrate the care pathways and financial planning across all the services they commission and provide for patients.
That aspect of the changes brings new risks as some of the new entitlements of practices are open ended for example the achievement of quality markers yet the funding is resource limited.

PCTs will commission primary care from practices under the new GMS rather than having agreements with individual GPs. That gives practices more flexibility about how they work to deliver services and choices about which additional and enhanced services they want to offer.

The contract has four principal funding streams:

The Global Sum - a weighted capitation allocation to practices to meet the basic needs of their registered patients including the cost of practice staff, locums and training. It is calculated nationally from information submitted by PCTs. It includes resources for additional services BUT practices can choose not to provide some or all of these and accept an abatement of their payment on a set tariff basis.

Enhanced services - which are payments for a wide range of care including for example achieving high percentage take-up of childhood immunisations, influenza immunisations, minor surgery, minor injury services.

Quality payments - earned by practices for delivering high quality services within the terms of the standard Quality Outcome Framework.

Premises - existing premises will continue to be funded on either a cost rent or notional rent basis with the option to switch. However the new investment will in future be managed on a more strategic basis by a lead PCT in each SHA area, through a planned, prioritised programme of new investment on behalf of that SHA, together with the matching revenue stream.

A further important change of financial arrangements is that practice computing investments will become the responsibility of the PCT rather than the practice one.

(NPDT has published a summary of the new arrangements - "A Guide to nGMS/PMS for Practice Management" on its web site at **www.npdt.org** and at www.natpact.nhs.uk/primarycarecontracting)

The detailed definition of the various streams of resources available to PCTs and practices is set out in the Statement of Financial Entitlement (at **www.doh.gov.uk/gmscontract**) which has been out for consultation and will shortly be issued in final form.

Financial Issues

PCT finance teams have four key roles in ensuring their PCTs secure the maximum benefit for patients from these changes:

1. **Financial Strategy -** to ensure the opportunities offered by the new framework and the resultant flexibilities in the use of resources are explored and realised in all service and financial planning.
2. **Financial Management -** to ensure financial control is maintained over these new resource limits for primary care services. This will require a different set of financial management systems and reporting.
3. **Corporate Governance -** to ensure the public investment in primary services is applied within the regulatory framework, including maintaining a clear audit trail and record of expenditure, and ensuring there are not duplications of investment as previous primary care innovations are absorbed into the new framework.
4. **Paymaster -** to ensure the PCT operates a reliable and secure payment process that remunerates practices promptly and efficiently within the rules for the care services they provide.

Financial Strategy

PCT finance teams need to integrate the new streams of resources with the other commissioning expenditure streams in their overall financial strategies. Previously these expenditures have been "non cash limited" and outside the planning purview of PCTs.

Part of the financial strategy is to ensure the PCT is fully informed about all the opportunities to secure new resources for developing primary care under the various streams of new GMS/PMS.

Drawing primary care services into the resource limit system creates opportunities to seamlessly commission services from primary providers that were traditionally commissioned from the secondary sector.

Financial strategies should identify potential areas of existing secondary commissioning that could be delivered more cost effectively by primary providers under the new arrangements.

Local Delivery Plans & Service Level Agreements/Contracts

The collaborative commissioning framework of the NHS and the commitment to move to longer term agreements have the logical concomitant that PCTs' Local Delivery Plans and Service Level Agreements or Contracts with Foundation Trusts should clearly signal the areas being considered for enhanced primary care intervention. Ideally PCTs would agree a guesstimate of the proportion and case mix of the care intended to move to a primary setting with their principal secondary care providers. It is important for continuity of care and the financial stability and long term investment plans of providers that a jointly owned picture of the likely shifts is developed. PCTs have the last word in decisions about what care to buy for the populations they serve and which provider to buy it from. They are not obliged to reach consensual agreement with providers.

