Financing the Health Economy

Kent County Councils'
NHS Overview and Scrutiny Committee

Chairman: Mr Alan Chell

December 2005

CONTENTS

Executive Summary

Kent County Council NHS Overview and Scrutiny Committee began its review of the Kent and Medway Health Economy in 2002, because it believes that good financial management is essential for efficient local health services for Kent residents. Each year there have been further developments in a complex financial and managerial environment. The new Kent and Medway health organisations began the financial year 2002/3 with £15m debt between them[1]. Since then they have worked hard to meet new targets, keep in financial balance, and repay debts. In recently released national financial projections for the financial year 2005/6, Kent and Medway compared well against other areas.[2]

This review looks towards a period where there will be greater challenges and potentially greater financial turbulence since NHS OSC began. Nationally as well as locally health organisations are moving towards new ways of working which we are told will lead to better health care. Certainly there has been unprecedented investment in health funding over a few years. Yet nationally, health organisations are showing larger deficits – how does this occur and what do health managers need to help them manage their budgets?

The journey towards Payments by Results has been a long one and will not be complete until 2008.

Patient Choice at the point of GP referral does not begin until 1 January 2006. NHS OSC found, as always, health service managers working tremendously hard yet faced with further challenges. The number of new strategies, all with management needs, and the short time scale, means that meeting target savings will be a struggle. The reconfiguration of the health organisations is expected to bring benefits, but health care will only suffer if the local focus and experience gained in good budget management established since 2002 is lost by the requirement to reduce administrative costs.

[1] KCC NHS OSC Interim report – Autumn 2002
[2] DoH In year financial forecasts 2 December 2005.

1. INTRODUCTION

1.1 Overview and Scrutiny of the NHS

The Health and Social Care Act 2001 makes statutory provision for local authorities with social services responsibilities to extend their Scrutiny and Overview functions to cover Health. Kent County Council's National Health Service Overview and Scrutiny Committee became a legal entity when the local authority Overview and Scrutiny Committee's Health Scrutiny Functions Regulations 2003 were implemented on 1 January 2003. The Department of Health's guidance for the Scrutiny of the National Health Service has been followed when undertaking this review.

1.2 Select Committee Report Up-date

This annual up-date is part of a series begun in 2002, to assess the likely results of the current financial year in the light of the past year's results. An interim report was produced in December 2002. A full Select Committee report followed in the autumn of 2003, making 19 recommendations.[3] In 2004 the full NHS OSC, under the continued Chairmanship of Dr T R Robinson, interviewed witnesses and produced a short up date report, reiterating the four main recommendation, and shown in Appendix IV. This 2005 report is based on witness sessions which were attended by the full NHS Overview and Scrutiny Committee, including representatives from the Public and Patient Involvement Forums.

The Terms of Reference for the original topic review were:-

> *"To investigate and identify any improvements to the financing of the Health Economy in Kent and its impact on Health, Social Care and Community including clarifying the following: -*
>
> *(a) the current position with regard to financing the Health Economy in Kent;*
>
> *(b) the demographic and cost issues for the South East of England; and*
>
> *(c) the financial flows and the transactional costs".*

1.3 This report focuses on:-

- Events in the Kent and Medway health economy since November 2004.
- The health organisations' view of the likely outcome of financial year 2005-6 and beyond.
- The future for the Kent and Medway health economy and the challenges which it faces.

Details of the witnesses seen are shown in Appendix 1. Summarised transcripts of the witness sessions are available on request in a separate volume. As always, the

[3] Appendix IV shows the outcomes of these recommendations.

NHS OSC is very grateful for the time spent by witnesses from all the health organisations who have spent time preparing answers and attending meetings.

