By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 25 March 2011.

Subject: NHS Financial Sustainability: Part 1 – Commissioning.

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1. NHS Finances – Overview

(a) Under the current system, Primary Care Trusts (PCTs) are responsible for around 80% of NHS funding and use this money to commission services to meet the health needs of their populations. These revenue allocations are made directly to PCTs by the Department of Health.

(b) On 15 December 2010, the allocations for 2011-12 were announced by the Department of Health. The overall total was £89 billion – most of this is 'recurrent revenue allocations', but £3.4 billion was non-recurrent allocations for primary dental services, general ophthalmic services and pharmaceutical services, and an additional £648 million was made available to support joint working between health and social care[1].

(c) A weighted capitation formula is used as the basis for allocating budgets to PCTs with the intention of reflecting the different needs of each area. The formula is complex but is based on the PCT populations adjusted for their age distribution, additional needs over and above that of age and the Market Forces Factor (MFF) which takes account of the unavoidable differences in the cost of providing services in different parts of the country. Appendix 1 lays out the various components of the weighted capitation formula[2].

(d) The development of the formula is overseen by the Advisory Committee of Resource Allocation which makes recommendations to the Secretary of State on possible changes.

(e) This produces a weighted capitation target which may not be the same as the actual current allocation and the gap is referred to as the difference from target (DFT). PCTs are moved towards their target at a pace set by Ministers.

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[1] Department of Health, http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_076547

[2] Taken from *Resource Allocation: Weighted Capitation Formula Seventh Edition*, Department of Health, 8 March 2011. Fuller details of the different parts can be found in this document. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124947.pdf

(f) The money PCTs receive is not ring fenced, though there are a number of constraints. NHS Trusts and other providers receive funds from PCTs for providing services through contracts or through tariffs, such as the Payment by Results (PbR) system used in the acute sector. Different systems of currencies and tariffs are being developed for different sectors of the health economy.

(g) The distinction between a currency and a tariff is as follows:

1. "Currencies are the unit of healthcare for which a payment is made. They can take a number of forms, covering different time periods – for instance, in acute physical PbR, outpatient attendances are paid on a contact basis, whilst for long term conditions we are looking to develop annual payments adjusted for complexity, which would be more like the care cluster approach. Our initial commitment in mental health is to develop currencies that are being used nationally.

2. "Tariffs are set prices for a given currency unit. The collected nationally determined prices for HRGs are sometimes referred to as the tariff. We have committed to examining the case for a national mental health tariff following the establishment of national currencies. Without a national tariff, prices for a given currency can be set locally or regionally (i.e. at SHA level)."[3]

3. HRGs, Healthcare Resource Groups, are the chosen currency for acute healthcare in England. They are "standard groupings of similar treatments which use similar levels of healthcare resources."[4]

(h) A number of specialised services, such as paediatric cardiology services, are commissioned regionally or nationally.

(i) The remaining 20% (approx.) of the NHS budget includes capital spending along with funds allocated for the delivery of both regional and national programmes and services[5].

(j) In the future the Government proposes that one of the roles of the new NHS Commissioning Board will be to allocate resources for 2013-14 when GP Consortia will take over most of the commissioning currently carried out by the PCTs (see section 3).

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[3] The Department of Health, February 2010, *Payment by Results Guidance for 2010/11,* p.95, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf

[4] The Department of Health, September 2010, *A Simple Guide to PbR*, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

[5] *NHS funding and expenditure*, House of Commons Library Standard Note, 12 January 2011, http://www.parliament.uk/briefingpapers/commons/lib/research/briefings/snsg-00724.pdf

(k) The PCT revenue allocations for England for 2011/12 can be found in Appendix 2[6].

2. NHS Operating Framework

(a) The NHS Operating Framework for 2011/12 was published by the Department of Health the same day as the PCT allocations were announced (15 December 2010). This document sets out what the NHS needs to achieve during what it refers to as a 'transition year'[7].