Some secondary providers and health pundits have painted a very negative picture of the prospects for secondary care if PCTs develop alternative provision. That is not a realistic view, as both primary care and secondary care have scope to develop due to combination of the needs of an aging population, rising public expectations and increased investment in the NHS, bringing it up to European levels . Even where PCTs have developed a wide range of services in primary care as an alternative there is continued new investment in secondary care. It is a question of balance; the new GMS arrangements and resources create a climate and opportunities to improve primary alternatives to secondary care.

Incentive to innovate

The advent of national price tariffs for secondary care from April 2005 (April 2004 in the case of Foundation Trusts) opens up a wide range of opportunities for primary providers to deliver care such as minor injury services, medical admission triage centres, minor surgery and a wide range of diagnostic testing both profitably and economically.

PCTs that have developed alternatives to admission demonstrate that primary innovations can deliver good quality care for less than the acute tariff. For example emergency medical admissions with a zero length of stay (of which there has been a substantial increase nationally during 2003/04) will generally cost circa £1500 at acute tariff, many minor injury centres with diagnostic services can treat those needs more cost effectively and free beds and staff time in Hospitals to treat the patients with more complex needs.

Value for Money and Business Cases

Value for Money is a key part of financial strategy in PCTs and it will be useful to consider each proposal for investment in new services or different patterns of primary provision against clear criteria. The ideal model would be to use a standard format business case to assemble and assess proposals. The purpose is to ensure good value for money and a consistent and fair approach between practices. The headings and considerations include:

- The service issue involved - e.g. minor injuries
- How is the need currently met - e.g. partly acute, partly another GPSI
- What are the alternatives, should the PCT contend the proposal by seeking an alternative from another source e.g. the local Independent Sector Treatment Centre
- The scale of the service change - how many patients, trend of need, a public health analysis and view if it is a major issue
- The current cost of that service and its trend/need for new investment, the cost of the new service against the same forecast trends, the savings from doing it in primary care
- Risks - e.g. a change in threshold for intervention thus drawing in more patients than were expected
- Affordability in the PCT's overall planning priorities (ideally all the proposals should be considered simultaneously once a year as part of the LDP to ensure a proper ranking against priorities.

Corporate Governance

Corporate Governance requires PCTs to consider investments openly and for proposers to avoid participating in decisions where they may have a conflict of interest. Business cases require PCT Public Board consideration and approval.

Comparative Information

Finance teams could gather comparative information about developments in other PCTs both within their SHA area and beyond to ensure they are aiming toward the leading edge of new primary investments. SHAs have a role to coordinate the new GMS arrangements across PCTs and are in a good position to draw together comparative information about the level and mix of primary investment across the new headings of the contract. PCT finance teams can also compare practices within the PCT to identify scope for further expansion of enhanced services.

Quality

The introduction of Quality & Outcomes Frameworks to reward enhanced quality in primary care is a key element of the new contract's strategy to strengthen primary care. The QOF spans four domains with the greatest emphasis being on the clinical one where up to 550 points out of 1050 can be attained. Organisational arrangements receive up to 184 points, additional services attract 36 points and patient experience 100 points. There are also 180 points for overall breadth of care. Finance teams in PCTs will need to assess the financial implications of practices initial aspirational targets and ensure their systems can pick up and evaluate the actual achievement information as the data starts to flow during 2004.

Out of Hours Services

Many PCTs are finding that the level of resources released by practices opting out of providing Out of Hours services falls substantially short of the cost of PCTs making alternative arrangements. This cost will fall on the growth resources available for primary care and may pre-empt other investments unless innovative better value for money arrangements can be devised. PCT finance teams need to keep this “essential service” issue under close scrutiny until robust solutions are implemented.

Financial Management

There is a balance between opportunities and risk in the new arrangements and PCTs' financial strategies should include a risk assessment, a means of monitoring and identifying the risk areas at an early stage and identify options for managing risks as they emerge.

Now primary care resources fall within the resource limit it may be necessary to hold modest reserves to meet foreseeable unfunded variations for example practices achieving higher quality scores than were forecast, or the cost of PCT delivered Out of Hours services exceeding the claw back from opted out practices.