2. Strategic Context

2.1 Worsening National Picture for the National Health Service

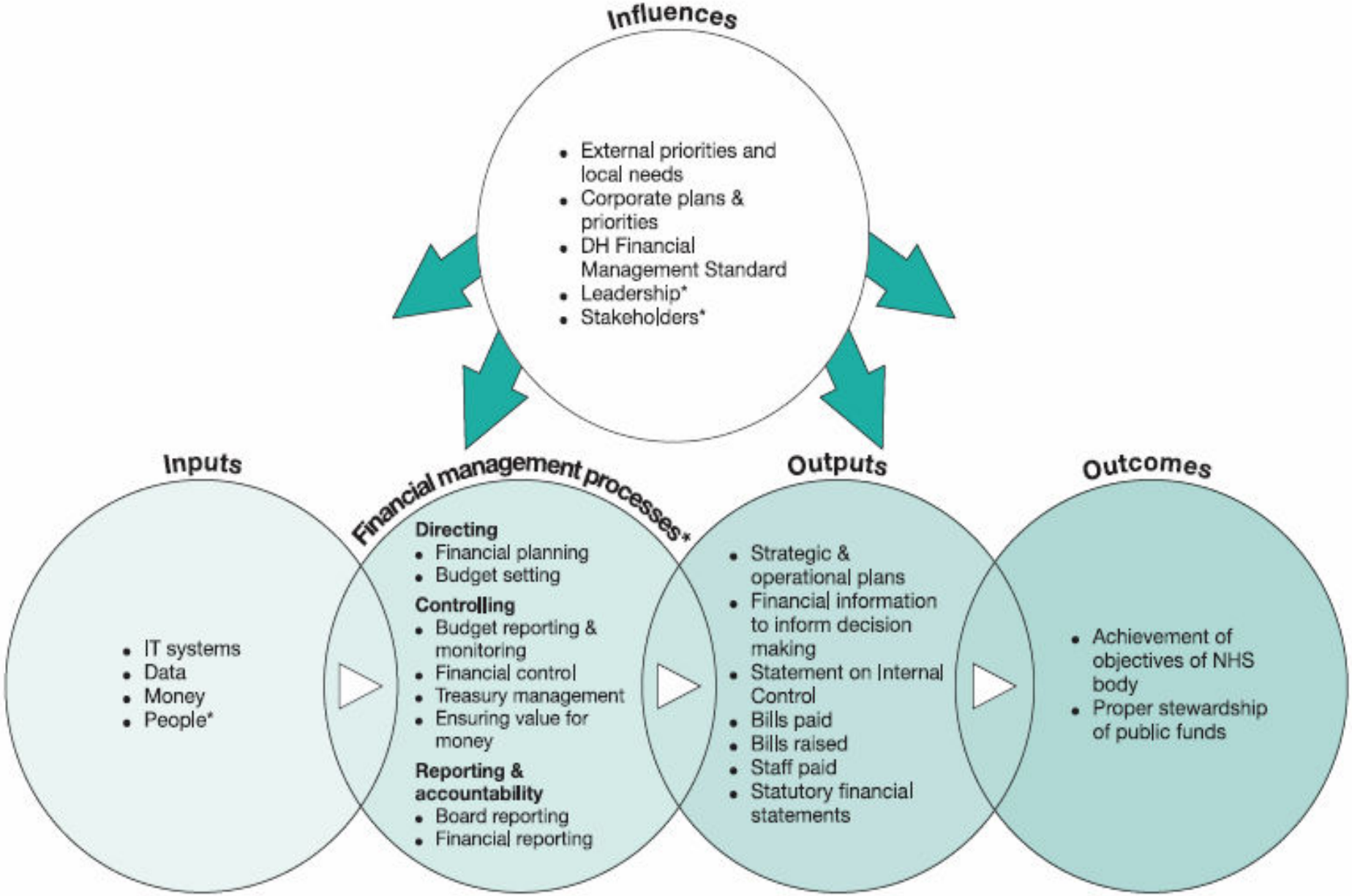
2.1.1 Kent and Medway health economy ended the financial year 2004/5 with a small deficit of £2.2m on its £1.8bn resource allocation (0.12%). Although the final summarised accounts of the NHS will not be published until June 2006, for the first time in five years the NHS showed a small deficit overall, now confirmed at £219m[4]. While in 2002/3 six[5] strategic health authority areas (out of 28) reported an aggregate overspend, this rose to seven in 2003/4, and twelve in 2004/5.[6]

Kent and Medway SHA area was one of these in each year, albeit with a deficit which has shrunk each year. By June 24 2005, when the 2003/4 summarised accounts were published, auditors were already expressing concern about the financial standing of 32% of NHS bodies in 2004/5.

