This supporting information has been prepared to assist the auditor in performing their planning to inform their work on VFM arrangements under Auditor Guidance Note 3 (AGN 03). The supporting information is intended to provide additional sector specific context only. It is NOT part of the statutory guidance and auditors are only required to have regard to the explicit requirements set out in AGN 03.

Auditor Guidance Note 3 (AGN 03) Supporting Information:

Clinical Commissioning Groups

December 2021

This document forms part of the suite of supporting information designed to assist auditors in planning their work on VFM arrangements.

The suite of supporting information comprises this document and the following:

Local health bodies

- NHS trusts and foundation trusts (FTs)

Local government bodies

- Local authorities
- Police and Fire & Rescue bodies
- Combined authorities
- Other local bodies

These documents will be updated from time-to-time to reflect new, significant sector developments, or updates to the statutory guidance.

Supporting information does not include organisation-specific information. Accordingly, the issues included are **neither prescriptive nor exhaustive,** and do not substitute for the consideration of local context.

What's new?

The main changes to the supporting information include:

- Impact of Covid-19
- Finance regime including cash and capital 2021-22
- Spending Review 2021
- People Plan and workforce
- Primary care co-commissioning: Update to CCGs with delegated arrangements
- Integration of health and care services – updated with details of Health and Care Bill and Integrated Care Systems (ICSs)
- Primary Care Networks
- Better Care Fund
- Social care
- NHS Oversight Framework: CCG year-end assessment 2020-21
- Sector resources

Background

This section provides some general information about the sector.

A Clinical Commissioning Group (CCG) is a clinically-led statutory NHS body responsible for the planning and commissioning of health care services for its local area. CCGs were established by the Health and Social Care Act 2012. This Act abolished strategic health authorities and primary care trusts (PCTs), transferring health commissioning to other bodies. CCGs replaced PCTs on 1 April 2013.

Each CCG is led by a governing body, the members of which include GPs and other clinicians, such as nurses and consultants. CCGs are responsible for about 60% of the NHS budget, commission most secondary care services, and play a part in the commissioning of GP services. The secondary care services commissioned by CCGs are:

- planned hospital care;
- rehabilitative care;
- urgent and emergency care (including out-of-hours and NHS 111);
- most community health services; and
- mental health services and learning disability services.

CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health

and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers.

NHS England commissions primary care services, for example GPs, dentists and opticians, however primary medical services is devolved to most CCGs through primary care co-commissioning. NHS England also directly commissions 'specialised' services (such as treatments for rare conditions and secure mental health care), military and veteran health services and health services for people in prisons (including youth offender institutions).

NHS England (NHS Commissioning Board) is an independent body, at arm's length to the government. Its main role is to set the priorities and direction of the NHS and to improve health and care outcomes for people in England. NHS England manages around £114 billion of the overall NHS budget and ensures that organisations are spending the allocated funds effectively. Resources are allocated to CCGs. NHS England maintains a register of all authorised CCGs.

Since their initial establishment, there have been a number of CCG mergers with 9 further mergers taking effect from 1 April 2021. This has reduced the number of CCGs to 106. The process of merging CCGs means that many remaining CCGs will now be larger organisations and will also include closer working between CCGs where they are preparing for a merger.

Details of the CCGs currently in existence, along with the mergers that have taken place, can be found on the NHSE website in the CCG Directory.

From 1 April 2019, NHS England and NHS Improvement have been working together as a new single organisation (NHSE&I), aligning the way they work to support system working although both remain separate legal entities. In July 2021 the Health and Care Bill was introduced to Parliament. The Bill will formally rename the NHS Commissioning Board to NHS England. In addition, NHS Improvement (comprising the Trust Development Authority & Monitor) will be brought into NHS England and accounted for within NHS England's accounts.

CQC monitors, inspects and regulates services that provide health and social care to make sure they meet fundamental standards of quality and safety. These include:

- treatment, care and support provided by hospitals, GPs, dentists, ambulances and mental health services;
- treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care); and
- services for people whose rights are restricted under the Mental Health Act.

CQC publishes its findings, including performance ratings. CQC also sets out what good and outstanding care looks like and can take action where care falls below standards.

The legal framework

This section sets out the legislation that governs the audited body's sector, together with any statutory guidance issued thereunder. It is included to provide auditors with information about the roles and responsibilities of the audited body as set out in law.

The National Health Service Act 2006 sets out the legal framework for healthcare commissioning in England. The Health and Social Care Act 2012 amended the bodies responsible for healthcare commissioning and thereby established and set out the legal framework for CCGs in England.

NHS England allocates a large proportion of the funding it receives from the DHSC to CCGs and supports them to commission services on behalf of their patients. In turn, CCGs are required to demonstrate probity and good governance in managing their finances and performance.

NHS England seeks to ensure that CCGs are delivering the best outcomes for their patients and have a high standard of financial management, are administering resources prudently and economically, and safeguarding financial propriety and regularity. Increasingly, account has been taken of CCGs' performance within their system and of system-level performance. Parliament has provided for specified but limited rights of intervention by NHS England into CCG functions, such as the power to issue directions to CCGs under certain circumstances.

Accounts requirements

Paragraph 17 of Schedule 1A of the National Health Service Act 2006 (the 2006 Act), requires each CCG to prepare annual accounts for each financial year ending 31 March. The annual accounts of each CCG, and any interim accounts the CCG chooses to produce, must be prepared in accordance with the Government Financial Reporting Manual for the relevant financial year, taking account of the application guidance contained in the Department of Health and Social Care Group Accounting Manual for the relevant financial year. Paragraph 17(7) requires each CCG to provide an electronic copy of the final approved and audited annual report and accounts, as one composite document, to the National Health Service Commissioning Board by the date(s) and using the method(s) notified via SharePoint. The annual report and accounts must be signed on behalf of the CCG by the Accountable Officer in accordance with the instructions notified via SharePoint.

Accountable Officer responsibilities

The National Health Service Act 2006 (as amended) states that each CCG shall have an Accountable Officer (AO) and that Officer shall be appointed by the NHS Commissioning Board (NHS England).

The AO of a CCG is charged with ensuring that their CCG complies with its:

- duty to exercise its functions effectively, efficiently and economically;

- duty to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness;
- financial obligations, including information requests;
- obligations relating to accounting and auditing;
- duty to provide information to the NHS Commissioning Board, following requests from Secretary of State; and
- obligations under any other provision of the NHS Act 2006 Act specified by the Board for these purposes. performs its functions in a way which provides good value for money.

The AO is responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money.

Health and Care Bill

In July 2021 the Health and Care Bill was introduced to Parliament. The Bill will formally rename the NHS Commissioning Board to NHS England. In addition, NHS Improvement (comprising the Trust Development Authority & Monitor) will be brought into NHS England and accounted for within NHS England's accounts.

The Bill will allow for the establishment of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) across England. This will be done at the same time as abolishing CCGs.

The ICB will take on the NHS commissioning functions of CCGs as well as some of NHS England's commissioning functions. It will also be accountable for NHS spend and performance within the system.

The Board of the ICB will, as a minimum, include a chair, the CEO and representatives from NHS providers, general practice and local authorities. Beyond that, ICBs will have the flexibility to determine governance arrangements in their area – including the ability to create committees and delegate functions to them. This would, for example, allow systems to create local 'place'-based committees to plan care where appropriate. ICBs will also need to ensure they have appropriate clinical advice when making decisions.

NHS England will agree ICBs' constitutions and will hold them to account for delivery.

Commissioning responsibilities for primary care services will also transition from NHSE to ICBs. These services have been delegated to CCGs for some time. The intention is that ICBs could be responsible for the commissioning and arranging of primary medical services, dentistry (primary, community and secondary services), community pharmacy and general ophthalmology in the future with NHS England retaining a more limited oversight role.

Staff currently employed by CCGs will transfer to ICBs, and NHS England has made an employment commitment to staff to provide stability and minimise uncertainty.

Each area will also have an Integrated Care Partnership or ICP, a joint committee which brings together the ICB and their partner local authorities, and other locally determined representatives (for example from health, social care, public health; and potentially others, such as social care or housing providers).

The ICP will be tasked with developing a strategy to address the health, social care and public health needs of their system, and being a forum to support partnership working. The ICB and local authorities will have to have regard to ICP strategies when making decisions.

The ICB and ICP will also have to work closely with local Health and Wellbeing Boards (HWBs) as they have the experience as 'place-based' planners, and the ICB will be required to have regard to the Joint Strategic Needs Assessments and Joint Local Health and Wellbeing Strategies (JHWSs) produced by HWBs.

Further detail on ICBs and ICPs can be found below in the section on integration of health and care services.

Sector developments and contextual information

This section contains contextual information that may be relevant to the body's general arrangements. It also sets out some of the current developments within the sector that may be relevant to the body's arrangements .The material may be helpful to auditors when undertaking their planning.

The examples below are neither prescriptive nor exhaustive, and should not be used as a checklist. The information in this section does not cover developments at individual audited bodies and auditors are also likely to need to draw on their own local knowledge.

NHS finance regime and planning process

NHS Long Term Plan

The NHS Long Term Plan, published on NHS England's website on 7 January 2019, sets out how the NHS intends to address the challenges regarding funding, staffing and increasing inequalities and pressure from a growing and ageing population. The document is split into seven chapters and sets out:

- ways in which the NHS will move to a new service model which aims to give patients more options, better support, and properly joined-up care;
- how the NHS plans to strengthen its contribution to prevention and health inequalities;
- the NHS's priorities for care quality and outcomes improvement;
- plans for improving the NHS workforce;
- plans for a digitally enabled NHS;

- how the 3.4% five-year NHS funding settlement intends to help improve NHS financial sustainability; and
- the next steps in implementing the Long Term Plan.

NHS financial sustainaibility

The continuing financial pressures within the NHS provider and commissioning sectors have been widely publicised, including in our 2020 report NHS financial management and sustainability. This report is the NAO's eighth report on the financial sustainability of the NHS. The report concludes that the NHS is treating more patients but has not yet achieved the fundamental transformation in services and finance regime needed to meet rising demand. The short-term fixes that the Department, NHS England and NHS Improvement put in place to manage resources in a constrained financial environment are not sustainable. The extra money brought in to stabilise the finances of NHS bodies has continued to drive volatility and variability among trusts, while patient waiting times continue to deteriorate and the number of people waiting for treatment continues to increase.