A Secure Transition

PCT finance teams need to carefully map the old primary funding flows to the new ones to avoid errors and omissions and ensure their PCTs receive all the potential resources available for their population. Clear working documents with a robust audit trail are necessary to support the change and ensure practices have the full options set out to consider. There is a big culture change for staff who operated the old Red Book reimbursement for practices and it is essential that they receive training, briefing and regular updates on the new arrangements to ensure a smooth transition. The key message is that PCTs now have to manage GMS rather than just process it.

Finance teams may need additional staff resources both in the short and medium term to manage the new arrangements and ensure accurate, timely financial information including trends and forecasts are available to the PCT each month.

Most PCTs have developed their expertise in commissioning primary care through the PMS arrangements but this is still a big step beyond that and will require a great deal of senior PCT management time and effort to implement it successfully. This will be an ongoing process as the new arrangements are a framework for supporting reform, not an end point in their own right.

Financial Management Framework

The new arrangements increase the complexity of analysis and reporting to create and manage budgets on the new headings and to regularly update forecasts.

PCTs will need to keep accurate records of the allocation to each practice for each of the areas of the primary care contract and of the actual results as performance and volume information becomes available during the year. It is vital to produce forecasts using trends as they emerge in order to manage the overall resource limit for the year. There is a complex potential cross over of services between practices and with PCT directly provided services because of the choices open to practices to opt out of some care areas. The financial management coding and analysis can be designed to track each aspect of service provided to practice catchment populations regardless of which organisation delivers that element of care. That is important for ensuring equity, overall control and avoiding duplicate payment for care.

The headings and an illustration of the cross over analysis for a Practice's population are set out in APPENDIX 1 as an illustration. It would be useful to map the previous provision and payment against the same headings to be able to track and account for the changes introduced.

The finance team can assist the PCT Board and PEC by designing simple summary tables with charts to show the overall pattern of primary care provision by practice, by practice population and by care area. These are likely to be needed annually for creating the Local Delivery Plan and monthly during the year to control expenditure.

There are major information issues in the new contract including regular quarterly updates of practice populations to support the essential services payments and information about performance in the four domains of the Quality & Outcomes Framework. PCTs will have updated practice systems but are reliant on the National Programme for IT to deliver some of the changes needed in the Exeter System in time for April 2004 payments and on GP systems contractors for the bolt on elements to support QOFs due by August 2004.

This spreadsheet is available at www.natpact.nhs.uk/uploads/FinFrnd.xls

Example of analysis of primary care provision for one Practice's population by provider

This example uses percentages rather than £ expenditure for the sake of simplicity BUT the real version needs BOTH