2.1.2 At the end of 2003/4, Kent and Medway Strategic Health Authority were removed from the Department of Health's list of Strategic Health Authorities of concern; a recognition of both the improvement in services and the ability to live within budget. It has been further recognised by the Department of Health as being 'high performing' in financial year 2004/5 The Kent health organisations had made substantial savings and improved the efficiency of their services. They were assessed as a 'good performing' SHA with demonstrable improvement on the previous year's performance. Although Kent and Medway health economy has thus bucked national trends, the worsening national picture will mean that the area can expect no special treatment or funds to help financial balance in 2005/6.

2.1.3 The worsening financial situation, and the challenges lying ahead, explained further in this section, have led to the National Audit office producing its book: 'Achieving first-class financial management in the NHS' [7] including this diagrammatic representation of the financial management process which demonstrates the complexity of the health economy:

[4] Department of Health 1 Dec 2005
[5] National Audit office press notice 25/6/2005
[6] The others were: South West Peninsula, Avon, Gloucs & Wilts., Hampshire and IOW, Surrey Sussex, NW London, Norfolk, Suffolk and Cambridgeshire
[7] Audit Commission, April 2004



Note: ** Denotes a dimension in the CIPFA model (paras 7-10).*

Source: *Audit Commission*

Aware of the challenges ahead, the Audit Commission has determined to support health organisations in their financial management:-

> *'Financial management arrangements in the NHS need to improve to ensure that the benefits of current and extra funding are realised fully in improved service delivery'*[8]

2.1.4 The worsening financial situation has recently been featured more extensively in media coverage. The in-year financial forecasts for each NHS Trust, Primary Care Trust (PCT) and Strategic Health Authority (SHA) were published on 1 December 2005. These un-audited figures show that half way through the financial year NHS bodies are forecasting a net deficit by year-end of around £620 million. The Department of Health has set a target to the Health Organisations that the overall deficit for 2005/6 should be reduced to £200m. There have been a record number of public interest reports[9] issued by the Audit Commission. More are expected, including one for Maidstone and Tunbridge Wells NHS Trust. The Audit Commission will issue a report early in 2006 which sets out the lessons to NHS bodies of the lessons to be learned from these failures and the steps that should be taken to prevent financial failure.

The most rigorous challenge will be the greatly extended range of the Payment by Results system from April 2006[10].

2.2 Payments by Results:-

> *'Payment by results is the single biggest change to the NHS financial regime in recent years'.*[11]

2.2.1 'Payments by Results' is the name for the system that introduces a national tariff or price for each medical procedure. Providers, mostly Acute Hospital Trusts, are paid for the volume and type of work that they do. It aims to stimulate activity, reduce waiting lists, reward efficiency and facilitate patient choice and plurality of provision by allowing the 'money to follow the patient'; It replaces the previous system of block contracts and locally agreed prices where providers were paid a set amount regardless of the work they carried out, based on the amounts paid in previous years adjusted for pay and prices increases and population changes.

2.2.2 About 15% of medical procedures, or Healthcare Resource Groups, (HRGs) became chargeable by a standard tariff multiplied by volume from 1 April 2004. The remaining elective[12] procedures joined the system from 1 April 2005.

---

[8] Audit Commission, April 2004

[9] Section 8 of the Audit Commission Act 1998 requires the appointed auditor to consider whether to issue a report in the public interest on any significant matter during an audit, and to bring it to the attention of the audited body and the public. For health bodies, Section 10 of the Act requires the auditor to send a copy of the report to the Secretary of State, and the health body must consider its contents as soon as practicable in a meeting open to the public.

[10] It will be extended to include diagnostic, non-elective, and critical care in the acute sector.

[11] Audit Commission, Improving Financial Management in the NHS

[12] Elective procedure – subject to the choice or decision of the patient or physician, applied to procedures that are advantageous to the patient but not urgent.

