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

To: Health Overview and Scrutiny Committee, 19 April 2011

Subject: NHS Financial Sustainability. Part 2: Acute Sector.

---

1. Introduction

(a) The previous Background Note on NHS Financial Sustainability provided an overview of NHS Finances. The focus then was on Primary Care Trusts (PCTs) who are responsible for around 80% of NHS funding. Budgets are allocated to individual PCTs using a weighted capitation formula. PCTs use this money to commission services to meet the health needs of their populations. For reference, a selection of information around PCT allocations for 2011/12 in Kent and Medway is contained in Section 4.

(b) The focus of this Note is on the acute sector. There are four acute hospital Trusts based in Kent and Medway providing secondary care and hospital based healthcare services. They also provide a range of tertiary services (more specialised care) as well as services in the community. These are:

1. Dartford and Gravesham NHS Trust

2. East Kent Hospitals NHS University Foundation Trust

3. Maidstone and Tunbridge Wells NHS Trust

4. Medway NHS Foundation Trust

(c) Under the current proposals as set out in the NHS White Paper and Health and Social Care Bill, all NHS Trusts are to become Foundation Trusts (or part of an FT) by 1 April 2014 and NHS Trust legislation would be repealed (meaning non-FT NHS Trusts will not exist). Monitor currently regulates FTs but under the proposals it would become the economic regulator for the health sector. 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.

(d) As things are now, there are a number of differences between NHS Trust and NHS Foundation Trust (FT) status. One of the areas of difference is around financial duties:

1. NHS Trusts have a duty to break even, meaning that their expenditure must not exceed their income, taking one financial

year with another. Spending on capital and cash held must be within certain limits.

2. FTs are not statutorily required to break even, but must achieve the financial position set out in their financial plan. One main measure of an FT's financial performance is EBITDA (earnings before interest, tax, depreciation and amortisation)[1].

2. NHS Finances – Acute Sector

(a) The majority of the income received by NHS Trusts and FTs comes from the commissioning process with PCTs and other NHS Trusts[2]. A little over 50% of acute trust income comes from the Payment by Results (PbR) tariff, which equates to around a third of PCT budgets. Providers also receive income from locally agreed payments which do not come within the scope of PbR. Some hospitals receive funding for education and training and/or research and development[3].

(b) PbR was introduced in 2003/04 and was designed to link the payments made to healthcare providers (NHS Trusts, FTs and the independent sector) with the activity undertaken by them. It currently covers the majority of acute inpatient and outpatient care as well as accident and emergency. For example, the tariff is £59 for a minor A&E attendance and £8,226 for a coronary artery bypass graft[4].

(c) A distinction is made between currencies and tariffs in NHS finances. A currency is the unit of healthcare for which a payment is made and the tariff is the price paid for that unit of healthcare.

(d) The tariff prices are largely based on the reported average cost of services. In 2010/11, best practice tariffs determined by best clinical practice rather than average cost was introduced for a small number of area and these are likely to expand significantly in the future.

(e) Unbundling a tariff refers to occasions when the individual service elements of a care pathway is separated out so that it is possible to commission them separately.

(f) The tariff may be adjusted for long/short stays, specialised services or for supporting particular policy goals. Taking this into account, the tariff received by a provider is multiplied by the market forces factor (MFF).

---

[1] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

[2] Ibid., p.15.

[3] Department of Health, *A simple guide to Payment by Results*, September 2010, p.63, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119985

[4] Ibid., p.8.

This is nationally determined and unique to each provider. This is used to reflect the fact that providing services in some areas of the country is more expensive than in others due to staff costs, land and so on.

(g) PbR income can thus be set out as: activity x price x MFF[5].

(h) There are two versions of the MFF index. The first is the underlying index used in the weighted capitation formula and the second is the payment index used in PbR.

Table 1: Market Forces Factor[6]

Trust	**Market Forces Factor Payment Index Value for 2010/11**
Dartford And Gravesham NHS Trust	1.149808
East Kent Hospitals University NHS Foundation Trust	1.052939
Maidstone And Tunbridge Wells NHS Trust	1.111648
Medway NHS Foundation Trust	1.102137

(i) NHS standard contracts are used by commissioners when contracting healthcare services. The contract includes activity plans. If there is a difference between the value of the activity and the planned contract value, this may result in an additional payment being made by the commissioner to the provider, or a refund from the provider to the commissioner[7].

(j) The Commissioning for Quality and Innovation (CQUIN) payment framework is a national framework within which local quality improvement goals can be agreed between commissioner and provider. A proportion of provider income is made conditional on achieving the goals of the CQUIN scheme. In 2011/12 the full CQUIN payment value is 1.5% of the Actual Outturn Value of the provider contract[8].