The New Contract Headings	Provider					
Analysis of care provision for Practice 1	Practice 1	Other Practices in the PCT	The PCT	Independent Sector	Secondary Care Provider	Total provision for Practice 1 Population
Essential Services						
Management of patients who are ill, or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable.	100%					100%
General management of patients who are terminally ill	100%					100%
Management of chronic disease in the manner determined by the practice, in discussion with the patient.	100%					100%
Additional Services						
Cervical screening	50%	50%				100%
Contraceptive services	50%	50%				100%
Vaccinations and immunisations	100%					100%
Childhood vaccinations and immunisations	100%					100%
Child health surveillance	100%					100%
Maternity services (excluding intra partum care)	50%	25%			25%	100%
The minor surgery procedures of curettage, cautery, cryocautery or warts and verrucae and other skin lesions	0%	50%		25%	25%	100%
Enhanced Services						
These are essential or additional services delivered to a higher specified standard, or services not provided through essential or additional services. Examples are extended minor surgery, or services provided by practitioners with special interest. PCOs will be free to commission enhanced services as appropriate to meet local health need. There are three groups of enhanced services:						
Directed enhanced services						
National enhanced services						
Local enhanced services						
Directed Enhanced Services						
These services must be commissioned by each PCO, but will not always be provided by every practice. Nationally developed specifications and costs have been developed for these services. Directed enhanced services are:						
Childhood immunisations (high population coverage)	100%					100%
Influenza immunisations (over 65 and at risk groups)	100%					100%
Minor surgery (above that included as an additional service)	0%	50%		50%		
Services to support staff dealing with violent patients	0%		100%			100%
Quality Information Preparation	100%					
Access to general medical services			100%			100%
For some of these services the PCO will need to make sure all their patients can access the service should they need to (for example services for potentially violent patients), for others, eg. Quality information preparation and access schemes, they need to allow all practices the chance to participate.						
National Enhanced Services						
National specifications and benchmark costs for these services have been developed. PCOs will agree national enhanced services to meet local needs using the specifications, but as a guide only, as there is no requirement to provide all of these services in a PCT area. If the delivery of the service is agreed with a GMS practice then the practice may expect, and may only be willing to offer, the service on the basis of the national specification and prices.						
National enhanced services include:						
Anti-coagulant monitoring	0%		100%			100%
Provision of near-patient testing	0%	50%		50%		100%
Specialist care of patients with depression	0%	100%				100%
Patients who are alcohol misusers	100%					100%
IUD fittings	0%	100%				100%
Patients suffering from drug misuse	100%					100%
More specialised services for patients with multiple sclerosis	0%	100%				100%
Intra-partum care	0%		25%		75%	100%
Provision of immediate and first response care	0%	50%	50%			100%
Minor injury services ?? Enhanced care of the Homeless		50%	50%			100%
More specialised sexual health services		100%				100%
Local Enhanced Services						
Any other enhanced service, which the PCO wishes to agree with a practice or another provider, will be classed as a local enhanced service.	25%	25%	25%	25%		100%

Primary Care Prescribing

Prescribing costs are a significant proportion of the resources managed by PCTs (typically 15%). Prescribing expenditure increases faster than other NHS spending because of the development of new drugs and new applications of existing drugs, NICE approvals, implementation of National Service Frameworks and the more rapid transfer of patients back to primary care from acute care.

Managing prescribing budgets well is mission critical for all PCTs. A balance has to be struck between supporting the use of new technologies, minimising waste and controlling costs within available resources. The PCT can dramatically improve the health of its population by early adoption of proven new drug technologies for example statins in the field of Coronary Heart Disease prevention.

Good financial management is essential to support the PCT's prescribing leads, practices, pharmacists and secondary care partners to achieve the best value for money in primary prescribing.

The extent of the finance team's role will vary between PCTs as there are many different organisational arrangements for managing prescribing. The finance director will want to ensure that the people managing prescribing receive good quality financial advice and support. The finance director has a duty to ensure that the arrangements in the table above are delivering reliable financial information for the Board and other PCT staff to act upon.

The key issues for managing prescribing are summarised below with annotations about the finance team's inputs:

What	How
Organisational arrangements	• Clinical leadership & engagement • Joint working arrangements with PCTs and secondary care Trusts • Professional pharmaceutical advisors • Professional financial involvement
Policies	• Prescribing policy direction agreed by the PCT Board • Joint policies across the health economy for introduction/evaluation of new drugs including the processes by which funding will be approved • Common formulary • Use the extensive advice & information from the Prescription Pricing Authority including the Electronic Prescribing Analysis & Cost Tool (EPACT) - see web site www.ppa.org.uk
Planning - three year Local Delivery Plans	• Decisions on the overall primary prescribing uplift are a Board decision taken in the context of all the other planning priorities in the health economy with strategic financial advice
Setting practice prescribing budgets	• Practice budgets will be a compromise between formula funding (astro pu based), current expenditure and trends • Developing the budget setting options is a joint task between practices, prescribing leads and the finance team • Decisions on options are a Board matter with professional advice
Achieving good value for money	• Professional clinical and pharmaceutical analysis of practice prescribing, including trends • Comparative expenditure by practices (astro pu weighted) • Peer review • Promotion of use of generic drugs • Managing repeat prescribing • Alignment of prescribing policy with secondary care (to avoid pricing anomalies)
Managing budgets	• Timely reports and analysis provided to practices and the Board, including expenditure against profile, variations, forecasts of the year end impact if those variations continue • Incentives for practices to manage within the prescribing budgets (including negative incentives of making access to development resources dependent on managing prescribing) • Action should be taken on variances and followed up to ensure it is happening arrangements may include:
Risk management	• Assessment of the risks for the planning period ahead including the programme of NICE reviews & trends on particular drugs • A (small) contingency reserve with clear rules about how & by whom it may be deployed • Risk sharing between practices and with other PCTs to minimise impact of cyclical variations • Risk sharing with secondary trusts for new high technology high cost treatments that may switch to primary • Reducing other planned developments to fund overspendings