Non-elective and outpatient care has been deferred to 2006/7, except for Foundation Trusts, where the system was introduced fully from 1 April 2005. Foundation Trusts introduced the system a year earlier than the rest of the NHS. Thus the NHS is in a transitional phase, with Payments by Results partly in place. So far there is a notional date of 2008-9 for Mental Health Trusts to adopt payment by results for mental health treatment, but there is as yet no international model for workable tariffs for complex long-term conditions such as depression or bi-polar disorder.[13]

2.2.3 The national tariffs for procedures are calculated on the average cost across England. Thus if a health organisation can, overall, provide medical procedures at less than the average cost, they will gain financially. Conversely, if procedures cost more, providers will need to spend more than they receive in income. Tariffs are up-dated each financial year to reflect pay and prices increases, abated by expected efficiency improvements. It is not clear how accurate this up-date will be in reflecting actual extra costs. Health organisations also receive a top-up reflecting the market forces factor, reflecting geographic variations. The market forces factor does not appear to reflect the extra costs health organisations must bear in the expensive South East of England. High property prices make working in the health service less attractive for workers subject to national salary scales so recruiting staff is more difficult.

2.2.4 The new framework aims to reward hospitals fairly for the work that they do, so they receive additional income if activity increases but will suffer losses if fewer patients are treated. There are powerful incentives for Trusts to keep activity up and to increase both volume and complexity of cases. On the other hand, Primary Care Trusts have very strong financial incentives to manage carefully the demand for health services, providing appropriate care more cheaply in the community and reducing the number of patients who need to be admitted to secondary care in acute hospitals.

2.2.5 The Audit Commission found in its report: 'Early Lessons from Payments by Results'[14] that the early implementers of the systems were on balance, positive about the change, although it predicted that it would cause financial tension and potential instability. Early implementers of Payments by results have found that the relationship between the Primary Care Trusts and Foundation Trusts have been tested, even in areas where this was historically good. Some ended in formal disputes which needed independent arbitration in 2004/5. They found that good partnerships could be maintained through:-

- Building trust and maintaining transparency through data sharing.

- Agreeing a common view of the health economy's needs including its financial position and how demand should be managed to deliver a common realistic set of expectations. This might be an area where NHS OSC could help, although it remains unclear how this could be implemented.

- Reaching a common understanding of the main clinical pathways so that there are no surprises through unexpected changes in clinical practice and patient pathways.

[13] King's fund briefing on Payments by results 1/4/05
[14] Audit Commission, October 2005

- Avoiding over reliance on the contract but learning to have constructive dialogue which may become healthily heated at times.

- Ensuring relationships are strong by agreeing them at the most senior level, working to agreed processes and committing to partnership working with a community focus which is enshrined in the contract.

A key message from the early implementers of payments by results is that it has been time consuming and costly to implement, with additional, significant burdens on senior management.

2.2.6 There has been agreement across the monitoring bodies that PCT commissioning needs strengthening to be able to supply the increased sophistication that payments by results demands. The Audit commission believes that the reconfiguration of PCTs is necessary to result in fewer, larger and stronger commissioning bodies. Their view is shared by the Department of Health, which has announced a swift and radical reconfiguration programme to be implemented by October 2006. However, reconfiguration of health organisations in itself presents its own challenges.

2.3 Reconfiguration

2.3.1 On 17 March 2005, the Department of Health published 'Creating a Patient-led NHS – Delivering the NHS improvement plan' with the aim of creating an NHS which has the capacity and capability to move on from being an organisation which merely delivers services to people to being one which is totally patient led by responding to their needs and wishes. This would be achieved by:-

- Giving incentives to NHS Hospital Trusts by developing them into Foundation Trusts.

- Supporting PCTs in their development in a similar programme.

- Developing payments by results to provide appropriate financial incentives for all services.

- Utilising fully new human resources and IT programmes.

The Department of Health would support the organisations, at the same time by:-

- Strengthening the role of the NHS Bank - it has not been revealed how this will happen.

- Improving the way the NHS handles service and organisational failures.

- Improving the way that service change and reconfiguration is managed.

This report accepted that the supreme challenge was to consolidate a financially health and stable position in the years up to 2008 which is the last year of the current funding agreement. The end of the 2004/5 financial year revealed just how potentially turbulent introducing Payments by Results will be.