(b) The key points of the NHS Operating Framework for 2011/12 are as follows:

- Average growth in PCT recurrent allocations of 2.2%.
- PCTs will receive allocations totalling £648 million to support social care in addition to the £150 million funding for reablement services incorporated into recurrent PCT allocations.
- The delivery of the QIPP (Quality, innovation, productivity and prevention) challenge of £20 billion efficiency savings for re-investment has been extended by one year to the end of 2014/15.
- No automatic capital allocation for PCTs – any capital funding to be granted on a case-by-case basis.
- An overall tariff reduction between 2010/11 and 2011/12 of 1.5%.
- New outpatient attendance tariffs to be introduced. New currencies and tariffs to be developed (and led locally).
- Hospitals will not be reimbursed for emergency readmissions within 30 days of a discharge from an elective admission. Other readmission rates to be agreed locally.
- Where providers and commissioners agree, services can be offered below the tariff price.
- Strategic Health Authorities are to oversee the development of PCT 'clusters' with a single executive team to oversee the transition and support emerging GP consortia (including the assignment of PCT staff to consortia). Locally, Ann Sutton has been appointed to lead the cluster consisting of NHS Eastern and Coastal Kent, NHS Medway and NHS West Kent[8].

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[6] Sourced from *Resource Allocation: Weighted Capitation Formula Seventh Edition*, Department of Health, 8 March 2011, p.76, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124947.pdf

[7] Department of Health, NHS Operating Framework, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

[8] NHS Eastern and Coastal Kent, 1 February 2011, http://www.easternandcoastalkent.nhs.uk/whats-new/latest-news/local-nhs-leaders-step-up-to-challenge-of-reform/

- GP consortia will not be responsible for PCT legacy debt prior to 2011/12. PCTs and consortia to work closely together to prevent PCT deficits prior to 2013/14, when GP consortia will have their own budgets.
- Developing consortia will receive £2 per head to support this process. Running costs of £25 to £35 per head are expected by 2014/15.
- A number of new commitments were made on health visitors, family nurse partnerships, the cancer drugs fund, military and veterans' health, autism, dementia and carers support.
- The areas listed as areas for improvement include healthcare for people with learning disabilities, child health, diabetes, violence, respiratory disease and regional trauma networks.

(c) Details around the extension of the "any willing provider" (AWP) model are being considered by the Department of Health at present, with the expectation "it would apply to many NHS-funded services in future. The 2011/12 Operating Framework made clear that AWP will be introduced for community services during 2011/12."[9]

(d) QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams[10] aimed at making efficiency savings to be reinvested in services. These twelve are divided into three areas, as set out below:

Table 1: QIPP Workstreams[11]

Commissioning and Pathways	Provider Efficiency	System Enablers
• Safe care • Right care • Long term conditions • Urgent and emergency care • End of life care	• Back office efficiency and optimal management • Procurement • Clinical support • Productive care • Medicine use and procurement	• Primary care commissioning • Technology and digital vision

(e) The Operating Framework also states that the four tests for service reconfiguration set out in May 2010 stand. These are:

- support from GP commissioners;

[9] Dear Colleague Letter from Sir David Nicholson, NHS Chief Executive, *Equity and Excellence: Liberating the NHS – Managing the Transition*, 17 February 2011, p.14, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124479.pdf

[10] Department of Health website, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm

[11] Adapted from Department of Health, *QIPP workstreams*, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/index.htm

- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

(f) The duty of PCTs to consult overview and scrutiny committees on substantial service change is to remain during the transition.

3. *Equity and Excellence: Liberating the NHS*

(a) The Operating Framework for 2011/12 can be seen as setting out how the transition to the new system set out in the NHS White Paper, *Equity and Excellence: Liberating the NHS*, and the Health and Social Care Bill currently progressing through Parliament.

(b) Simplified diagrams comparing the current to the proposed structure can be found in Section 4.

