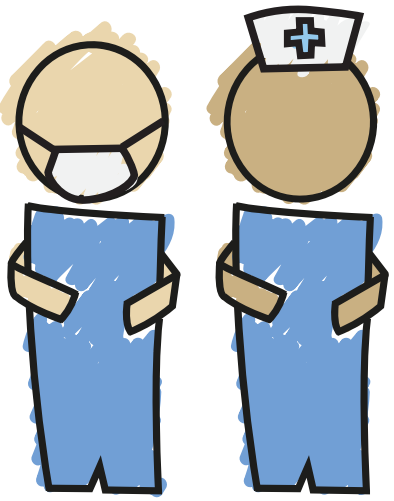
MAKING PEOPLE COUNT

FUTURE FOCUSED FINANCE

PAYMENT SYSTEMS AND CONTRACTS FOR NHS PROVIDERS



SOURCES OF INCOME

NHS Trusts are funded in two different ways

1. Revenue Financing of the day to day running of the Trust
2. Capital Financing for the purchase of assets (building and equipment)

The majority of the revenue for NHS Trusts comes from commissioning, for most hospitals this is predominantly from CCGs, some Trusts will also be directly commissioned by NHS England to provide specialist services.

Other sources include:

EDUCATION, TRAINING AND RESEARCH

Local Education and Training Boards (LETBs) provide a lump sum payment to Local Education Providers (LEPs) to cover the direct costs of delivering education and training for each placement for one year. A LEP is an organisation, such as a hospital or trust that delivers postgraduate medical education and training (i.e. the trainee's employer).

There are two components to the tariff:

- Salary support - For 2014-15, salary support is 50% of the basic salary costs for the post across all grades (including "on-costs", such as pension and national insurance contributions, and London weighting where applicable). The remainder of the salary costs must be met by the LEP.

- Placement fee - The placement fee funds all the "direct costs" involved in delivering the education and training needs for an individual trainee. The fee for 2014-15 is £12,400 (multiplied by the Market Forces Factor).

PRIVATE PATIENTS

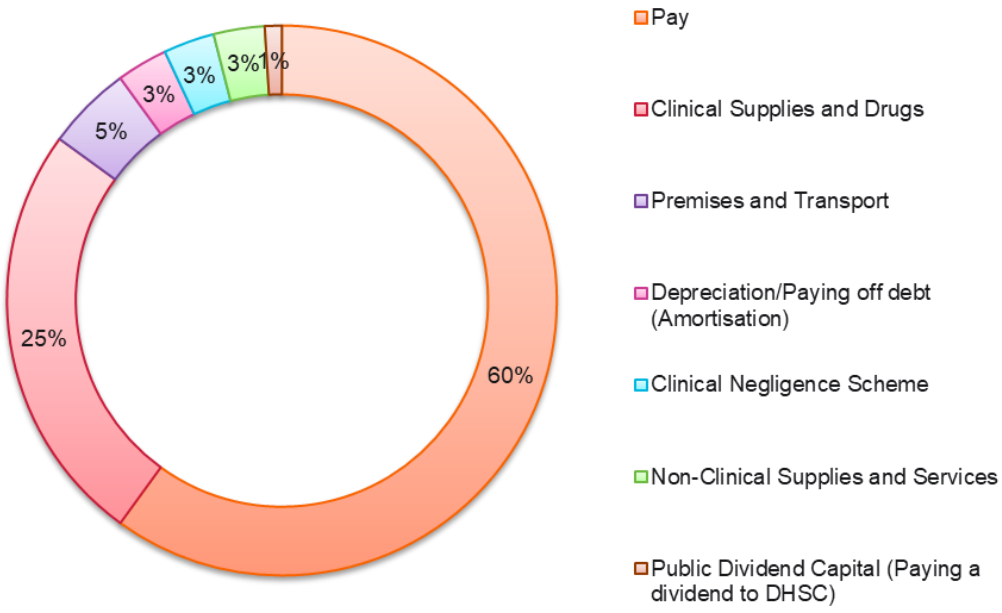
- There is a cap for Foundation Trusts, where only 49% of their income can come from non-NHS sources (which is mainly from private patients, but also includes car parking, leasing etc.)
- Cap for Mental Health Trust is 1.5%
- There is no official cap for NHS Trusts
- Average income from Private Patients is 2%, though some hospitals earn much more eg the Royal Marsden (30%), Harefield and Brompton (20%)

LEASING OF PROPERTY

- The proportion of funding that comes from the non-clinical sources varies. For example, In the East Midlands, the leasing of property provides a very small proportion of funding, where in London, hospital such as Guys and St Thomas earn a considerable amount of money from property leasing.