2.3.2 By 28 July 2005, Nigel Crisp, the Chief Executive of the NHS, wrote to all Chief Executives of NHS Organisations and other stakeholders[15] to introduce 'the optimal configuration of PCTs and Strategic Health Authorities' alongside the reconfiguration of ambulance services, to be implemented by December 2006. Central to this reconfiguration is the requirement to make substantial savings in administration costs:-

> *'Improvements in commissioning, the determination to make progress on working with local authorities on Choosing health, and the commitment to make £250m of savings in overhead costs, require NHS organisations to change and develop'.* [16]

2.3.3 Primary Care Trusts were introduced as part of the NHS Plan to give a local focus to commissioning and to improve the efficiency of local health services. These reasons, if they were valid in 2002, must be still valid now.

The £250m administrative savings target will be allocated from 2008/9 and will be distributed to Strategic Health Authorities on a 'fair shares weighted capitation' basis. Redundancy costs will be financed from the in-year management cost savings in 2005/6, 2006/7, and 2007/8 so that the full saving is available from 2008/9. SHAs will be required to provide an audit trail from the 2005/6 costs to the target savings from 1 April 2008.[17]

Kent and Medway's contribution to these savings will be **£8.5m**. SHAs will determine how each local target will be met from the proposed organisational reconfiguration. A project board has been set up under the title 'Fitness for Purpose' Commissioning a Patient-led NHS[18], with a full time project team led by Darren Grayson (Seconded from CEO of East Kent Coastal PCT). The Department of Health has announced that Public consultation will begin on 14 December 2005 and last until February 2006.

2.3.4 The Strategic Health Authority's preferred recommendation, based on the initial discussion phase, is for:-

- Three Primary Care Trusts:-
    - One, covering the predominantly East Kent District Council areas of Dover, Thanet, Canterbury and Swale.
    - One covering the rest of Kent including Ashford, Maidstone, Tonbridge and Malling, Sevenoaks, Dartford and Gravesham District Council areas.
    - Medway including Medway Unitary Authority.
- A Strategic Health Authority covering Kent, Medway, Surrey and Sussex.

---

[15] Chief executives of Local authorities, Directors of social Services, Primary Care Trust Professional Executive Committee (PEC) chairs
[16] Sir Nigel Crisp, 28 July 2005
[17] Letter from Deputy Director of Finance, DoH, to Directors of Finance SHAs, 3 October 2005.
[18] Recommendations from Kent and Medway Strategic Health Authority – Kent and Medway SHA 13th October 2005

2.3.5 KCC has responded to the proposals with its view that there should be:-

- One Primary Care Trust for the whole of Kent County Council Area.
- One for Medway co-terminus with the Medway Unitary Authority.

At the same time Kent Ambulance Trust are proposing a merger with Surrey and Sussex Ambulance Trusts.

East Kent NHS Social Care and Partnership Trust and West Kent NHS and Social Care Trust, the two Mental Health Trusts, will merge from 1 April 2006.

Recommendation for the Strategic Health Authority and Primary Care Trusts:-

1. The Strategic Health Authority and Primary Care Trusts must show how the £8.5m saved during reconfiguration is redirected to front line services.

The NHS OSC will monitor this.

This recommendation up-dates Nos. 2 and 4 of previous NHS OSC reports - to monitor the realism of savings plans and their implementation whilst maintaining high quality care and access targets, and keep a tight control on budget management in view of this high level of savings.[19]

Apart from administrative savings, the reconfiguration of PCTs has been claimed as a facilitator for patient choice, as PCTs will be larger, and thus more capable of sophisticated commissioning with a variety of health care providers. What is Patient choice, when does it begin, and how will it affect Doctors in General Practice?

2.4 Patient Choice and Practice Based Commissioning

2.4.1 From 1 January 2006, patients should be able to book the date and time of their referral to hospital, and to choose where they would like to go, from a selection of four or five healthcare providers. Information including data on hospitals' star ratings and waiting times will be available to help patients make that choice, in consultation with their GP. This has been brought about by an electronic booking system called 'Choose and Book'. In Kent and Medway there are varying degrees of readiness for the December 2005 deadline, because of delays with the different parts of the complex Information Technology connections.