Years of short-term funding decisions for the health sector means that resources have moved away from areas of investment in the future, such as the workforce, public health and capital. This will need to be rebalanced to ensure that the ambitions set out in the NHS Long Term Plan are realised. To bring about lasting stability, the NHS needs a financial restructuring programme not just a recovery programme. If integrated care systems are to be successful, funding mechanisms and incentives need to support collaborative behaviours. The delivery of long-term financial sustainability is at risk unless every organisation is on a realistic path to breaking even. Until the Department and NHSE&I have implemented more sustainable solutions and dispensed with short-term financial fixes, the NAO cannot conclude that they have delivered value for money through their collective actions.

2021-22 Funding regime

As in 2020-21, the 2021-22 financial year is split into two halves with a different funding regime in each. The regimes are largely a continuation of those introduced in response to Covid-19, and set out in two lots of operational planning and implementation guidance, issued in March and September 2021. Details of each funding regime are set out below and further information is included in Annex 1. For reference, a recap of the funding regime that was in place for 2020-21 has been maintained in Annex 2.

2021-22 financial regime – first half of the year (H1)

NHS England & Improvement issued its 2021-22 operational planning guidance in March 2021. This was published along with with implementation guidance that provided further detailed policy and technical information to enable Integrated Care Systems (ICSs) and their constituent organisations to develop and agree operational plans.

The finance and contracting arrangements for the six-month period from 1 April 2021 to 30 September 2021 ('H1 2021-22' or 'H1') set out details of the H1 arrangements. These included an additional £8.1bn of funding provided by government, of which £7.4bn was available over the first half of 2021-22 to reflect the ongoing impact of COVID-19. The government also provided an additional £1.0bn for elective recovery and £0.5bn for mental health recovery across 2021-22.

The key H1 arrangements are set out below:-

- System funding envelope, comprising adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities.
- Block payment arrangements will remain in place for relationships between NHS commissioners and NHS providers.
- H1 block payments with NHS providers should be amended to reflect the changes to system funding envelopes. Block payments with CCGs outside the system ('inter-system') and NHS England contracts for directly commissioned services will be uplifted by 0.5%.
- Payment timelines will return to pre-COVID timelines as set out in the NHS Standard Contract terms.
- Written contracts must be in place where non-NHS providers are being commissioned to provide services (other than core primary care).
- Systems will have access to additional growth funding for the following services: acute, mental health, primary medical care and community.
- Additional non-NHS income support through the Covid-19 allocation, to be distributed to the lead CCG.
- Efficiency requirements for both NHS and non-NHS providers

2021-22 financial regime – second half of the year (H2)

Updated operational planning guidance was issued in September 2021 which reflected the financial settlement for the second half of the year. It also included details of the financing regime for the six month period from 1 October 2021 to 31 March 2022 ('H2 2021-22' or 'H2'). Further details of the H2 regime were published in Guidance on finance and contracting arrangements for H2 2021/22. The aims set out in the guidance were restoration and recovery of services; recovering finances to a sustainable footing; and enabling continued system collaboration.

The H2 arrangements are broadly consistent with a continuation of the H1 framework described above. System funding envelopes containing adjusted CCG allocations, system top-up and COVID-19 fixed allocation remained in place, as wells as block payment arrangements for relationships between NHS commissioners and NHS providers.

Cash and capital regime for 2021-22

NHSE&I introduced a new cash and capital regime for 2021-22 which builds on the arrangements established in 2020-21. The guidance on NHS system capital envelopes provides an overview of the new approach to capital funding in the NHS from 2021-22 and includes:-

- Details of the NHS capital settlement – the total provider allocation was set at £6.2bn compared to £5.8bn in 2020-21. This was split between system-level allocation (£3.9bn), nationally allocated funds (£1.2bn) and other national capital investment (£1.1bn).

- Overview of the Health Infrastructure Plan (HIP) which aims to make clearer links between local spending plans and national spending limits.

- Methodology for system allocations e.g. what expenditure is included and excluded, and the basis on which the envelopes were distributed.

- Planning and reporting arrangements including the introduction of enhanced reporting for ICSs/ Sustainability and Transformation Partnerships, who may need to explain variances against plan for key categories of spend.

Covid-19 – wider considerations – Procurement Policy Notes.

In March 2020 the Cabinet Office issued guidance note Practice Note (PPN) 01/20 for public bodies on how to procure extremely urgent, unforeseeable requirements made necessary as a direct result of the COVID-19 outbreak including, in exceptional circumstances, using regulation 32(2)(c) under the Public Contract Regulations 2015. The Cabinet Office also issued PPN 02/20 setting out further information and guidance for public bodies on payment of their suppliers to ensure service continuity during and after the current Covid-19 outbreak. The actions suggested in the paper include making payments in advance of need, suspending payment by results requirements and paying for services as normal despite disrupted or suspended service delivery. Such actions would normally be prohibited under Managing Public Money without explicit HM Treasury consent, as being novel, contentious and repercussive.

In summary, PPN 02/20, when read alongside the supporting letter from Sir Tom Scholar (Accounting Officer, HM Treasury) to accounting officers, provided HM Treasury consent for certain payments in advance of need to suppliers, subject to certain conditions. HM Treasury were clear in their letter that this consent did not alleviate Accounting Officers from their usual duties to ensure that spending was regular, proper and value for money.

PPN 04/20: Recovery and Transition from COVID-19, published in June 2020, built on the provisions contained within PPN 02/20.

NHSE&I has updated its guidance, published 31 March 2021, which sets out how NHS organisations should respond to supplier requests for support now that Cabinet Office procurement policy notes PPN02/20 and PPN04/20 have expired. It also provides an update on

the use of PPN01/20. This guidance does not replace any primary or secondary care guidance issued in relation to 2020/21 contracting and should be read in conjunction with H2 guidance.

Spending Review 2021

The Spending Review 2021 (SR21), published on 27 October 2021, sets departmental budgets up to 2024-25. It confirms that departmental spending will grow at an average of 3.8 per cent annually. SR21 aims to support economic recovery following the pandemic, and to support the government's plans to reduce regional inequalities across Britain.

The DHSC settlement is set out in the tables below:

	£ billion						Average annual real terms growth	
	Outturn 2019-20	Outturn 2020-21	Baseline 2021-22	Plans 2022-23	Plans 2023-24	Plans 2024-25	2021-22 to 2024-25	2019-20 to 2024-25
Resource DEL (1)	133.5	136.3	147.1	167.9	173.4	177.4	4.10%	3.30%
of which: NHS England and Improvement	123.7	125.9	136.1	151.8	157.4	162.6	3.80%	3.10%
Capital DEL (1)	7	8.6	9.4	10.6	10.4	11.2	3.80%	7.20%
Total DEL (1)	140.5	144.9	156.4	178.5	183.8	188.6	4.10%	3.50%
Ringfenced COVID-19 DEL	0	47.4	33.8	-	-	-	-	-
Total DEL including ringfenced COVID-19 DEL	140.5	192.3	190.3	-	-	-	-	-
(1) Excluding ringfenced COVID-19 DEL								
Source: Spending Review 2021, Chapter 4 Departmental Settlements – Department of Health and Social Care table 4.1								

SR21 settlement:

- provides a £43.9 billion cash increase in core resource spending over the Parliament to £177.4 billion in 2024-25, which is equivalent to a real-terms growth rate of 4.1% on average over the SR21 period;
- provides a £4.2 billion cash increase in capital spending over the Parliament to £11.2 billion in 2024-25, which is a 3.8% real-terms growth rate over the S21 period;
- is supported by revenue raised from the new Health and Social Care Levy and an increase to the rates of dividend tax; and
- confirms a commitment to provide the NHS with the future resources needed to tackle Covid-19 and the elective backlog. This includes £9.6 billion for Covid-19 programmes and related health spending, and over £8 billion to tackle the elective backlog by delivering more checks, scans and procedures.

SR21 provides investment which aims to improve the quality and efficiency of care through:

- confirmation of £4.2 billion over the SR21 period to make progress on building 40 new hospitals by 2030;
- £2.3 billion over the SR21 period to transform diagnostic services with at least 100 community diagnostic centres (CDCs) across England to permanently increase diagnostic capacity;
- £2.1 billion over the SR21 period for innovative use of digital technology so hospitals and other care organisations are as connected and efficient as possible;
- £1.5 billion over the SR21 period for new surgical hubs, increased bed capacity and equipment;
- around £300 million over the SR21 period to complete the programme to replace mental health dormitories with single en suite rooms; and
- a new budget of £150 million over the SR21 period to invest in NHS mental health facilities linked to A&E and to enhance patient safety in mental health units.

The DHSC settlement provides further investment into the NHS workforce, research & development, and schemes to reduce health disparities. It also aims to improve social care outcomes with £5.4 billion confirmed for adult social care over the next three years – £3.6 billion directly to local government; £1.7 billion to the wider social care system; and the remaining funding through the local government settlement.

For an overview on supply terminology, please see Annex 3.

People Plan and workforce

Staff costs make up the largest part of NHS expenditure. The size of the nursing workforce, and the cost of agency staff, have both attracted public attention in recent years.

NHS England published its People Plan for 2020-21 in August 2020. The plan sets out actions to support transformation across the whole NHS.

In November 2021 NHS England published its report on the future of NHS human resources and organisational development. The report outlines the ten-year strategy for the human resources (HR) and organisational development (OD) services in the NHS. It is aimed at HR and OD directors, chief people officers, HR and OD practitioners, managers, leaders and anyone with an interest in HR and OD.
The report highlights the need for change particularly within integrated care. NHS England's vision centres around eight themes which are referenced throughout the report. Chapter Four of the report sets out the actions planned to achieve the vision.

In September 2020, the Public Accounts Committee (PAC) published its report NHS nursing workforce. This finds that nurses have played a "vital" role in caring for people during the Covid-19 outbreak despite nearly 40,000 unfilled nursing post vacancies which had already put staff and

services under strain. The Government has committed to 50,000 more nurses by 2025, but the PAC says the DHSC does not understand the nursing needs of the NHS and does not know how many nurses are needed, or where and in what specialism.

The report draws a number of conclusions including:

- There has been further delay to the overdue NHS People Plan and there is a risk that the NHS is focussing on short-term pressures at the expense of the necessary long-term strategy.
- The DHSC could not show that its commitment to 50,000 more nurses by 2025 matches the actual need for nurses in the NHS.
- The PAC are not convinced that the DHSC has plans for how the NHS will secure 50,000 more nurses by 2025.
- The nursing needs of social care remain an unaddressed afterthought for the DHSC.
- The Covid-19 outbreak presents new challenges, as well as opportunities, for improving the recruitment and retention of nurses in the NHS.