Other Sources of Income include Car Parking & Catering

NHS PROVIDER EXPENDITURE % BUDGET



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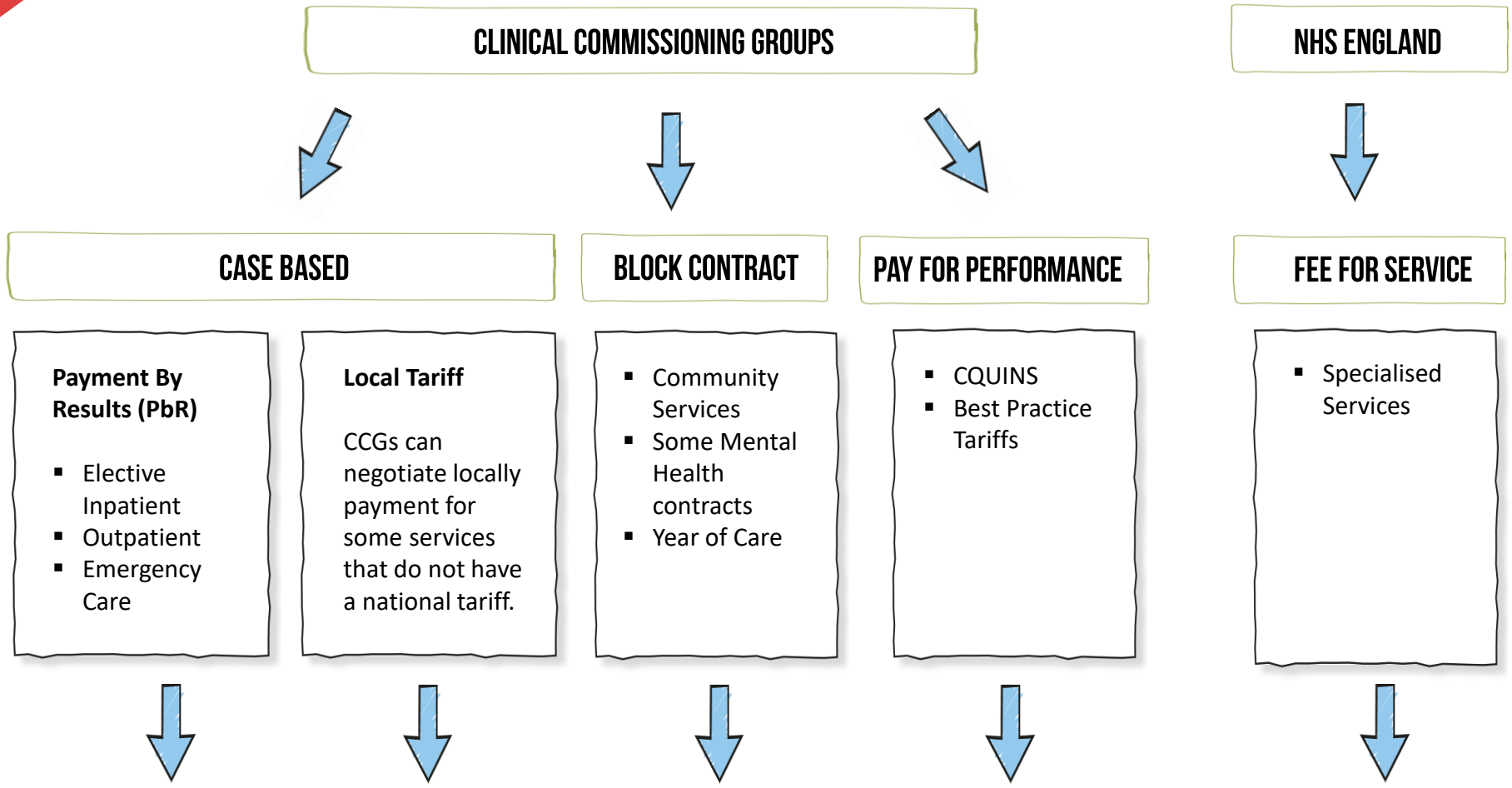