---

[5] Ibid. p.14.
[6] Information for Table 1 taken from: Department of Health, *2010-11 tariff information spreadsheet*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_115898.xls#'13. MFF Index Values'!A1
[7] Department of Health, *A simple guide to Payment by Results*, September 2010, p.15, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119985
[8] Department of Health, *Using the Commissioning for Quality and Innovation (CQUIN) payment framework – A summary guide*, 20 December 2010, p.6, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123008.pdf

(k) The private finance initiative (PFI) is a way of funding major capital investments in the NHS. Contracts with the private consortia that design and build hospitals (for example) typically last for 30 years. The NHS Trust or FT leases the building during this time. PFI scheme assets and liabilities are generally included in the Statement of Financial Position of both NHS Trusts and FTs[9].

(l) There are two PFI schemes related to Acute Trusts in Kent - Dartford and Gravesham NHS Trust and Maidstone and Tunbridge Wells NHS Trust[10].

(m) Under the proposals contained in the NHS White Paper, *Equity and Excellence: Liberating the NHS*[11], and the Health and Social Care Bill[12] currently progressing through Parliament, the majority of health services will be commissioned by GPs and their practice teams through consortia. This will include the majority of services in the acute sector.

(n) Under the same proposals, some acute sector services will be commissioned by the NHS Commissioning Board as it will be responsible for commissioning a number of specialised services currently commissioning regionally or nationally. The NHS Commissioning Board will also commission primary care services such as community pharmacy, ophthalmology, dentistry along with primary medical services provided by GPs.

3. Any Willing/Qualified Provider

(a) The areas covered by patient choice, and the Any Willing Provider model (AWP), will be gradually extended in the future. The 2011/12 Operating Framework made clear that AWP will be introduced for community services during 2011/12.[13]

(b) On 30 March 2011, the Department of Health published further details on provision in *Making Quality Your Business. A guide to the right to provide*[14]. This document shifted to discussing patient choice of Any

---

[9] Audit Commission and Healthcare Financial Management Association, *NHS Trust accounts A guide for non-executives* and *NHS foundation trust accounts A guide for non-executives*, 2010, http://www.audit-commission.gov.uk/health/audit/financialmgmt/nhsaccountsguidesfornonexecutives/pages/default.aspx

[10] Department of Health, *New hospital schemes*, November 2010, http://www.dh.gov.uk/en/Managingyourorganisation/NHSprocurement/Publicprivatepartnership/Privatefinanceinitiative/Newhospitalschemes/index.htm

[11] http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

[12] http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

[13] 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

[14] Department of Health, 30 March 2011, *Making Quality Your Business. A guide to the right to provide*,

Qualified Provider (AQP). It provides the following outline of how AQP will work in the future:

1. "Patients choose any provider who meets NHS standards and prices. Money follows them and the choices they make about where and by whom to be treated."

2. "To qualify as an AQP, providers will be subject to a qualification process. They will be required to show that they can meet the conditions of their licence with CQC and/or Monitor (if necessary), provide safe quality services to the contractual standards set by the NHS Commissioning Board and meet NHS prices – either set nationally or locally."[15]

(c) This same document also provided information on the development of staff-led enterprises through right to provide (R2P).

1. "At the widest level, the right to provide is for all staff working within health and social care. Depending on where you work, the process you go through will differ."[16]

4. 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'[17].

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

1. Average growth in PCT recurrent allocations of 2.2%.

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.

3. 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.

---

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125578

[15] Ibid., p.32.

[16] Ibid., p.8.

[17] Department of Health, *NHS Operating Framework 2011/12,* 15 December 2010, p.3, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122738

4. No automatic capital allocation for PCTs – any capital funding to be granted on a case-by-case basis.

5. An overall tariff reduction between 2010/11 and 2011/12 of 1.5%.

6. New outpatient attendance tariffs to be introduced. New currencies and tariffs to be developed (and led locally).

7. 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.

8. Where providers and commissioners agree, services can be offered below the tariff price.

9. 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).

10. 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.

11. Developing consortia will receive £2 per head to support this process. Running costs of £25 to £35 per head are expected by 2014/15.

12. 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.

13. 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) QIPP (Quality, Innovation, Productivity and Prevention) is a series of 12 workstreams[18] aimed at making efficiency savings to be reinvested in services. These twelve are divided into three areas, as set out in the following table:

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

Table 2: QIPP Workstreams[19]

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

4. PCT Allocations for 2011/12.

Table 3: PCT Allocations in the South East for 2011/12[20]

PCT	2011/12 Total Revenue Allocation (£000s)	Total Revenue Allocations Per Head (£)
Brighton and Hove City	481,688	1,822
East Sussex Downs and Weald	567,802	1,692
Eastern and Coastal Kent	1,277,363	1,725
Hastings and Rother	333,765	1,900
Medway	435,279	1,601
Surrey	1,683,186	1,523
West Kent	1,027,962	1,499
West Sussex	1,299,123	1,615

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

[20] Extracted from Department of Health, *Exposition Book 2011-12*, (Book A), 8 March 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124949