2.4.2 The Strategic Health Authority were able to report on 6 November 2005 that the following numbers of bookings had been made across the County:-

[19] Appendix IV

PCT	No of Practices	Bookings
Ashford	8	115
Shepway	12	190
Canterbury and Coastal	9	105
East Kent Coastal	8	19
Medway	5	0
Swale	2	0
Maidstone Weald	2	6
South West Kent	3	0
Dartford, Gravesham and Swanley	0	0
Total	**49**	**435**

There had been 26,830 bookings made nationally by this date. It can be seen that this system has some way to go before it is universal.

2.4.3 Close on the heels of patient choice, is the introduction of Practice Based Commissioning (PbC). From April 2005, there have been notional budgets at GP level and GPs will have been able to have financial information about the cost of their referral decisions. The PbC National Timetable has been brought forward with the expectation that Primary Care Trusts will have 100% coverage by the end of 2006. 2005/6 has been used by most PCTs as a preparatory year. One project is scarcely implemented before another must begin and this must be undertaken at the same time as a radical reconfiguration is beginning.

2.5 Other Changes Implemented

2.5.1 During 2004/5, changes in staff pay and conditions have become fully implemented and these can be summarised as:-

1. The **European Working Time Directive**. This applied a 56-hour week for Junior Doctors and came into force in August 2004.

2. The **General Medical Services Contract**. (New GPs' contract) came into force on 1 April 2004. General Practitioners were able to opt out of providing out of hours' services for their patients. Alternative 'Out Of Hours' services were in place by September 2004 and their full financial effect is being felt in year 2005/6.

3. The **new consultants' contract**. This became effective from 1 October 2003 for those consultants who formally opted to transfer on to it. Its financial effects are now fully embedded into budgets.

4. **Agenda for change**. This brought a career structure to NHS workers and began to be implemented from 1 October 2004. For some organisations this is the first full year of its financial implications.

2.5.2. **Working with KCC Adult Services**. At the same time, relationships between Health organisations and Kent County Council Adult Services are closer than ever before.

The **Innovation Forum** project concentrates on offering alternatives to admission to hospital, which provides better health outcomes for frail elderly people. KCC and the Strategic Health Authority have signed an agreement to work together on Public Health, with the establishment of a new Public Health Directorate at KCC.

One of the most contentious issues has been the **funding of continuing, or long term care**. Local authorities fund social or personal care, and have the ability to charge clients according to means. The NHS funds nursing care, which is free. However, in the light of the landmark 1999 Coughlan judgement, Health authorities were found to have applied inconsistent criteria to decide whether people were eligible for NHS funding for care in nursing homes. The effect was that patients had to pay for their own care when the NHS should have paid for it. Following a report from the NHS Ombudsman on continuing care in 2003, the Department of Health requested all SHAs to:-

- establish a set of eligibility criteria for NHS continuing health care to operate across their area
- review cases retrospectively and
- complete the review process within time scales.

Although there was £180m allocated to pay for the reimbursement of claimants, there was no contribution towards the administrative costs of these reviews, which was a further burden for SHAs and PCTs to manage and fund.

The NHS Ombudsman's follow up report in December 2004 found that there had been improvement in retrospective reviews, and that there had been some improvements to frameworks for assessing eligibility since her 2003 report. These welcome developments still fell short of the guidance and support required, and the Ombudsman recommended that further improvements would result from the establishment of a **national framework** for continuing care and its application. [20]

In 2004 the Health Minister announced the development of a national framework for continuing care. This aims to improve the consistency and quality of the assessment process and make it easier to understand and operate. Work on this difficult area continues.

A Health Select Committee report on continuing care recommended an abolition of the distinction between personal and nursing care, but this has been rejected on grounds of the huge costs it would generate.

While Adult Services and the NHS are working closer together, the demands of the bureaucratic structure of the Health service, local government and the inspection framework are preventing the further development of shared budgets.

[20] NHS Funding for long term care: Follow up report - NHS Ombudsman Dec 2004.

The Strategic Context is more complex than ever, and means that at the same time that health organisations are introducing new ways of commissioning and charging they are also expected to reconfigure their management and make considerable administrative savings.

How successful are the Kent and Medway health organisations and how prepared are they for these challenges?