7 - Working in partnership

The NHS has for some years worked in partnership, through informal and formal structures, primarily with partners in the public sector, the most common agreements being with local authorities. The Health Act 1999 gave new powers to the NHS and local authorities to pool budgets where appropriate. Under section 31 of the Act a range of pooled budgets have been established, usually for those services where both bodies have a key role to play in direct service provision, or commissioning of services (for example, services for people with learning disabilities).

The following issues need to be addressed by all health organisations considering a partnership agreement - whether a formal pooled budget or a more informal arrangement (for example joint advisory groups where organisations come together to ensure coherence between their respective activities such as service planning). For the purposes of this document, these are viewed from a PCT perspective. PCT Finance Directors will need to satisfy themselves that the following issues have been addressed and that agreements have been formally agreed by PCT Boards.

- Does the NHS have the powers to enter into the proposed partnership agreement?
- Are there: a clear purpose and shared objectives for the partnership?
- Is the proposed arrangement congruent with the strategic and operational aims and objectives of the PCT?
- Does the partnership reflect current (or future proposed) patterns of service delivery. For example, in many cases it is usual for PCTs to collaborate and jointly agree a pooled budget with social services, according to the geographic boundaries for service delivery.
- Is there clarity regarding the financial and management arrangements, including:-
  - Financial contributions to the partnership/pooled budget (including eligibility criteria and service quality standards)
  - Monitoring and review arrangements (including service information for monitoring and review of service delivery and accounting arrangements such that each organisation can account for resources committed to partnership/pooled budget arrangements satisfactorily)
  - Management of the partnership, at both strategic and operational levels.
  - Risk management (both financial and service risk, particularly in relation to the treatment of forecast overspends against the agreed budgets)
  - Does the proposed partnership agreement meet governance requirements? (legal and auditor opinions should be sought in the early stages when considering a partnership to ensure appropriate use of NHS powers and that proposed management arrangements and reporting meet governance standards)
  - Is the duration of the agreement clear, and are arrangements in place to enable variation or dissolution of the agreement should that be necessary?

For further information:-

A wide range of publications are now available to support PCTs and other organisations planning to enter into partnership agreements. The following may be particularly relevant:-

Health Act 1999

Health and Social Care Act 2001

Implementation of Health Act Partnership Arrangements, Department of Health, 2000

NHS Finance Manual

Pooled Budgets: A Practical Guide for Local and Health Authorities, CIPFA, 2001

Working Together: Effective Partnership Working on the Ground, Treasury 2002

Financial Control and Budgeting for NHS Partnerships - A Practical Guide, CIPFA, 2003

8 - Financial Accountancy

PCT finance directors duties include ensuring their trusts have adequate systems and records to account for the use of the resources under their control.

These issues are comprehensively covered by existing DoH guidance which is on the web as follows:

The DoH manual Delivering Excellence in Financial Governance (on the web at www.doh.gov.uk/financialgovernance) sets out the accountancy aspects of the role in depth together with links (see www.info.doh.gov.uk/doh/finman.nsf) to the NHS Finance Manual which sets the standards and format for the accounts of NHS bodies.