The report also makes a number of recommendations including:

- NHSE&I and HEE must prioritise publication of the substantive long-term workforce plan as soon as possible utilising the NHS's existing long-term funding allocations.
- NHSE&I and HEE should update and publish the results of their modelling work on the demand for NHS nurses, including details for regions and specialisms and any impacts arising from the Covid-19 outbreak.
- As part of the published people plan, the DHSC, NHSE&I and HEE should include a set of costed and detailed action plans for each of the different supply routes for nursing, and how many nurses each route is expected to contribute to the overall nursing workforce. They should consider what national actions, for example on pay, they may need to take to increase recruitment and retention.
- The DHSC should set out its understanding of the nursing requirement across health and social care, and how it expects its actions will support nurse recruitment and retention in social care.
- The PAC welcome NHSE&I's publication of early lessons from Covid-19. NHSE&I should ensure it also makes available a full and frank assessment of the new challenges to nursing recruitment and retention specifically and how health providers should address them, particularly where this could disadvantage certain groups for example students or minority ethnic staff.

NHS Improvement has published guidance Reducing expenditure on NHS agency staff: rules and price caps. On 16 September 2019, new agency rules were enacted that required trusts to use only substantive or bank workers to fill admin and estates shifts, with trusts allowed to request an exemption under certain conditions. However, NHS Improvement recognises that more estates and facilities staff, particularly cleaners, porters and security staff, are required to help the NHS respond to Covid-19. Therefore, for the rest of the Covid-19 response, trusts will no longer need to

request an exemption for any estates and facilities agency workers. NHS Improvement ask that that trusts inform them (retrospectively if needed) of their plans.

Primary care co-commissioning

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning aims to support the development of integrated out-of-hospital services based around the needs of local people. It is part of a wider strategy to join up care in and out of hospital and is intended to lead to a number of benefits for patients and the public.

As of 1 April 2021, all CCGs have delegated commissioning arrangements for primary medical services. More information, along with case studies, can be found on NHS England's website here.

All GP practices are members of their local CCG. Within each CCG, some GPs are members of their CCG's governing body. Under these arrangements there is potential for some GPs and their colleagues to make commissioning decisions about services they provide, or in which they have an interest. Where this is the case there is a risk that commissioners may put, or be perceived to put, personal interests ahead of patients' interests. In June 2017 NHS England published revised statutory guidance for CCGs to put in place systems and processes to identify and respond to potential conflicts of interest. This includes mandatory conflicts of interest training and introduces the requirement for an annual audit of conflicts of interest management within their internal audit plans.

CCG support arrangements

CCGs have discretion to procure commissioning support. For a range of commissioning support services, each CCG can choose whether to use a Commissioning Support Unit (CSU) rather than their own internal staff. CSUs were established to support CCGs in their commissioning, initially hosted by NHS England as part of its organisational structure, but are now autonomous organisations and are self-sustaining entities in a competitive market.

CSU specialist support services include:

- Contract management and negotiation
- Service transformation and redesign
- Business Intelligence
- Information governance
- Financial management
- HR, Estates, IT
- Healthcare procurement and market management
- Non-clinical purchasing
- Communications and patient engagement

- Bespoke services such as individual funding request management, infection prevention, governance and quality

Integration of health and care services

In December 2015, the NHS Shared Planning Guidance 2016-17 - 2020-21 outlined a new approach with the aim of further integrating health and care services. NHS bodies and local councils formed partnerships in 44 areas covering all of England, to improve health and care. Each area developed proposals, known as sustainability and transformation plans, built around the needs of the whole population in the area, not just those of individual organisations.

The footprints are locally defined, based on natural communities, existing working relationships and patient flows, and take account of the scale needed to deliver the services, transformation and public health programmes required, along with how they best fit with other footprints. It is important to note that the partnerships are not statutory bodies, and do not replace existing local bodies, or change local accountabilities.

Each sustainability and transformation partnership (STP) was required to produce and agree a sustainability and transformation plan.

There are a number of aspects to STPs where weaknesses in arrangements may include:

- lack of clear and measurable outcomes;
- lack of capacity within organisations to implement the plans;
- lack of a clear accountability structure for delivery;
- potential conflicts between partnerships and the strategic plans of individual organisations; and
- insufficient funding to deliver transformational change.

Potential conflicts of interest arising from new models of care and changes in commissioning arrangements are included in Annex K: Conflicts of interest and New Models of Care within NHS England's revised statutory guidance on conflicts of interest management. NHS England also published a toolkit in February 2019 on managing conflicts of interest, which includes templates and case studies to support CCGs. A recent NHS England internal audit identified eight areas where the management of conflicts of interest could be improved. In response to that, NHS England asked CCGs to revisit the conflicts of interest guidance to ensure that there were appropriate systems, processes and local knowledge in place to make sure that conflicts were managed effectively. The areas for improvement included:

- procurement decisions and contract monitoring processes;
- completeness of registers of interests, gifts and hospitality;
- governance structures for managing conflicts of interest;
- managing conflicts when making joint decisions with other partners, e.g. other CCGs or Local Authorities;

- conflicts of interest training;
- accepting gifts, hospitality and sponsorship;
- management of conflicts of interest in meetings; and
- appointments to and changes of roles and responsibilities within decision-making bodies.

Integrated Care Systems (ICSs) and Integrated Care Partnerships (ICPs)

ICSs

In some areas STPs have evolved to become Integrated Care Systems (ICSs), a new form of even closer collaboration between the NHS and local councils. ICS leaders will gain greater freedoms to manage the operational and financial performance of services in their area. The NHS Long Term Plan set out the aim that every part of England would be covered by an ICS by 2021, replacing STPs but building on their work to date.

In July 2021 the Health and Care Bill was introduced to Parliament. The Bill sets out the intention for each part of England to have an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB). The ICP is a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

The ICB will be a statutory body responsible for the commissioning of healthcare services in that ICS area, bringing the NHS together locally to improve population health and care. The objective is to empower clinicians, carers and public health experts to operate collaboratively across health and care, as part of plans to tackle inequalities across the country.

NHSE&I's priorities and operational planning guidance sets out the expectation for NHS providers and commissioners to develop ICSs as organisations in preparation for the statutory establishment of Integrated Care Boards. This includes designated ICB CEOs and regional directors being asked to sign a readiness to operate statement in March 2022, confirming that all relevant preparations and due diligence have been carried out to enable the ICB to fulfil its statutory functions from 1 April 2022.

NHSE&I published the Integrated Care System: Design Framework which sets out its intentions (subject to Parliamentary approval) of how NHS leaders and organisations will operate with their partners in ICSs from April 2022. This includes governance, management and funding arrangements. NHS E&I also co-produced guidance with the Local Government Association (LGA) on the development of place-based partnerships as part of statutory integrated care systems. This seeks to support all partner organisations in ICSs to collectively define their place-based partnership working, and to consider how they will evolve to support the transition to the new statutory ICS arrangements from April 2022.

To find out more about ICSs please refer to the NHS E&I website here, which includes a list of ICSs.

ICPs

The Department of Health and Social Care (DHSC) published an ICP engagement document setting out the DHSC, NHS England and the Local Government Association's expectations for the role of Integrated Care Partnerships (ICPs) within Integrated Care Systems (ICSs). It aims to support local authorities, integrated care boards, and other key stakeholders in considering what arrangements might work best in their area when laying the foundations for establishing ICPs.

The engagement document builds on the principles for ICPs set out in the design framework. It aims to:-

- offer further detail on what DHSC see as the role of, and opportunities for, ICPs as one of two core elements of ICSs;
- provide further explanation around the statutory framework for ICPs, as legislated for by the Health and Care Bill;
- set out the guiding expectations DHSC has for ICPs in their operation and delivery; and
- give stakeholders more clarity on timings for establishment of ICPs and how this fits with the establishment of other elements of the system.

The establishment in law of an integrated NHS and LA model for ICSs places ICPs on a statutory footing. As a statutory committee, ICPs will:-

a) be required to be established in every system;
b) have a minimum membership required in law (the ICB and LAs); and
c) will be tasked with producing an integrated care strategy for their areas.

The Health and Care Bill (Clause 20 – Integrated Care Partnerships and strategies) sets out several mandatory requirements for LAs and ICB Boards and chairs. These are detailed in Annex B of the engagement document and the accompanying explanatory notes. The Bill states that the ICP's integrated care strategy should have regard to the NHSE&I Mandate and any guidance issued by DHSC, and explicitly covers the issue of integration and the use of Section 75 arrangements, including pooled funds. Although not specified in the Bill, the strategy should also consider a joint workforce plan, including the NHS, local government, social care and Voluntary Community and Social Enterprise (VSCE).

The ICP is a core element of the statutory arrangements for ICSs which cannot be fully functional without an ICP. DHSC therefore expect that all systems will have at least an interim ICP up and running when statutory ICBs commence as planned in April 2022, subject to the passage of the Health and Care Bill through Parliament. Specifically, DHSC expect an interim ICP to comprise a chair and a committee of at least statutory members (the ICB and LAs), and for there to be agreement on how the committee will be resourced. Local authorities will not have access to any additional funding to support the ICP but should agree with their health counterparts how best to provide the necessary secretariat and other functions vital to the partnership. Regarding membership, some ICPs may have established the membership from April 2022, while others still in their interim form may still be building their membership.

As the engagement document is connected to the Health and Care Bill, elements of the document are subject to change until the legislation passes through Parliament and receives Royal Assent.

Primary Care Networks

A primary care network (PCN) is a form of partnership working that consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, with the intention to offer more personalised, coordinated health and social care to their local populations under the NHS long term plan.

All GP practices are expected to be part of a PCN, although participation is voluntary. As PCNs develop, they are expected to work jointly with other organisations to deliver neighbourhood care and set out these working arrangements as part of their network agreement. Each PCN must have a named clinical director who must be a practicing clinician within that PCN. To expand the primary care workforce, PCNs are also able to recruit to other roles in order to meet the needs of their local populations.

A number of different income streams will fund the development and operation of PCNs. Each PCN will have a nominated practice which receives the payments on behalf of the network. PCNs receive an amount of core funding from CCG allocations per registered patient per year. Further funding is received from the CCG to fund the clinical director role, from the primary medical care allocations. In addition, each practice that participates in a PCN will receive a participation payment from NHS England. This is paid directly to the practice.

Further information on PCNs is available on NHS England's website, including frequently asked questions.

The Healthcare Financial Management Association (HFMA) has also published a briefing *How it works – primary care finance and primary care networks* which gives an overview of primary care finance and primary care networks.