CONTRACTS

NATIONAL TARIFF

Also known as Payment for activity. Payments, called tariffs are made using a classification system that group hospital activity in to units of currency that are clinically similar and have similar resource requirements. In England, this classification system is called Health resource groups (HRGs) and the latest version has 2100 different currencies. The national tariff represents approximately 60% of payments to acute care providers.

Advantages:

- Payment based on activity, good to reduce waiting lists.
- Encourages efficiency as the tariffs are calculated using average costs and so this encourages those hospitals with higher than average costs to become more efficient.

Disadvantages:

- Difficult to budget for both sides (Final cost/payment depends on activity).
- Barrier to integration – as organisations need numbers to generate income, so may be less willing to consider other options (community-based options)
- Organisation are less willing to stop income generating work (mainly elective) work, despite other pressures
- There is a risk that providers are less focused on quality. The National tariff does contain best practice tariffs which along with CQUINs try to link payments with quality of care, though they are limited in scope and have limited impact.

BLOCK

Agreement to provide a particular service for a particular population for a fixed amount. Paid in advance and generally independent of level of activity or number of people treated
In recent years, there has been an increase in the use of block contracts (rather than PBR) for acute organisations to enable better financial planning.

Advantages:

- Predictable income and expenditure
- More amenable to integration/considering pathway options and models of care
- Useful in areas where activity levels are difficult to measure

Disadvantages:

- Lack of transparency and accountability
- Inevitably leads to increased waiting lists as no incentive to increase work/efficiency.
- Changes in cost during contract are not accounted for

FEE FOR SERVICE

Rarely used in the UK.

Providers are paid retrospectively per unit of activity undertaken.

Advantages:

- Providers are paid for all treatment they choose to provide.
- Supports quality and comprehensive care as the provider has no incentive to withhold or skimp on care.
- Once new treatments and technologies are on the reimbursement list can be rapidly rolled out as they are paid for.

Disadvantages:

- Difficult to financially control and plan for
- No incentive for efficiency
- Commissioners pay for increasing costs
- No incentive for prevention or collaboration

FEE FOR PERFORMANCE

In the UK, this system is used as part of another contract to financially incentivise quality improvement. Whilst mainly used in general practice, NHS providers contracts utilise CQUIN payments (Commissioning for quality and improvement) to reward good practice. There are national and local CQUINs which comprise up to 2.5% of the value of the contract.

Advantages:

- Encourages quality improvement
- Ability for NHS England and CCGs to target specific areas for improvement

Disadvantages:

- Budgets are often calculated on the assumption that CQUIN payment will be received, can be seen as a penalty if not achieved.
- CQUINS change every 1-2 years and providers will need to invest each year to obtain CQUIN payment, whilst often also funding the ongoing costs from previous CQUINs

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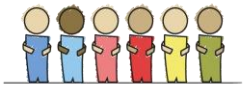

FUTURE FOCUSED FINANCE

CAPITATED

Lump sum payments are made to care providers to provide certain care services to a defined population.

The amount is determined by the number of people being served. It is not linked to the amount of care given. Often the capitation is weighted according to demographics of the population.

This is the basis of the new models of care suggested in the Five Year Forward View. There will also incorporate a fee for performance aspect to these payments.

Advantages:

- Encourages preventative care
- Facilitates collaboration and shifting of care out of hospitals and in to the community.

Disadvantages:

- Can be a disincentive as providers are paid irrespective of care given,
- Do not factor in changes in demand
- To achieve the benefits it requires different organisations to work together to coordinate care