The HFMA and accountancy profession also offer useful information in this field which can be accessed via these web links:

The Healthcare Financial Management Association - www.hfma.org.uk

The Chartered Institute of Public Finance and Accountancy - www.cipfa.org.uk

The Institute of Chartered Accountants in England and Wales - www.icaew.co.uk

The Association of Chartered Certified Accountants - www.accaglobal.com

The Chartered Institute of Management Accountants - www.cimaglobal.com

9 - Financial Governance

The statutory duties of NHS Finance Directors and the role of the finance function in the field of governance are comprehensively covered in the DoH publication “Delivering Excellence in Financial Management” (see web reference www.doh.gov.uk/financialgovernance)

The main areas of governance are:

1. Board Reporting & Advice
2. Financial processes & procedures

“Delivering Excellence in Financial Management” quotes a useful list of criteria from the controls assurance standard which PCT finance teams can use to assess the overall position on financial governance - see the extract below:

1.	*Financial objectives for the organisation are clearly defined, approved by the Board, and conform to Department of Health requirements.*
2.	*Board level responsibility for financial management is clearly defined and is supported by clear lines of financial accountability throughout the organisation.*
3.	*There is an Audit Committee overseeing the financial aspects of governance.*
4.	*Standing Financial Instructions, based on the Departmental model and updated to reflect current requirements, have been formally adopted by the Board, and promulgated throughout the organisation.*
5.	*Financial risk management processes exist throughout the organisation.*
6.	*There is an effective and documented system of internal control for all financial management systems.*
7.	*There is an adequately resourced, trained and competent finance function.*
8.	*All employees, including managers and the Board, are provided with adequate information, instruction and training on financial management.*
9.	*The Board reviews the effectiveness of its system of internal control for financial management at least annually.*
10.	*The Board receives regular reports on financial performance and activity. It is made aware of significant risks and determines and takes appropriate action.*
11.	*The Head of Internal Audit provides an annual assurance to the Audit Committee on the effectiveness of organisation's financial arrangements based on this standard.*
12.	*The organisation can demonstrate that it has done its reasonable best to meet its key financial objectives.*

The combination of the mandatory functions of the Finance Director and the Financial Management Standard largely define the key governance agenda for the Finance function.

PCT Finance Directors have two different roles on the Board as the source of professional financial advice and as a corporate Board member contributing to the overall direction of the Board's policies and governance. The DoH guidance focuses mainly on the professional contribution to the Board but the Finance Staff Development team's recent publication “Shaping the Future, from numbers to knowledge” (see web reference www.fsdnetwork.com) focuses on the wider role of the finance function and has a useful self assessment checklist to help judge progress and development needs.

10 - External and internal audit

The following section outlines the role of the PCT Director of Finance and the Board in relation to the appointment and operation of internal and external audit. Detailed advice should be sourced from the following publications (from which this overview has been drawn)

- Delivering Excellence in Financial Governance (Department of Health March 2003)
- NHS Internal Audit Standards
- Audit Commission Code of Practice
- Audit Committee Handbook (updated 2001)

The PCT should ensure an effective relationship with both internal and external audit, particularly when innovative arrangements are planned (in particular new forms of partnership arrangement)

External Audit

External auditors are appointed by the Audit Commission and governed by the Code of Practice published by the Audit Commission. They report on:-

- Financial governance issues relating to legality, financial standing, internal financial controls, financial conduct, fraud and corruption
- The organisation's financial statements
- Value for money

Taking into account an assessment of risk and reviews required by the Audit Commission, the external audit plan will be agreed with the Audit Committee, Chief Executive and Director of Finance.

The Director of Finance should ensure a good partnership between external and internal audit and regular liaison between finance staff and external audit as appropriate, In particular this should relate to the external audit plan, and new/revised arrangements which the organisation is planning to enter into (for example partnership arrangements). The responsibility of external audit to offer guidance and support in these areas can act as helpful support, particularly in the initial stages of a partnership arrangement, ensuring legal powers etc.

Internal Audit

Internal audit reviews, evaluates and reports on internal financial controls to the Board, through the Audit Committee. Their programme is informed by an assessment of risk to the organisation and consultation with the Director of Finance and external audit. Reports to the Audit Committee will identify the outcomes of such reviews, recommendations and follow-up to assure the Committee that recommendations have been implemented.

