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Subject: NHS Financial Sustainability. Part 3: Mental Health, Community Health, and Ambulance Services

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1. Introduction

(a) Previous Background Notes on NHS Financial Sustainability have focused on Primary Care Trusts and the Acute Sector.

(b) The focus of this Note is on the financial structure of the ambulance service, community health and mental health sectors. The main NHS providers of these services in Kent are the following:

1. South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

2. Kent and Medway NHS and Social Care Partnership Trust (KMPT).

3. Kent Community Health NHS Trust (KCHT) (established 1 April 2011).

2. NHS Finances - ambulance service, community health and mental health sectors

(a) In the background note on NHS finances in the acute sector, information was provided of the Payment by Results (PbR) tariff which accounted for over half of an Acute Trust's income and a third of PCT budgets[1].

(b) PbR is currently under development for ambulance services, community services and mental health. As PbR is developed for other services, they may not take the same form as it has in the acute sector. They may not, for instance, have both a national currency and a national tariff. 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[2].

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[1] 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

[2] Ibid. pp.58, 61.

(c) Mental health has been identified as the main priority for the expansion of PbR, initially with a national currency and local prices[3].

(d) A national mental health currency was published in 2010/11 - the 'care cluster'. It was developed by the NHS in the North East and in Yorkshire and Humber.

1. "The clusters identify patient need over a given period of time, and apply to both admitted patient and community care. They therefore balance the risk between commissioners and providers. Commissioners do not have to pay extra for each contact and intervention. Providers know they will be get paid for each patient they care for and they also have an incentive to innovate and support the patient in the most cost effective setting. "[4]

(e) The NHS Operating Framework 2011/12 mandated "the allocation of service users to mental health care clusters"[5]. Work is being undertaken locally by KMPT and the lead commissioner, NHS Medway, on local tariffs based on these clusters[6].

(f) A number of specialised services where the number of affected patients is relatively small are commissioned either regionally by one of the ten Specialised Commissioning Groups, or nationally by the National Commissioning Groups. In mental health this includes secure services and some personality disorder services[7].

(g) Emergency ambulance services in the area covered by SECAmb are commissioned collaboratively by the relevant PCTs. The South East Coast Specialised Commissioning Group (SECSCG), hosted by NHS West Kent, leads on this[8]. Patient Transport Services (PTS) have historically been commissioned by health service providers, but the commissioning responsibility moved to PCTs in April 2009; PCTs took over PTS funding from hospital Trusts from April 2010[9].

(h) Ambulance services are currently commissioned on a cost and volume basis but the Operating Framework stated the Department of Health

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[3] Ibid., p.44.
[4] Ibid., p.44.
[5] Department of Health, *The Operating Framework for the NHS in England 2011/*12, p.53, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf
[6] Kent and Medway NHS and Social Care Partnership Trust, *2010-11 Annual Report*, pp.40-41, http://www.kmpt.nhs.uk/Downloads/whats-happening/april-2011/tbm270411-att16.pdf
[7] SECSCG, *Specialised Mental Health*, http://www.secscg.nhs.uk/home/specialised-services/specialised-mental-health/?locale=en
[8] SECSCG, *Ambulance Commissioning*, http://www.secscg.nhs.uk/home/tertiary-contracts/ambulance-services/?locale=en
[9] SECAmb, *Integrated Business Plan 2010-2015*, p.18-19, http://www.secamb.nhs.uk/about_us/document_library.aspx?cat=34

will "seek to amend the scope of ambulance service reference cost data collection to underpin currencies for use in 2012/13"[10].

(i) Work is also ongoing in developing currencies and tariffs for community services and move away from block contracts[11]. For example, currency options have been developed for the Healthy Child Programme[12].

(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[13].

3. Any 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.[14]

(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*[15]. This document shifted to discussing choice of Any Qualified Provider (AQP). It provides the following outline of how AQP will work in the future:

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[10] Department of Health, *The Operating Framework for the NHS in England 2011/12*, p.53, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122736.pdf

[11] Department of Health, *A simple guide to Payment by Results*, September 2010, p.45, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119985

[12] Department of Health, *Currency options for the Healthy Child Programme,* http://www.dh.gov.uk/en/Healthcare/TCS/Currencyandpricingoptionsforcommunityservices/index.htm

[13] 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

[14] Department of Health, *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

[15] Department of Health, 30 March 2011, *Making Quality Your Business. A guide to the right to provide*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125578

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."[16]

(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."[17]

4. Foundation Trust Status

(a) There are a number of differences between NHS Trust and NHS Foundation Trust (FT) status. Under the current proposals as set out in the NHS White Paper[18] and Health and Social Care Bill[19] (in its current form), 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.

(b) One 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)[20].

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[16] Ibid., p.32.
[17] Ibid., p.8.
[18] Department of Health, http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm
[19] Parliament, http://services.parliament.uk/bills/2010-11/healthandsocialcare.html
[20] Academy of Medical Royal Colleges and Audit Commission, *A Guide to Finance for Hospital Doctors*, July 2009, p.23, http://www.audit-

5. 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'[21].

(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.

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).

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commission.gov.uk/health/audit/financialmgmt/hospitaldoctors/Pages/hospitaldoctors9jul2009.aspx

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

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[22] aimed at making efficiency savings to be reinvested in services. These twelve are divided into three areas, as set out below:

Table 2: QIPP Workstreams[23]

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

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

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