Better Care Fund

The Better Care Fund (BCF) came into being during 2015-16 and takes the form of a local, single pooled budget that aims to fund ways that the NHS and local government throughout England can work more closely together. It provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from CCG allocations, winter pressures funding, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (iBCF).

Collection of BCF plans will recommence in 2021-22. This follows the requirement to submit BCF plans being lifted in 2020-21 given the exceptional pressures on systems due to COVID-19. Full details and requirements of the 2021-22 planning round can be found at Better Care Fund planning requirements 2021-22.

Given the ongoing pressures in systems, only minimal changes have been made to the BCF in 2021-22. DHSC and the Department for Levelling Up, Housing and Communities (DLUHC) have published the Better Care Fund (BCF) Policy Framework 2021 to 2022. This confirms how local authorities and clinical commissioning groups (CCGs) should proceed with finalising plans and pooling agreements for funding under the BCF in 2021 to 2022 and sets out the national conditions for the Fund.

Minimum contributions to the BCF, 2021-22

BCF funding contribution	2021-22 (£m)
Minimum NHS CCG contribution	4,263
improved Better Care Fund	2,077
Disabled Facilities Grant	573
Total	6,913

The national conditions for the BCF in 2021-22 are that:

- a jointly agreed plan between local health and social care commissioners, signed off by the HWB;
- NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution;
- invest in NHS-commissioned out-of-hospital services; and
- a plan for improving outcomes for people being discharged from hospital.

Minimum CCG contribution

The NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of CCG allocations. NHS England will consider conditions (including those that allow for recovery of funding), in consultation with DHSC and DLUHC where the national conditions are not met. These powers do not apply to the amounts paid directly to local authorities from government. The expectation remains that, in any decisions around BCF plans and funding, ministers from both departments will be consulted.

The government is keeping under review further support for the Covid-19 response and recovery, including funding for the hospital discharge policy. Final BCF spending plans for the second half of the year should take into account future funding decisions relating to the hospital discharge policy. Plans will need to continue to meet the conditions of the fund.

The flexibility of local areas to pool more than the mandatory amount will remain. As in previous years, the NHS contribution to the BCF will still include funding to support the implementation of the Care Act 2014, which will be set out via the Local Authority Social Services Letter. Funding previously earmarked for reablement and for the provision of carers' breaks also remains in the NHS contribution.

Disabled Facilities Grant

Funding was paid to local government via a section 31 grant in May 2021. The DFG capital grant must be spent in accordance with an approved joint BCF plan, developed in keeping with this policy framework and the planning requirements. As in previous years, in 2-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers of local government (county and district councils) working jointly to support integration ambitions.

Improved Better Care Fund (iBCF) funding

The iBCF grant was paid to local government via a section 31 grant in May 2021. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

NHS trusts and FTs may be involved as provider organisations in local BCF arrangements. Auditors may wish to consider the impact of BCF plans and achievements in their VFM arrangements planning.

Social care

In May 2020, the government announced a £600 million ring fenced Infection Control Fund to tackle the spread of Covid-19 in care homes. It was given to local authorities to help care homes cover the costs of implementing measures to reduce transmission. One of the measures included in the fund is that the NHS will ensure that each care home has a named clinical contact to provide better access to clinical advice through weekly check-ins to review their patients, and offer direct support for staff with use of equipment and medication.

In September 2020, the government announced its Adult social care: coronavirus (Covid-19) winter plan 2020 to 2021 which included extending the Fund until March 2021, with an additional £546 million provided to help the care sector in England restrict the movement of staff between care homes. In April 2021, the Infection Control Fund was consolidated with the existing Rapid Testing Fund, to support additional testing of staff in care homes, and enable indoors, close contact visiting where possible. This was first extended to September 2021 with an extra £251m of funding, followed by a further extension to March 2022 with an extra £388m of funding to support the care sector over the winter period.

The taskforce was set up in June 2020 to oversee the delivery of two packages of support for the care sector – the Adult Social Care Action Plan and the Care Home Support Plan, and to advise the government on what it considers needs to be in place across the care sector in England to respond

to Covid-19 ahead of the winter months. The report contains 52 recommendations, with responsibility for actions assigned across several organisations including CCGs, providers and local authorities.

In September 2021 the government announced its new plan for healthcare, adult social care, and their new funding plan with the policy paper Build Back Better: Our Plan for Health and Social Care. The paper explains the government's plan to introduce a new Health and Social Care Levy, and to include a cap on social care costs.

NHS Oversight Framework

NHS England and NHS Improvement issued the NHS Oversight Framework for 2021-22, which outlines a joint approach the organisations will take to oversee organisational performance and identify where commissioners and providers may need support.

NHS England has a statutory duty to undertake an annual assessment of CCGs. This was previously carried out under the Improvement and Assessment Framework (IAF) and, for 2019-20, the previous iteration of the NHS Oversight Framework.

For NHS trusts, NHS Improvement has statutory powers of direction as described in the NHS TDA Directions 2013. Where mandated support is required for an FT, NHS Improvement's regional teams may call on the powers in the Health and Social Care Act 2012, using powers under the National Health Service Act 2006.

The NHS Oversight Framework for 2021-22 replaces the NHS Oversight Framework for 2019-20. Organisations will be categorised into one of four 'segments' based on the level of support required. These range from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements.

Accompanying the NHS Oversight Framework for 2021-22 the following document has also been published: NHS oversight metrics for 2021/22.

NHS England published its NHS Oversight Framework – CCG year end assessment 2019-20 in November 2020 setting out the indicators to assess CCGs. Due to the COVID-19 pandemic, several regular collections were suspended or delayed – as a result some indicators could not be used, or data was used from earlier in the year rather than the most recent quarter. The exact time periods used for each indicator are provided in the table at Annex B within the document. The overall assessment ratings for CCGs 2019-20 were also published in November 2020 and available here.

Governance reporting

This section sets out the Annual Governance Statement reporting requirements for the audited body.

The Integrated Care System: Design Framework includes a section on managing the transition to statutory ICSs. The indicative outputs expected in every ICS over the course of the transition period in 2021/22 are set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas).

By end Q1 Preparation	• Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements. • Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.
By end Q2 Implementation	• Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately. • Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies. • Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles. • Draft proposed new ICS NHS body MoU arrangements for 2022/23, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. • Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint. • Begin due diligence planning.
By end Q3 Implementation	• Ensure people in impacted roles are well supported and consulted with appropriately.52 | Integrated Care Systems: design framework • Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles. • ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. • Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.

By end Q4 Transition	• Ensure people in affected roles are consulted and supported. • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force). • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance. • Commence engagement and consultation on the transfer with trade unions. • Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022. • Ensure that revised digital, data and financial systems are in place ready for 'go live'. • Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement.

Local bodies' own governance reporting provides helpful, although not necessarily comprehensive, information about the subject matter for auditors' work.

Existing requirements to support Annual Governance Statements are set out below. **Auditors should not consider these requirements as prescriptive or exhaustive, or use the framework as a "checklist"**.

- A statement confirming that although the CCG is not required to comply with the UK Corporate Governance Code. CCGs may wish to report on their corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code they consider to be relevant to the clinical commissioning group. The approach should be agreed in discussion with the CCG auditors.
- Key features of the CCG constitution in relation to governance (including the split of responsibilities and decision making between the Membership Body and the Governing Body).
- Information about the Membership Body and Governing Body, their committees and sub-committees, including membership, attendance records and coverage of its work (terms of reference).
- Information about any committees, sub-committees and joint committees established by the CCG constitution, including membership, attendance records and coverage of its work (terms of reference).

- The Membership Body and Governing Body's performance including their assessment of their effectiveness.
- Membership of the CCG's Audit Committee.
- Key elements of your risk management strategy, including the way in which risk (or change in risk) is identified, evaluated, and controlled to:
  - Prevent risk;
  - Deter risks arising (e.g. fraud deterrents); and
  - Manage current risks.
- How the control mechanisms work and risk appetite is determined:
  - How risk management is embedded in the CCGs activity (e.g. how equality impact assessments are integrated into core business or how incident reporting is openly encouraged and handled.)
  - How the CCG involves public stakeholders in managing risks which impact on them.
- An explanation that the system of internal control is the set of processes and procedures in place in CCG to ensure it delivers its policies, aims and objectives and it is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The statement should set out that the system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.
- How risks to data security are being managed via the information governance management framework and information governance processes and procedures in line with the information governance toolkit.
- There are processes in place for data incident reporting and investigation of serious incidents.
- Information risk assessment and management procedures are being developed and a programme will be established to fully embed an information risk culture throughout the organisation. Describe how risk has been assessed, including the CCG's risk profile, and how it has been managed.
- A brief description of the CCG's major risks to governance, risk management and internal control separately identifying in-year and future risks, how they are/will be managed and mitigated and how outcomes are/will be assessed (subject to public interest test).
- Any risks to governance, risk management and internal control newly identified during the financial year and after the year end (subject to public interest test).
- A description of the principal risks to compliance with the CCG licence and actions identified to mitigate these risks, particularly in relation to, the effectiveness of governance structures, the responsibilities of Directors and committees; reporting lines and accountabilities between the Governing Body, its committees and sub-committees and the executive team, the submission of timely and accurate information to assess risks to compliance with the CCG's licence and the degree and rigour of oversight the Governing Body has over the CCG's performance.
- Describe the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including some comment on the role and conclusions of the board, the audit committee, if relevant, the risk/ clinical governance/ quality committee/risk

managers/risk improvement manager, internal audit and other explicit review/assurance mechanisms.

- An outline of the actions taken, or proposed to deal with any significant internal control issues and gaps in control, if applicable.
- Reference to internal audit including the head of internal audit's opinion in full and a list of audit reports which have concluded no or limited assurance. Include any revealed deficiencies as risks have materialised (significant issues).
- Provide information about the quality of the data used by the Membership Body and Governing Body and they find it acceptable.
- Confirm an appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report.
- Confirm that all business critical models have been identified and that information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.
- Comment on the level of compliance demonstrated by completion of the IG Toolkit.
- Provide details of any Serious Untoward Incidents relating to data security breaches, including any that were reported to the Information.
- Confirmation that correct arrangements are in place for the discharge of statutory functions, have been checked for any irregularities, and that they are legally compliant, in line with the recommendations in the Harris Review.
- Ensuring all staff undertake annual information governance training and implementing a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.
- Describe the key process that has been applied to ensure that resources are used economically, efficiently and effectively, including some comment on the role of the Governing Body, internal audit and any other review or assurance mechanisms.
- Describe the key ways in which leadership is given to the risk management process and staff are trained or equipped to manage risk in a way appropriate to their authority and duties (including comment on guidance provided to them and ways in which the CCG seeks to learn from good practice).
- Describe the key elements of the way in which public stakeholders are involved in managing risks which impact on them.
- Where the CCG relies on third party providers, comment on how assurance is received, the effectiveness of these arrangements and whether any improvements are planned into the future.