(c) The main elements of the proposals are set out below:

1. NHS Commissioning Board –

i. This will be a non-departmental public body accountable to the Secretary of State with an overarching duty to promote a comprehensive health service. As set out above, the Board will take on the responsibility for allocating resources to GP consortia. It will publish commissioning guidance and model care pathways (based on quality standards produced by NICE). The price-setting structure will be the responsibility of the Board, along with developing model and standard contractual terms for providers.

ii. It will be responsible for the financial performance of consortia and hold them to account for the quality outcomes they achieve. It will also have some specific powers in connection to consortia – ensuring there is comprehensive coverage of England by consortia; ensuring all GP practices are part of a consortium; overseeing a failure regime for consortia.

iii. The Board will also undertake some commissioning. It will commission primary care services (such as community pharmacy, ophthalmology and dental services along with primary medical services provided by GPs). It will also commission a number of services currently commissioned regionally or nationally.

2. GP/commissioning consortia –

i. The majority of health services will be commissioned by GPs and their practice teams through consortia. These will be

statutory bodies and all holders of a primary medical services contract must belong to a consortium. There is considerable local flexibility around the size and structure of these consortia as well as their geographical coverage, and these elements are open to change over time. They will be required to put robust governance arrangements in place and will have an Accountable Officer (not necessarily a clinician).

3. Monitor –

i. Monitor currently regulates NHS Foundation Trusts but under the proposals would become the economic regulator for the health sector. Its three core functions will be to promote competition where appropriate; regulate prices for NHS funded services; and support the continuity of services. The Bill allows for Monitor's role to be extended to regulating adult social care at a later date by Government.

ii. NHS commissioners will consult locally on services which are to be designated as subject to additional licensing conditions with Monitor and which Monitor will ensure continue to be provided, even if the provider fails.

4. Foundation Trusts (FTs) –

i. All NHS Trusts are to become Foundation Trusts (or part of an FT) by 1 April 2014 and NHS Trust legislation would be repealed (meaning non-FT NHS Trusts will not exist). A Provider Development Authority will be set up to performance manage NHS Trusts until they become Foundation Trusts; this Authority will then be wound down. A number of changes are also being made to the governance and financial freedoms of FTs.

5. Health and Wellbeing Boards (HWBs) –

i. Upper tier authorities will be required to set up a HWB, which will be a statutory committee. The membership will consist, at a minimum, of one elected representative, the director of adult social services, director of children's services, director of public health and representative from the local HealthWatch, and one representative from each relevant commissioning consortia (unless the HWB agrees to a single representative of more than one consortia). There will also be involvement from the NHS Commissioning Board. Local authorities and GP consortia will have a responsibility to produce a Joint Strategic Needs Assessment (JSNA) and will develop them through the HWB. They must also develop a joint health and well-being strategy (JHWBS) which will set out how the needs identified in the JSNA will be met.

ii. Other powers and responsibilities, except that of scrutiny, can be conferred on the HWB.

6. Scrutiny –

i. From April 2013, the functions of the current Health Overview and Scrutiny Committee will be conferred on the local authority directly. The exercise of this function could be through a specific health scrutiny committee or through a different arrangement (with the exception that it cannot be exercised by the HWB).

ii. The powers of health scrutiny will expand to include any NHS funded provider and any NHS commissioner. The Bill will allow the regulations around referrals of substantial service change to be changed. The decision to refer is likely to require a meeting of the full council. There is likely to be consultation specifically on health scrutiny regulations at a later date.

7. HealthWatch –

i. Local Involvement Networks (LINks) will transform into Local HealthWatch. They will be commissioned and funded by upper tier local authorities and be based in local authority areas. The functions of promoting and supporting public involvement in the commissioning, provision and scrutiny of local health services will continue. The local authority will be able to commission HealthWatch to provide advice and information to people about health and social care.

ii. The local authority will also commission NHS complaints advocacy services, which may or may not be commissioned from HealthWatch. Commissioning of independent mental health advocacy will also move to local authorities, but will be separate from the NHS advocacy services.

iii Local HealthWatch will have the power to refer issues to HealthWatch England. HealthWatch England will be a statutory committee within the Care Quality Commission (CQC) and will support the Local HealthWatches as well as escalating concerns received from them within the CQC.