3. Results of Financial Year 2004/5

3.1.1 Kent and Medway health economy ended the financial year 2004/5 with a deficit of £2.2m, compared with total income of £1.8bn - 0.12%. Achieving break even so exactly that income matches expenditure has been described by the Strategic Health Authority graphically as:-

'Landing a jumbo jet on a postage stamp'[21]

An analysis of the four Health Economies is shown on figure (1), together with a comparison with the previous two years. There has been marked improvement over the last three years.

However, there were several worrying developments.

3.1.2 Dartford and Gravesham Health Economy

Once again, the PCT and the NHS Hospital Trust struggled to get the balance right between activity and income. They have the combination of a high performing provider – Darent Valley Hospital – and a commissioner beset by rising demand. In 2004/5 for the first time, both Dartford, Gravesham and Swanley PCT and Dartford and Gravesham NHS Trust both were in deficit, although a smaller overall amount than in previous years, with an overall deficit of £2.2m, reduced from £5.5m.

3.1.3 Canterbury Coastal PCT

Canterbury and Coastal PCT posted a deficit of £2.276m, the first in the PCTs existence. Without support this would have been £4.561m

The main reasons for this overspend are stated as:-

- Increases in the number and cost of Placements for people with learning disabilities, mental health problems and continuing care requirements.
- The costs of implementing the new GMS contract in General Practice, including the Out of Hours service and the Quality and Outcomes Framework.
- Referrals to specialist centres and tertiary providers.

[21] Bob Alexander 11th November 2005

The PCTs financial recovery plan identified that the previous risk sharing and block contract arrangements in place in East Kent were a contributory factor to the overspend. In line with Payment by Results the PCT has therefore moved to cost per case contracts which will reduce the amount the PCT pays providers for relevant services

3.1.4 Swale PCT

Although Swale PCT ended 2004/5 with a relatively small overspend of £449k, there remained underlying deficit problems. The year-end deficit projection for 2005-6 has increased to £3.8m[22].

3.1.5 Maidstone Weald PCT

The largest single overspend in the County was Maidstone Weald PCT, with a final outturn figure of £3.715m deficit. The PCT was required to repay £2.4m support to the Strategic Health Authority, which it had received in 2003/04 and in addition itself provided a similar level of support to local health economy partners – i.e. Maidstone and Tunbridge Wells NHS Trust. Although these commitments were supported by a financial recovery plan, during the year the PCT faced significant overspends on:-

- Specialist and tertiary activity.
- Private sector placements in the areas of mental health, learning disabilities and children's services.

The detail of the overspends were not considered by the Committee. The overspend will be deducted from the PCT's resource allocation in 2005/06.

3.1.6 Conclusion – Financial Year 2004/5

There is no doubt this was the most difficult year so far for Primary Care Trusts. In 2004/5, NHS OSC reported that one of the most striking achievements of the Strategic Health Authority was to establish the four Kent and Medway health economies and for them to be viewed as thriving entities, comprising both commissioners and providers in each - NHS Hospital Trusts, Primary Care Trusts and Mental Health Trusts, each economy mutually supportive. Challenges are now being faced as PCTs and NHS Trusts move from one funding regime to another. NHS Hospital Trusts, with performance targets to meet, are able to treat patients at a faster rate that the commissioners can fund. NHS Hospital Trusts are moving into a new era where they will be expected to become Foundation Trusts, and as such will be run on a footing much more like a FTSE 100 business. Primary Care Trusts, on the other hand, are now moving from the era where they were able to plan how much they were paying for secondary care because their commitments were based on the previous year's contract. These changes, although not complete, have meant that three out of eight ended the financial year with a deficit. However, some organisations have never been in deficit and future reviews will focus on more specific issues of concern for both the Health organisations and Kent County Council services.

Current challenges for PCTs are reviewed in chapter five.