Sector resources

This section sets out some of the key stakeholders and their publications that auditors might find useful when understanding the sector.

National Audit Office: The NAO scrutinises public spending for Parliament. It publishes various outputs relevant to the audited body's sector; in this case on health and social care. Reports that might be of particular interest to auditors of NHS trusts and FTs include:

- Local Auditor Reporting Tool (updated November 2021): The Local Auditor Reporting Tool has been updated to reflect 2020-21 auditor reports for NHS providers and NHS commissioners. It has also been updated to show auditor reports that have since been issued for outstanding local government audits for the years 2017-18, 2018-19 and 2019-20, but does not yet reflect any local government reporting for 2020-21. The tool will continue to be updated periodically to include any reports that have been issued that were previously outstanding or where the auditor has exercised additional powers and duties. The tool presents factual information showing the auditor's opinion on the financial statements; reporting on significant weaknesses in VFM arrangements; and whether the auditor has exercised any of their additional powers and duties.

- NHS backlogs and waiting times in England (published December 2021)
- Investigation into supply chain finance in the NHS - National Audit Office (NAO) Report (published October 2021)
- Cyber and information security: Good practice guide - National Audit Office (NAO) Report (published October 2021)
- Briefing for Health Select Committee on DHSC White Paper 'Integration and Innovation: working together to improve health and social care' (published August 2021)
- Test and trace in England – progress update (published June 2021)
- Initial learning from the government's response to the COVID-19 pandemic (published May 2021)
- The adult social care market in England (published March 2021)
- Protecting and supporting the clinically extremely vulnerable during lockdown (published February 2021)
- The Department of Health and Social Care annual report and accounts 2019-2020 (published January 2021)
- Investigation into the housing of rough sleepers during the COVID-19 pandemic (published January 2021)
- Investigation into preparations for potential COVID-19 vaccines (published December 2020)
- The government's approach to test and trace in England – interim report (published December 2020)
- The supply of personal protective equipment (PPE) during the COVID-19 pandemic (published November 2020)
- Investigation into government procurement during the COVID-19 pandemic (published November 2020)

- Investigation into how government increased the number of ventilators available to the NHS in response to COVID-19 (published September 2020)
- Childhood obesity (published September 2020)
- Readying the NHS and adult social care in England for COVID-19 (published June 2020)
- Guide for Audit and Risk Committees on Financial Reporting and Management during COVID-19 (published June 2020)
- Managing PFI assets and services as contracts end (published June 2020)
- Overview of the UK government's response to the COVID-19 pandemic (published May 2020)
- Digital transformation in the NHS (published May 2020)
- Dentistry in England (published March 2020)
- The NHS nursing workforce (published March 2020)
- NHS financial management and sustainability (published February 2020)
- Review of capital expenditure in the NHS (published February 2020)
- Investigation into the rescue of Carillion's PFI hospital contracts (published January 2020)
- Round-up for Audit Committees (published November 2019)
- Departmental overview: Department of Health and Social Care (published October 2019)
- Challenges in using data across government (published June 2019)
- Investigation into NHS Property Services Limited (published June 2019)
- Investigation into penalty charge notices in healthcare (published May 2019)
- Progress delivering the Emergency Services Network (published May 2019)
- Guidance for audit committees on cloud services (published April 2019)
- NHS waiting times for elective and cancer treatment (published March 2019)
- Progress of the 2016-2021 National Cyber Security Programme (published March 2019)
- NHS financial sustainability (published January 2019)
- Local auditor reporting in England 2018 (published January 2019)
- Investigation into NHS spending on generic medicines in primary care (published June 2018)
- Reducing emergency admissions (published March 2018)
- The adult social care workforce in England (published February 2018)
- Investigation into the clinical correspondence handling in the NHS (published February 2018)
- Care Quality Commission regulating health and social care (published October 2017)
- Investigation: WannaCry cyber attack and the NHS (published October 2017)
- Guidance to Audit Committees on cyber security (published September 2017)
- NHS Ambulance Services (published January 2017)

The following organisations produce publications on their websites from time to time which auditors may find helpful:

HFMA: The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. It publishes briefings for practitioners on finance and governance matters which auditors may find helpful in understanding the key issues within the NHS sector. Relevant publications are summarised below by topic area.

HFMA – audit publications

Year-end survey 2020/21 (published October 2021): HFMA's sixth sector wide year-end survey asked about the preparation and audit of the 2020-21 annual report and accounts and includes auditors' views as well as those from NHS bodies.

The HFMA's response to MHCLG's Local audit framework: technical consultation (published September 2021): The HFMA has responded to the MHCLG's consultation on changes to the local audit framework. There are a number of common issues faced in health and local government audit and Audit Reporting and Governance Authority (ARGA) will have a key role in monitoring, reporting and coordinating solutions in a way that works across the whole system. Any changes made will impact across the whole of the audit market.

External audit reports: the role of the audit committee (published June 2021): This short paper is intended to support audit committee members to easily understand the range of external audit reports and additional powers. This update reflects the updated NAO auditor guidance notes on: VFM arrangements; NHS planning; and auditor reporting, as well as their supplementary guidance note on going concern.

The external audit: best practice in working well together (published March 2021): The annual external audit is not only a key statutory requirement for NHS organisations, but should provide important and valuable insight into the financial governance of the organisation. This briefing aims to support members by summarising the current audit context and sharing tips from auditors, finance professionals and non-executive directors on what they have found to help the audit of the financial statements go as smoothly as possible.

The NHS external audit market: current issues and possible solutions (published February 2021): This briefing considers the background to the current audit arrangements in the NHS; recent events impacting the wider audit market, up to and including the Redmond review; and current issues for NHS bodies and their auditors based on the outcome of a survey of finance directors and discussions with auditors and other interested parties. The issues include the tendering process; audit interest; risk capacity; and fees.

HFMA – accounting publications

Financial reporting watching brief 2021/22 and beyond (October 2021 update) (updated October 2021): This briefing covers changes and developments in accounting standards, best practice in financial reporting and government reporting requirements. It covers the current financial year

but also looks ahead to identify changes which will affect the NHS in the future. The briefing is produced for each accounting and standards committee meeting and is updated four times a year.

What does good look like for costing in the NHS? (published September 2021): This briefing describes HFMA members' views on what good looks like for costing.

NHS environmental sustainability guidance map (published August 2021): The HFMA has produced an NHS environmental sustainability guidance map. The map brings together the key guidance, tools and examples to support the NHS in meeting its commitments to environment sustainability.

The role of the NHS finance function in addressing health inequalities (published July 2021): This short paper considers what is meant by health inequalities, what causes them and the impact that they can have on people's health and the NHS. It considers the role that NHS finance staff can play in tackling inequalities and introduces a new HFMA programme of work to support members in this endeavour.

Benefits in kind: deadlines (published June 2021): Covid-19 has resulted in NHS bodies making payments to staff that are benefits in kind. A PAYE settlement scheme (PSA) allows the employer to pick up the tax liability.

2020/21 annual report and accounts checklist (published April 2021; updated June 2021): This is the fifth version of the checklist that reflects guidance issued up to 22 June and is intended to be a simple way of identifying, on a line by line basis, the issues that are expected to have an impact on the 2020/21 annual report and accounts.

Improving data quality for costing community and mental health services (published June 2021): This joint HFMA and Grant Thornton UK LLP briefing focuses on improving the quality of data for mental health and community services.

Mental health guidance and resources map (published May 2021): The HFMA has produced a mental health map which brings together key national guidance and useful resources to support NHS finance professionals. Aimed primarily at NHS finance professionals in both provider and commissioner organisations, this map provides a quick reference guide to key guidance documents and case study examples, as well as other resources.

The HFMA's response to the consultation on the 2021/22 national tariff payment system (published May 2021): The HFMA has responded to the consultation on the 2021/22 national tariff payment system and is broadly supportive of the proposed changes and the introduction of the aligned payment and incentive approach. However, they have raised concerns about the timing of the implementation, given current demands on finance teams and structural changes underway.

Going concern - assessment and reporting requirements in difficult times (published April 2021): The guidance on going concern assessments and disclosures in the GAM and FT ARM has been revised for 2020/21. At the same time, guidance to auditors has also been amended. This briefing sets out the impact of those changes on the roles and responsibilities of both management and auditors.

HFMA environmental sustainability round-up – April 2021 (published April 2021): This round-up highlights the latest developments in the NHS and wider finance profession as the movement for improved environmental responsibility gathers pace. This briefing highlights a number of sustainability updates, including the IHEEM and HEFMA's 'A healthcare engineering roadmap for delivering net zero carbon in estates' guidance, the NHS Forest, and the Accounting for Sustainability (A4S) Academy.

Costing and data quality: improving the quality of non-financial data required for costing (published February 2021): This joint HFMA and Grant Thornton UK LLP briefing focuses on why NHS boards and system leaders need to ensure that the quality of non-financial data used in costing is of a high quality.

HFMA – governance publications

The HFMA's response to the consultation on the system oversight framework 2021/22 (published May 2021): The HFMA has responded to the consultation on the 2021/22 system oversight framework. The HFMA is broadly supportive of the consultation which aims to provide an aligned and clear approach to the oversight of ICSs and the NHS organisations within them. However, they believe further detail is needed to understand how the oversight approach will practically work to meet the key principles it sets out.

NHS corporate governance map (updated February 2021): The map brings together the key guidance and models to support effective corporate governance within the NHS. This update provides a number of links to new items from national bodies including the NHS white paper, working together to improve health and care for all and the new Government functional standard for counter fraud.

HFMA – integration/ Health and Care Bill publications

Evidence submission to the Public Bill Committee on the Health and Care Bill (published October 2021): The HFMA submitted evidence to the Public Bill Committee in September 2021 to share members' views on the Health and Care Bill, to be considered as the Bill progresses through Parliament.

The future financial sustainability of health and social care (published September 2021): On 6 July 2021 the Health and Care Bill, was given its first reading in Parliament and is now making its way through the various stages in the House of Commons and House of Lords. This briefing considers whether the bill enables the change that the health and social care system needs, both in the short term as the country seeks to recover from the pandemic and in the longer term as the sector more fully addresses population health and wellbeing. It builds on a joint HFMA and CIPFA roundtable discussion held on 21 July 2021 with senior leaders from across the NHS and social care.