8. Public Health –

i. A separate Public Health White Paper, *Health Lives, Healthy People*, was published by the Department of Health on 30 November 2010[12].

[12] The Public Health White Paper and related documents can be accessed at the Department of Health website, http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

ii A new service, Public Health England, will be set up as part of the Department of Health. This will involve the transfer of functions and powers from the Health Protection Agency and National Treatment Agency for Substance Misuse.

iii. Local health improvement functions will transfer to local government, along with ring-fenced funding. There will be a health premium linked to progress made against a proposed public health outcomes framework. Directors of Public Health will be employed by local government and jointly appointed by the local authority and Public Health England.

4. Current and proposed structure of the NHS

(a) These notes apply to the Notes in Chart 1 (next page), providing further background detail of the current structure of the NHS as it applies to Kent and Medway:

1. Strategic Health Authority (SHA) – NHS South East Coast covers Kent, Medway, Surrey, Brighton and Hove, East Sussex and West Sussex.

2. Primary Care Trusts (PCTs) – Three PCTS in Kent and Medway: NHS Eastern and Coastal Kent, NHS Medway and NHS West Kent. They are being brought into a single 'cluster'.

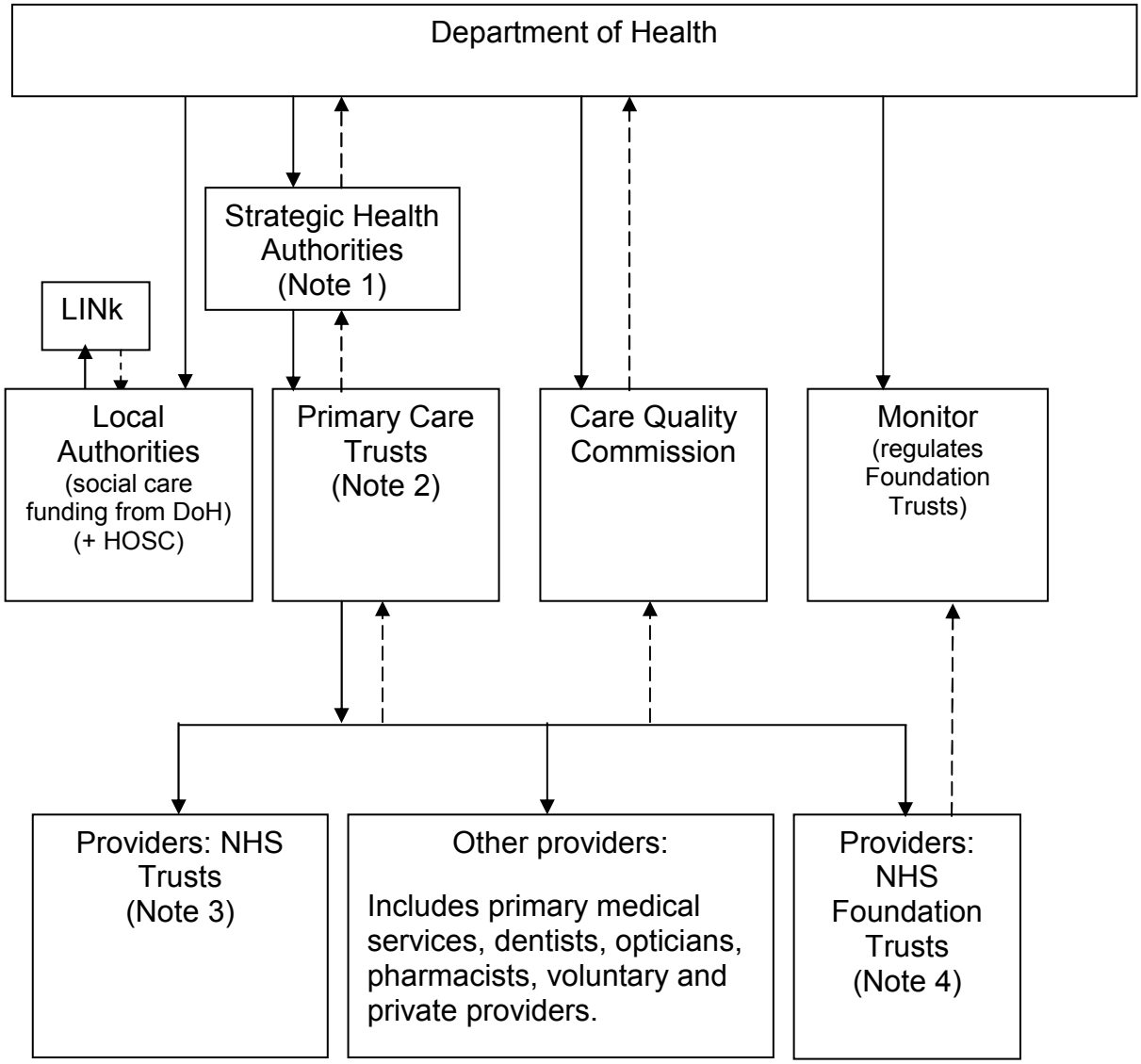
3. NHS Trusts – The main provider NHS Trusts in Kent and Medway are: Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust, Kent and Medway NHS and Social Care Partnership Trust, and Eastern and Coastal Kent Community Health NHS Trust (Kent Community Health NHS Trust as of 1 April 2011).