The Audit Committee

The role of the Audit Committee is covered in the Audit Committee Handbook (web reference). The Committee includes at least 3 non-executive directors and is a sub-committee of the Board (which should agree terms of reference of, and receive reports from, the Audit Committee). Its principal duties are to ensure there are processes in place to ensure effective risk management, financial control, compliance with Controls Assurance standards, arrangements for the prevention and detection of fraud, effective operation of internal and external audit and effective financial reporting to the Board.

Foundation Trust context

The Foundation Trust Contract enables the PCT to:-

- Be provided with financial information annually
- Allow financial records to be verified by the PCT (or the PCT's representative)
- Appoint an audit (at the PCT's expense) if the PCT has cause for concern in relation to payments made to a Foundation Trust.

The costs of the audit would be met by the Foundation Trust if the Commissioner has been significantly overcharged (percentage to be specified nationally within the Foundation Trust contract)

Although these powers are in place in the event of cause for concern, it is expected that their use would be rare, and that partnership working between the Trust and the PCT would avoid the need for formal third-party audit of financial records in this way.

11 - Developing the finance function

The rapid change of the delivery of health services towards a patient-focused and modernised NHS, where care is often delivered and commissioned through partnership arrangements, and patients are empowered through the introduction of patient choice (for example) will require a flexible and dynamic finance function to support those changes while maintaining the core values, set out in "Building on the Vision - The Staff Development Strategy for the Finance Function of the NHS" published in June 2001:-

Value	Definition
Professionalism	Acquiring and applying the knowledge, skills and practice which will enable all finance staff to meet customers' needs to consistently high standards
Integrity	Acting honestly, openly, impartially and fairly. Adopting an objective approach which is consistent and reflects the highest ethical standards
Partnership	Working with others to develop mutual understanding and trust to enable the organisations to achieve their corporate objectives
Innovation	Developing an environment which encourages enterprise, challenge and creativity and stimulates people to welcome change and manage risk
Commitment	Seeing things through to the end, putting the task and the needs of others first
Excellence	Demonstrating quality and constantly improving performance

Building on these core values, but recognising significant changes in the delivery of healthcare as the NHS expands and invests to meet future needs, with a rapidly developing information technology infrastructure Directors of Finance in PCTs will need to place increasing emphasis on developing finance staff to enable the finance function to:-

- Engage with the strategic agenda, and working with the Board in setting the strategic direction for the organisation, supporting this work with strategic analysis and knowledge management
- Ensure effective financial and analytical support to non-finance staff
- Innovate and ensure best use of resources
- Manage performance, including managing and supporting staff in the management of financial and non-financial risks
- Create and deliver effective partnership arrangements, both formal and informal
- Maintain confidence in the organisation through effective leadership, governance and communication arrangements.

The Finance Staff Development website includes development tools and pointers to a wide range of resources and materials, including the national programme of work sponsored by the Department of Health for the NHS. These materials, and those produced by other bodies (for example the accountancy bodies, HFMA) will enable Finance Directors to develop an overall finance development plan for the organisation, which is reflected in

- A training and development policy which is regularly reviewed, and resourced.
- Appraisal and Personal Development Plans for all staff, including Continuous Professional Development where appropriate

Given the size of the finance function in many PCTs, Directors of Finance should consider how networking arrangements could support and develop their staff, for example through sharing of resources, opportunities for secondment and producing training and development plans and policies.

11 - Developing the finance function continued

Additional resources

Finance Staff Development website	www.fsdnetwork.com
NHS Finance Staff Development website	www.doh.gov.uk/financedevelopment
Financial Governance	www.doh.gov.uk/financialgovernance
HFMA	www.hfma.org.uk
ACCA	www.accaglobal.com
CIMA	www.cimaglobal.com
CIPFA	www.cipfa.org.uk
ICAEW	www.icaew.co.uk

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