Summary of Build back better: our plan for health and social care (published September 2021): On 7 September 2021, the Prime Minister announced a new plan for health and care, with an additional £36bn to be spent over the next three years. This briefing sets out the key points

announced by the Prime Minister. Build back better: our plan for health and social care should be referred to for the further details that are available at this stage.

Starting well: ensuring that CCGs leave a good legacy (published August 2021): 2021/22 is year of transition into formal integration backed by legislation. For CCGs this means closing the statutory body and transferring their functions as they move into integrated care boards (ICBs). This briefing highlights the four key messages that discussions with HFMA members have identified so far.

Summary of the Health and Care Bill (published July 2021): The Health and Care Bill (the bill) was given its first reading in Parliament on 6 July 2021. Once the bill is enacted, it will bring the proposals set out in the white paper Working together to improve health and social care for all into effect. This briefing summarises the key parts of the bill focusing on those areas that will impact on HFMA members.

Summary of Integrated care systems: design framework (published June 2021): The Integrated care systems: design framework is clear that local systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable. The framework goes beyond the likely minimum statutory requirements in order to set out what is needed for ICSs to be successful. This briefing summarises the key points covered in the framework. The original document should be referred to for the full detail.

The HFMA's response to the Health and Social Care Committee's inquiry into the white paper on health and social care (published April 2021): The Department of Health and Social Care published their legislative proposals for the NHS on 11 February 2021, in the Integration and innovation: working together to improve health and social care for all white paper. The HFMA has submitted evidence to the Health and Social Care Committee's inquiry into the white paper.

The HFMA's response to the NHS provider selection regime consultation (published April 2021): NHS England and NHS Improvement have set out proposals to replace the current rules for procuring NHS healthcare services with a set of more flexible arrangements that are intended to better support the NHS ambition for greater integration and collaboration between NHS organisations and their partners, while reducing administrative bureaucracy.

Summary of Integration and innovation: working together to improve health and social care for all (published February 2021): This briefing sets out the key proposals in DHSC's legislative proposals for integration and innovation in the NHS.

HFMA – Covid-19 briefings

Covid-19 guidance map (updated April 2021): This brings together the key guidance to support NHS finance and governance professionals as they respond to the current pandemic. The map is split into six key sections: financial arrangements; financial governance; annual accounts and annual report 2019-20; fraud prevention; workforce; and further information on Covid-19 developments.

Nuffield Trust: The Nuffield Trust describes itself as "an authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK". It publishes a range of comments and articles on topical issues facing the NHS.

The King's Fund: The King's Fund is an independent charity working to improve health and health care in England.

House of Commons Library: Produces succinct and helpful briefings to support Members in their duties, and which are also useful to other readers. Notes likely to be of interest to auditors of NHS trusts and FTs include: The structure of the NHS in England.

The Health Foundation: An independent charity committed to bringing about better health and health care for people in the UK. It produces informative reports on issues affecting the NHS.

CQC: Monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. CQC publishes their findings, including performance ratings. CQC also sets out what good and outstanding care looks like and can take action where care falls below standards.

myNHS: brings together data on a range of performance indicators. The information on this site can be used to compare NHS providers over a range of measures.

data.gov.uk: The government collates several different datasets related to health which cover various different measures of patient outcomes and other indicators at the local health body level.

Delayed Transfer of Care (DTOC) tool: NHSE&I has developed a tool to enable trusts, CCGs and local authorities to understand where delayed transfers of care are in their area or system. The tool brings together data already submitted by NHS organisations and local authorities and indicates where their biggest delays are.

Annex 1 – Financial regime 2021-22 – additional details and links to guidance

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
Original Planning Guidance			
	• Operational Planning Guidance for 2021/22 published in March 2021, setting out priorities for the year • Updated guidance for second half of the year reconfirmed priorities and reflected financial settlement for the final 6 months of the year	2021/22 priorities and operational planning guidance 2021/22 priorities and operational planning guidance: October 2021 – March 2022	Summary of the 2021/22 priorities and operational planning guidance Summary of 2021/22 priorities and operational planning guidance – October 2021 to March 2022
Revenue Expenditure / Contracting			
1 April – 30 September (H1 Arrangements)	H1 arrangements • System funding envelope, comprising adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities. • Block payment arrangements will remain in place for relationships between NHS commissioners and NHS providers. Signed contracts not required. • H1 block payments with NHS providers should be amended to reflect the changes to system funding envelopes. Block payments with CCGs outside the system ('inter-system') and NHS England contracts for directly commissioned services will be uplifted by 0.5%.	Guidance on finance and contracting arrangements for H1 2021/22 2021/22 priorities and operational planning guidance:	The HFMA's response to the consultation on the 2021/22 national tariff payment system

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents

	• Payment timelines will return to pre-COVID timelines as set out in the NHS Standard Contract terms.
	• Written contracts must be in place where non-NHS providers are being commissioned to provide services (other than core primary care).
	• Systems will have access to additional growth funding for the following services:-
	  ○ Acute – access to the Elective Recovery Fund
	  ○ Mental health – additional CCG programme funding and service development funding (SDF) to enable delivery of MHIS and LTP priorities
	  ○ Primary medical care – additional agreed allocations
	  ○ Community – funding for demographic growth included in system envelopes; non-demographic growth available through SDF for transforming community services
	• Additional non-NHS income support through the Covid-19 allocation, to be distributed to the lead CCG (and transacted to NHS providers through block payment arrangements). This is the totality of funding available in relation to non-NHS income support. This includes funding for free NHS staff car parking while the policy remains in place.
	• Efficiency requirements for both NHS and non-NHS providers – 1.1% requirement for non-NHS providers within scope of National Tariff; 0.28% requirement applied to the growth in NHS provider block payments (and feeds through to CCG programme envelope growth and inflation on the system top-up and Covid-19 allocation). Targeted reductions in top-up funding will be applied to systems with carry-forward financial trajectory gaps which were funded through H2 20/21 arrangements.
	• Services funded outside of system envelopes:-
		Implementation guidance
		
		Consultation on the 2021/22 national tariff	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	○ Specialised high cost drugs and devices ○ Specific Covid-19 services ○ Non-clinical services contracted by NHS E&I transacted via invoicing ○ Allocations of national SDF • CCGs expected to deliver breakeven position. <u>Contracting</u> • Commissioners, NHS providers and IS providers should take action to ensure local contracts/ subcontracts are in place to meet system's needs for IS acute capacity from 1 April onwards; H1 system envelopes have been adjusted to move funding for IS services contracts by CCGs back to historical levels. Access to additional reimbursements will be exclusively through the Elective Recovery Fund arrangements (per implementation guidance). • NHS Increasing Capacity Framework remains in place. • 2021/22 National Tariff Payment System (NTPS) statutory consultation published – 20/21 NTPS remains in place until 21/22 NTPS comes into force. NTPS continues to be basis of contracting with non-NHS providers for in-scope services; NHS providers paid under block payment arrangements. • System enevelopes continue to contain an allowance for low-volume activity flows from distant CCGs. • Block payments are deemed to include CQUIN; no CQUIN scheme (either CCG or specialised) published. <u>Block payment arrangements</u> • Approach from H2 20/21 remains in place		

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents

	• Commissioner to provider invoicing suspended
	• For H1 block payment values should be based on:-
	  ○ Intra-system: systems advised to roll over latest intra-system value and uplift by 0.5% inflation factor
	  ○ Inter-system: will be issued with latest CCG inter-system values based on national contract tracker and uplifted by 0.5%
	  ○ NHSE directly commissioned services: systems will be issued with latest CCG inter-system values based on national contract tracker and uplifted by 0.5%
	• Systems may adjust block payment values with NHS providers within their system
	• H2 20/21 process for amending block payment between organisations within different systems will continue to operate.		

1 October - 31 March (H2 Arrangements)	• System funding envelopes and block payment arrangements remain in place as in H1. • H1 and H2 to be treated as a single financial period. • Systems are expected to deliver balanced position for the full financial year. • H2 non-NHS income support will be 75% of the H1 support. Funding for free NHS staff car parking has been rolled forward into H2 envelopes. <u>Updates to system envelopes</u> • 3% pay award uplift announced by government for NHS staff, to be backdated to 1 April 2021 – system envelopes to be uplifted to account for additional recurrent costs of uplift as wall as a non-recurrent adjustment for back pay. • Efficiency requirements for NHS providers have increased from 0.28% to 0.82%, applied to the growth in NHS provider block payments as in H1.	Guidance on finance and contracting arrangements for H2 2021/22 2021/22 priorities and operational planning guidance: October 2021 – March 2022: Submission guidance	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents

	Targeted reductions in top-up funding remain for systems based on their distance from their 21/22 Financial Improvement Trajectory funding envelope. The 1.1% requirement for non-NHS providers within scope of National Tariff remains.
	• Systems have access to the following capacity funding:-
	  ○ Non-elective services (including maternity services) – additional funding issued into H2 envelopes
	  ○ Elective services – access to additional funding through Elective Recovery Fund and Targeted Investment Fund
	  ○ Mental health services – H2 envelopes reflect the remaining element of the full-year funding notified at the start of H1
	  ○ Primary care medical services – H2 envelopes reflect the remaining element of the full-year funding notified at the start of H1. Additional resources will also be made available.
	  ○ Community services – as in H1 funding for demographic growth included in system envelopes; non-demographic growth available through SDF for transforming community services
	• Services funded outside the system envelopes remain the same as in H1, with the addition of elective recovery funding.
	