4. NHS Foundation Trusts – The main NHS Foundation Trusts in Kent and Medway are: East Kent Hospitals NHS University Foundation Trust, Medway NHS Foundation Trust, and South East Coast Ambulance Service NHS Foundation Trust.

(b) The above list does not exhaust the list of NHS Trust/Foundation Trust providers – some services are provided within Kent and Medway by other Trusts/Foundation Trusts (for example, South London and Maudsley NHS Foundation Trust) and residents of Kent and Medway access services provided outside the area (for example, tertiary services in London).

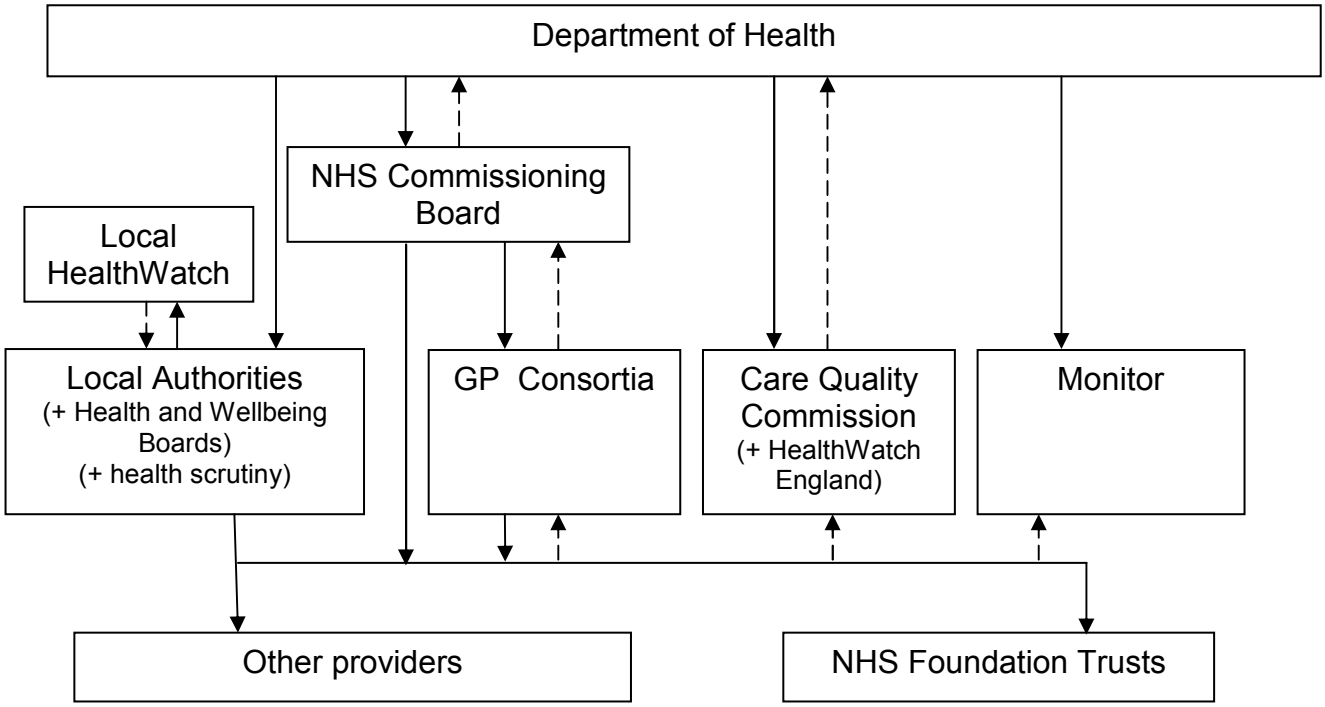
(c) Key to charts:

(d) Chart 1: Current Structure[13].



[13] Both charts adapted from: House of Commons Library, Research Paper 11/11, *Health and Social Care Bill*, p.7, http://www.parliament.uk/briefingpapers/commons/lib/research/rp2011/RP11-011.pdf

(e) Chart 2: Proposed future structure:



5. Summary Transition Timeline[14]

(a) 2011/12: Learning and planning for roll-out

- First year of QIPP delivery as part of broader delivery on Operating Framework priorities.
- SHAs to establish PCT cluster arrangements by June 2011.
- High level structure for NHS Commissioning Board and Department of Health set out in Spring 2011.
- NHS Commissioning Board executive appointments completed by October 2011.
- Shadow national arrangements progressively implemented for the NHS Commissioning Board, new Monitor, Public Health England, Health Education England and the Provider Development Authority.
- Sharing lessons from first wave adopters of consortia pathfinder and early implementer systems of health and wellbeing boards.
- More pathfinders and early implementers, including local HealthWatch.
- Plans drawn up for consortia, involving all GP practices.
- Emerging consortia to lead the process of securing staff, including PCT staff being made available.

[14] Taken from Dear Colleague Letter from Sir David Nicholson, NHS Chief Executive, *Equity and Excellence: Liberating the NHS – Managing the Transition*, 17 February 2011, p.12-13, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124479.pdf

- Plans to be drawn up for health and wellbeing boards.
- NHS trusts to apply for foundation trust status, or be planning application in 2012/13.

(b) 2012/13: Full preparatory year

- Second year of QIPP delivery.
- From April 2012, NHS Commissioning Board and new Monitor come into effect, SHAs are abolished, PCT clusters become accountable to the Board, and the Department will have made substantial progress on its change programme and established Public Health England. The Provider Development Authority oversees NHS Trusts.
- More learning from GP pathfinders and health and wellbeing board early implementers.
- Authorisation process of comprehensive system of consortia begins, with all practices as members, acting under delegated arrangements with PCTs.
- Health and wellbeing boards are in place.
- Comprehensive local HealthWatch arrangements in place.
- From April 2012, local authorities to fund local HealthWatch to deliver most of their new functions.
- Consortia notified of 2013/14 allocations.
- By the end of the year, a significant number of NHS trusts have achieved foundation trust status.

(c) 2013/14: First full year of the new system

- Third year of QIPP delivery.
- April 2013, PCTs abolished and all consortia assume new statutory responsibilities.
- April 2013, health and well being boards assume their statutory responsibilities.
- April 2013, Monitor’s licensing regime is fully operational.
- April 2013, local authorities to have responsibility for commissioning NHS complaints advocacy.
- By March 2014, the firm aim is that all NHS trusts have become foundation trusts. NHS trust legislation is repealed, and the Provider Development Authority ceases to exist.