	<u>Updates to contracting</u>
	• 21/22 NTPS published and will come into force 1 October 2021; until then 20/21 NTPS applies.
	• Still no 21/22 CQUIN scheme – under 21/22 NTPS CQUIN now only applies to providers in scope of the Aligned Payment and Incentive rules.
		2021-22 National Tariff Payment System	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	• Where CQUIN does not now apply under the API rules, national and unit prices published in the 21/22 NTPS have been uplifted by 1.25% to compensate; local prices to be negotiated locally but expectation is also a 1.25% uplift to prevent changes to CQUIN creating cost pressures. <u>Updates to block payment arrangements</u> • For H2 block payment values should be based on:- ○ Intra-system: systems advised to roll over latest intra-system value and uplift by 1.16% inflation factor ○ Inter-system: contract value should be uplifted by 1.16% inflation factor ○ NHSE directly commissioned services: contract values to be uplifted by 1.16% inflation factor • Block payments should also be uplifted by 10.5% in Month 7 only to fund back pay associated with pay award.		
Funding for Covid-19 services			
1 April – 30 September (H1 Arrangements)	•Systems will continue to receive fixed system envelope for Covid-19 services. •Systems to continue to review utilisation of allocation as part of determining optimal service design. Changes in funding to be transacted as block payment amendments. •Full list of Covid-19 items eligible to be funded outside of the envelopes to be issued, including a table of items where eligibility was removed between H2 20/21 and H1 21/22. •For Hospital Discharge Programme, Scheme 2 costs covered for patients discharged up to 31 March 2021 and for first six weeks of care (so some may continue into	Guidance on finance and contracting arrangements for H1 2021/22	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	H1). Further detail to be issued in relation to arrangements for patients discharged from 1 April 2021. •PPE to be procured nationally, funded and overseen by DHSC, until at least June 2021. •Nightingale sites due to close as acute care facilities. Where still utilised for Covid-19 services funded outside of system envelopes, cost should be recorded against relevant category. Where utilised for services funded from within envelopes costs should be borne by relevant region/ system.		
1 October - 31 March (H2 Arrangements)	•Systems will continue to receive fixed system envelope for Covid-19 services. •Additional efficiency applied in H2; further tapering in 2022/23. •Systems to understand additional Covid-19 costs and begin to establish plans to release them. •List of Covid-19 eligible for funding outside system envelopes will be available through monthly reporting guidance. <u>Changes from H1</u> •Hospital Discharge Programme: government will continue to fund first four weeks of post-discharge recovery where this is provided on or before 31 March 2022; no costs for care delivered in 22/23 will be funded by the scheme. •PPE to continue to be procured nationally, funded and overseen by DHSC, until at least 31 March 2022. •Long Covid services: full-year funding was confirmed to regions and systems during H1.	Guidance on finance and contracting arrangements for H2 2021/22	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
Cash regime			
1 April onwards	•Block payment arrangements rolled forward for H1 21/22 via in-month pattern. •Method of payment is through invoice payment file (IPF); invoicing should occur only in limited circumstances relating to NHS E&I non-healthcare items. •Commissioners to continue to pay NHS provider block on 15th of the month (or closest working day) until further notice (except in April when payment is to be made on 8th). •For funded Covid-19 programmes, providers will be reimbursed in arrears and CCGs will be reimbursed by allocation adjustment. •System top-up and Covid-19 allocation will be distributed to a lead CCG. •Amendments to provider funding for specialised high cost drugs/ devices will be reimbursed in arrears through amendments to block payments. •Where providers require supplementary cash support they may apply for it from DHSC via NHS E&I's Capital and Cash team.	Guidance on finance and contracting arrangements for H1 2021/22 Guidance on the cash and capital regime for 2021/22	
Capital Expenditure			
1 April onwards	•New regime announced for 2021-22 building on arrangements established in 2020-21, which were based on capital spending envelopes managed locally by STP/ICS •£6.2bn capital allocation for 2021/22, split between:- ○ System-level allocation (£3.9bn) to cover day-to-day operational investments, including £0.2bn for CIR, high and severe risk RAAC hospitals, diagnostic equipment and Covid-19 responses ○ Nationally allocated funds (£1.2bn) to cover nationally strategic projects already announced and/or construction such as hospital upgrades and new hospitals	Guidance on the cash and capital regime for 2021/22 Health infrastructure plan	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	○ Other national capital investment (£1.1bn) including national programmes such as CDHs, national technology funding and the continuation of the Mental Health Dormitory Replacement Programme •Health Infrastructure Plan (HIP) aims to make clearer links between local spending plans and national spending limits. •CIR and RAAC both included within system envelopes – RAAC is separately identified; CIR is not. •£52m included in system enevelopes to support replacement of aged diagnostic equipment (MRI & CT scanners). •No further Covid-19 capital available; any further expenditure to come from ICS/STP capital envelopes •System enevelopes include allocations for ambulance and mental health trusts •Mental health dormitory eradication and A&E refurbishment schemes are ringfenced and not part of capital envelopes. •Overspends against 21/22 envelopes will be deducted from 22/23 allocations. •Previously approved DHSC PDC and loan commitments with a spend profile in 21/22 will form first commitment against 21/22 system allocation for emergency financing. •Enhanced reporting introduced; quarterly delivery reporting introduced for key categories including RAAC and diagnostics. •NHS E&I to monitor performance against ICS/STP capital envelopes monthly. •Trusts to report capital spend for 21/22 and beyond against a more detailed set of categories.		

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	• Each ICS/STP must make clear which estate is surplus to requirements; capital proceeds will be available to the system to invest in the year of disposal and, by agreement, the two subsequent years. • NBV of disposed assets is recorded as a credit to CDEL and therefore increases spending power in the year it occurs. • Capital receipts from external charitable sources and grants provide additional spending power on top of issued ICS/STP capital envelope. • All expenditure financed through loan/finance lease funding from external sources will score against the ICS/STP capital envelope. • Implementation of IFRS 16 for NHS delayed until 1 April 2022.		
CCG Allocations			
1 April onwards	• CCG allocations were issued for 2019/20 – 2023/24 • Infographic published alongside to explain how the allocations process works • Differences between allocations and expected costs to continue to be addressed via top-ups. • CCG allocations will continue to be non-recurrently adjusted to reflect adjusted expenditure positions. • Non-recurrent Covid-19 fixed funding will be included within funding allocations and distributed to a nominated lead CCG within the system • Funding due to NHS providers should be paid by the lead CCG alongside the block contract values and top-up funding.	CCG Allocations 2019-20 - 2023-24 (All Funding Streams) NHS Allocations Infographic (CCGs 2019-20 Onwards)	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
BCF			
	• BCF planning recommenced for 21/22 •The government has confirmed that the Better Care Fund (BCF) will continue in 2021/22 and that the CCG minimum contribution will grow (in line with the planned Long Term Plan settlement) by 5.3% to £4.26bn. CCGs' envelopes include funding for growth to enable CCGs to meet their 2021/22 BCF commitments.	NHSE website - BCF pages Minimum allocations for the Better Care Fund from CCGs in 2021-22	

Annex 2 – Financial regime 2020-21 – additional details and links to guidance

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
Original Planning Guidance			
	• Original planning guidance for 2020-21 published in January • Subsequently suspended - see below	NHS Planning Guidance 2020-21 - January - Suspended	
Revenue Expenditure / Contracting - Non-Covid-19 Related			
	• New regime planned for 2020-21 - suspended in March due to outbreak of Covid-19	Covid-19 Phase 1 Response - 17 March Letter	
1 April - 31 July (H1 Arrangements)	• Block contracts for CCG/provider pairings based on Q3 AoB data (and standard contract) • Includes uplifts, and assumes MHIS delivery and 100% CQUIN • No invoicing for non-contracted activity – added to block contracts • System of national top-ups for reduced income (providers) • FRF suspended • Commissioner allocations remain unchanged (some small adjustments to be made) – top-up payments to CCGs on same basis as FRF • Specific additional funding allocations as set out in 17 March letter	Contracting and Payment - 26 March Guidance	HFMA Summary of coronavirus cost reimbursement guidance and revised financial arrangements 1 April - 31 July 2020 HFMA Covid-19 financial governance considerations
1 August - 30 September (H1 Arrangements)	• Above arrangements continued	Covid-19 Phase 3 Response - 31 July Letter	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents

1 October - 31 March (H2 Arrangements)	• Move to 'system envelopes' – allocation of funding at system level
	• Simplified contracting and payment arrangements retained (block contracts based on standard contract)
	• Systems expected to breakeven – organisations can deliver surplus/deficit positions by mutual agreement within system
	• System envelope covers most activity and includes:
	  ○ CCG allocations – covers block contracts with providers, being nationally calculated
	  ○ Directly commissioned (and specialised) services from NHS providers – being nationally calculated
	  ○ Top-ups to support achievement of breakeven
	  ○ Non-recurrent Covid-19 allocation – for the remainder of the year
	• Non-NHS income – expectation that will return to 2019-20 levels (except car-parking) – currently under discussion with HMT
		Covid-19 Phase 3 Response - 31 July Letter
		
		Contracts and payment guidance October 2020 - March 2021
			HFMA Summary of Contracts and payment guidance October 2020 to March 2021

Elective Incentive Scheme - 1 September onwards	• To support local systems in plans for recovery by incentivising routine elective activity • System level baseline for elective activity developed, with marginal rates applied to funding depending on level of activity against baseline • Scheme is currently being reviewed nationally	Elective Incentive Scheme - 20 August Letter	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
Revenue Expenditure / Contracting - Covid-19 Related			
1 April onwards	• Additional Covid-19 related costs claimed monthly through a separate top-up (providers) – NHSE/I challenge process and internal audit work to address	Covid-19 Phase 1 Response - 17 March Letter	
1 May onwards	• Costs that can be reclaimed more clearly defined as set out in annex 1 to 19 May letter – excludes items being procured nationally	Covid-19 Phase 2 Response - 19 May Letter	
From 1 October	• Moves to a fixed non-recurrent Covid-19 allocation to cover anticipated additional costs • System funding allocations calculated based on national Covid-19 costs incurred during Q1 of 2020-21 • Some reimbursement top-ups remain for, e.g. Nightingale hospitals, hospital discharge programmes • Funding due to NHS providers should be paid by the lead CCG alongside the block contract values and top-up funding	Covid-19 Phase 3 Response - 31 July Letter Contracts and payment guidance October 2020 - March 2021	
Capital Expenditure - Non-Covid-19 Related			
	• New regime announced for 2020-21 based on capital spending envelopes managed locally by STP/ICS	Cash and capital cover letter - 1 April	
1 April onwards	• Increased £5.8bn budget split out as (including small over-allocation to take account of uncertainties): ○ £3.7bn – system-level allocation for day-to-day operational investments (previously self-financed)	Guidance on NHS system capital envelopes for 2020-21	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	○ £1.5bn – nationally allocated funds for strategic projects already announced / in development ○ £0.8bn – other national capital investment including technology from NHSX – may subsequently be added to allocations during the year • Majority of expenditure to be self-financed through depreciation / cash held locally • Where insufficient cash is held, it can be provided through PDC (alternatively a DHSC loan may be provided where this is viable) • Covid-19 related expenditure covered separately • CRLs (capital resource limit) – a revised process to be implemented for NHS trusts – will align with ICS/STP plans • Disposals – capital proceeds are available to the system to invest in line with estates strategy in the year of disposal and 2 subsequent years in addition to the system-level allocations • Significant disposals with large proceeds – managed on a case-by-case basis requiring discussion with NHSE&I and DHSC as appropriate • Capital receipts from charities – can be used in addition to capital envelope in year that funding is received • Envelopes to take account of expenditure financed through loan/finance lease funding from external sources (including commercial borrowing and private finance) [IFRS 16 consideration]		

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
Capital Expenditure - Covid-19 Related			
	• Additional Covid-19 related capital expenditure covered in 17 March letter	Covid-19 Phase 1 Response - 17 March Letter	
From 1 April	• Criteria must be met in order to obtain reimbursement – up to £250k can be spent without prior approval and reclaimed retrospectively • PDC charges will not be levied on any funding supplied in connection with Covid-19 • CCGs – capital claims expected to be within £10m delegated budgetary limit, allocations to be adjusted • Providers – capital claims expected to be within £15m delegated budgetary limit	Covid-19 Phase 1 Response - 17 March Letter	
From 19 May	• Removes process for retrospective claims upto £250k • A single revised bid form template introduced for providers to use which covers Covid-19 capital expenditure of all values	Covid-19 Phase 2 Response - 19 May Letter	
From 1 October	• Moves to a fixed non-recurrent COVID-19 allocation to cover anticipated additional costs • Some reimbursement top-ups remain for, e.g. Nightingale hospitals	Covid-19 Phase 3 Response - 31 July Letter Contracts and payment guidance October 2020 - March 2021	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
CCG Allocations			
	• CCG allocations were issued in advance of 2020-21 • Infographic published alongside to explain how the allocations process works	CCG Allocations 2019-20 - 2023-24 (All Funding Streams) NHS Allocations Infographic (CCGs 2019-20 Onwards)	
1 April - 30 September (H1 Arrangements)	• 17 March letter confirmed that allocations remain unchanged • Differences between allocations and expected costs to be addressed via top-ups • Out of Hours (primary care) capacity increase – additional allocations to be paid to CCGs to pass on to providers • Additional local NHS 111 funding - additional allocations to be paid via CCGs where agreed	Covid-19 Phase 1 Response - 17 March Letter	
1 October - 31 March (H2 Arrangements)	• For M7-M12, CCG allocations will continue to be non-recurrently adjusted to reflect expected expenditure positions • Normal processes resume for adjusting allocations for additional agreed funding, e.g. funding for delivery of national service development and transformation programmes (SDF) • Except for specific Covid-19 services, national prospective and retrospective top-up funding ends on 30 September 2020 • Non-recurrent Covid-19 fixed funding will be included within funding allocations and distributed to a nominated lead CCG within the system	Covid-19 Phase 3 Response - 31 July Letter Contracts and payment guidance October 2020 - March 2021	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	• Funding due to NHS providers should be paid by the lead CCG alongside the block contract values and top-up funding		
PSF / FRF			
From 1 April	• Original planning guidance (which was suspended) confirmed that only FRF would apply for 2020-21 • Relevant sections have been removed from the 2020-21 GAM • Confirmed that FRF suspended in the 17 March letter – being replaced by top-up payments	NHS Planning Guidance 2020-21 - January - Suspended DHSC GAM 2020-21 Covid-19 Phase 1 Response - 17 March Letter	
Loans (financial support)			
	• Loan to PDC conversion and new arrangements set out • Under new arrangements support only provided where affordable within DEL limit and in compliance with Green Book – HMT approval may be required	Reforms to the NHS Cash Regime effective from 1 April 2020	
Historic Debt	• Interim revenue loans, including working capital facilities and interim capital debt at 31 March 2020 to be extinguished via £13bn PDC issue • Capital normal course of business (NCB) loans are excluded and remain repayable in line with current practice • Effective date of the transaction to repay the loan will be 30 September 2020	Reforms to the NHS Cash Regime effective from 1 April 2020	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	• All loans will be frozen at 31 March 2020 and interest payments will cease from that date • Amounts due for loan principal and accrued interest will be calculated and reconciled to provider's audited 2019-20 financial statements • DHSC does not expect any adjustment to balance sheets at 31 March 2020 or opening balances • Top-up payments will be adjusted so the revenue impact of the debt write off does not create a revenue gain or loss • Appropriate disclosures to be discussed with external auditor		
Future Revenue Support	• Future revenue support for exceptional short-term cash flow requirements and longer-term revenue support for providers in financial distress • Support will be provided as PDC – principal repayment not required, but PDC dividend will be payable at current rate (length of time payable for varies per guidance depending on whether provider is in surplus) • Separate arrangements in place for Covid-related activity so not expected that additional support will be required in this period (but still available) • No change to the application process • PDC dividend rate to be reviewed during 2020-21 (currently 3.5%) • Expected that payments to be lower this year due to operation of FRF [note that FRF has now been suspended]	Reforms to the NHS Cash Regime effective from 1 April 2020	

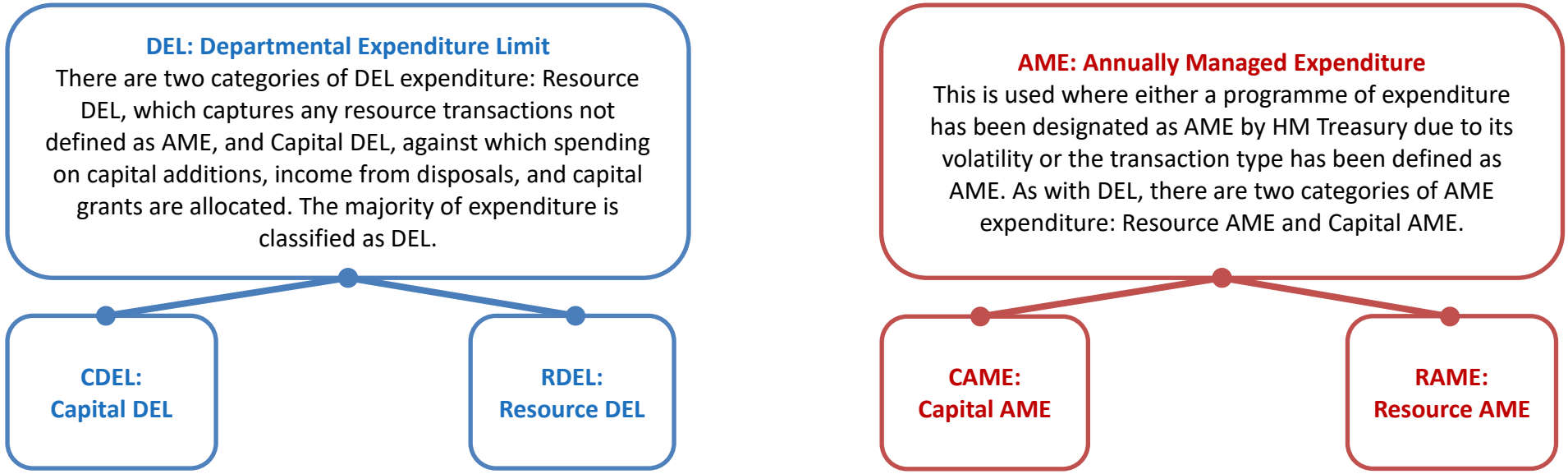
Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	• Time limited cashflow needs of less than one year from surplus providers where it is clear amounts will be repaid in full will be considered by DHSC, with a low daily interest charge		
Future Capital Support	• Capital regime based on capital envelopes provided to STP/ICS – primarily self-financed • An emergency capital allocation will be available for applications that meet the criteria – based on urgent and essential work that is unaffordable to the individual organisation • Support will be issued as PDC • PDC for capital expenditure related to Covid-19 is additional to the capital envelopes • Providers can receive a capital loan from DHSC by exception – must demonstrate that it is affordable within the STP/ICS envelope through guaranteed underspends from other providers across the area • PDC dividend may not be charged for certain assets under construction where high-paced / sizeable / high profile projects – to be confirmed by DHSC • PDC dividend not payable on PDC issued for Covid-19 related expenditure	Reforms to the NHS Cash Regime effective from 1 April 2020	
CQUIN and Contract Terms			
	• Separate guidance on CQUIN and the standard contract issued ahead of the 2020-21 financial year	CQUIN Guidance 2020-21	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	• Under H1 arrangements, monthly payments from CCGs to providers should include CQUIN and assume 100% delivery • H2 arrangements confirm that CQUIN suspended for 2020-21 – block contract payments should include these amounts • Organisational-level financial sanctions under the Contract remain suspended until 31 March 2021 • CCGs should also make CQUIN payments at the full applicable rate to non-NHS providers through 2020-21	NHS Standard Contract 2020-21 Introduction to the NHS Standard Contract 2020-21 Covid-19 Phase 1 Response - 17 March Letter Contracts and payment guidance October 2020 - March 2021	
BCF			
	• Systems not asked to produce plans for 2020-21 due to pandemic (but planning would have been underway) • Allocations for the CCG minimum contribution (see link) and the improved BCF (Excel link from BCF pages) were published ahead of 2020-21 • For the duration of the Covid-19 outbreak, systems should assume that spending from ringfenced BCF funds, particularly on existing schemes from 2019-20 and spending on activity to	NHSE website - BCF pages Minimum allocations for the Better Care Fund from CCGs in 2020-21 Contracts and payment guidance	

Date Range / Funding Area	Relevant Considerations	NHS Documents	HFMA Documents
	address demands in community health and social care, is approved • Systems should prioritise continuity of care, maintaining social care services and system resilience • Confirmed in H2 guidance that the requirement remains for CCGs to achieve the minimum contribution to the BCF • Within that the requirement for the minimum contribution to social care to grow by an average of 5.3% in cash terms continues to apply • NHS and LA partners should continue to work together to develop and deliver their BCF operational plans for the remainder of the year	October 2020 - March 2021	

Annex 3 – Overview of supply

A brief overview of supply terminology is set out below. More comprehensive definitions can be found in HM Treasury's Consolidated Budgeting Guidance (CBG) or the Supply Estimates Manual. There are two types of expenditure for supply purposes, both of which are sub-classified as either revenue or capital spending:



For supply purposes, the definitions of revenue and capital spend broadly follow the definitions as for financial reporting purposes:

- **Capital** – for new investment and net policy lending. In contrast to financial reporting requirements, research and development costs are also included in capital budgets.
- **Resource** – current expenditure such as pay or procurement and including depreciation, which is the current cost associated with the ownership of assets.