[22] SHA Board papers 16 November 2005

Figure 1

Kent Health Organisations – Summary of Financial Years 2002/3, 3/4, 4/5

The four Kent health economies	**Surplus/ deficit 2002/3**	**Under+/ over-spend 2003/4**	**Star rating 2003/4**	**Under+/ over-spend 2004/5**	**Star rating 2004/5**	**Notes extracted from Annual reports and Accounts**
	£'000s	£'000s	£'000s	**£'000s**	£'000s	
Dartford and Gravesham						
Dartford and Gravesham NHS Trust	**-2,710**	**61**	***	**-1,146**	***	Deficit caused by Agenda for Change, consultants' contract and Working Time Directive
Dartford Gravesham and Swanley PCT	**-1,189**	**-5,592**	*	**-1,122**	**	Planned support of £5.4m received from SHA. Deficit caused by higher activity in Darent Valley and London Hospitals, Quality and Outcomes framework + prescribing
Total for the health economy	**-3,899**	**-5,507**		**-2,268**		
East Kent						
East Kent NHS Hospitals Trust	**-11,371**	65	**	**453**	**	Financial support of £1.2m received to produce small surplus this year - £9.9m to be repaid by 31/3/2007
Ashford PCT	**51**	104	**	**157**	**	No financial problems - able to bring about innovations
Canterbury and Coastal PCT	**18**	18	**	**-2,275**	*	Support from health economy of £2.175m brought deficit down from £4.451m. Caused by cost of placements, GMS contract, and high cost of referrals.
East Kent Coastal NHS Teaching PCT	**19**	**35**	***	**89**	**	Received allocations of £1.2m for National Programme for IT and £690k for Patient Access Computer system which assisted in achieving financial balance.
Shepway PCT	**18**	**139**	**	**410**	**	A year of steady improvement
East Kent NHS and Social Care Partnership Trust	**-310**	**-225**	**	**289**	**	Achieved 4.8% efficiency savings. Redesign of services has helped to meet financial targets - mothballing ward at St. Martins
Kent Ambulance NHS Trust	**57**	**0**	*	**34**	***	From 2004-5 accounts
Total for the health economy	**-11,518**	**136**		**-843**		

Kent Health Organisations – Summary of Financial Years 2002/3, 3/4, 4/5 (cont'd)

The four Kent health economies	**Surplus/ deficit 2002/3**	**Under+/ over-spend 2003/4**	**Star rating 2003/4**	**Under+/ over-spend 2004/5**	**Star rating 2004/5**	**Notes extracted from Annual reports and Accounts**
	£'000s	£'000s	£'000s	**£'000s**	£'000s	
Medway						
Medway NHS Trust		**2,372**	**	**-270**	*	Still retain surplus over three year period
Medway PCT	N/A	**23**	*	**-197**	*	Overspend caused by high secondary referrals and higher pay costs
Swale PCT	**63**	**27**	*	**-449**	*	Financial difficulties shown by need to close wards at Community hospitals.
West Kent NHS and Social Care Trust	**28**	**24**	*	**23**	*	Made 1.7% efficiency savings within year and covered cost pressures in order to break even
Total for the health economy	**63**	**2,422**		**-893**		
South of West Kent						
Maidstone and Tunbridge Wells NHS Trust	**-4040**	**-8,968**	No stars	**126**	*	Included £9.7m non-recurring support from SHA - remains a cumulative deficit of £16.97 to go from balance sheet to be resolved by negotiations with DoH
Maidstone Weald PCT	**491**	**0**	No stars	**-3,715**	*	Required to repay £2.4M support to SHA from 2003/4- paid to MTW NHS Trust + overspends on referrals and placements
South West Kent PCT	**131**	**109**	*	**14**	**	From accounts 2004/5
Total for the health economy	**-3,418**	**-8,859**		**-3,575**		
Strategic Health Authority						
Kent and Medway Strategic Health Authority	**6**	**7,103**		**5,365**		Needed no assistance in 2004/5 from NHS bank
Total for the whole of Kent and Medway	**-18,766**	**-4,705**		**-2,214**		

4. Challenges Ahead for Kent and Medway Hospital Trusts

4.1 Deficits on the Balance Sheet

4.1.1 Public sector accounting has always been difficult for the public to understand. Within NHS accounts, the process of repaying deficits is particularly complicated to demonstrate in the published accounts. Maidstone and Tunbridge Wells NHS Trust say in their 2004/5 annual report and accounts:-

Maidstone and Tunbridge Wells NHS Trust

BREAK-EVEN DUTY

The Trust is required to break-even on Income and Expenditure taking one year with another. This duty is usually measured by assessing performance over a three-year period.

Due to the Trust having a deficit after the third year to March 2004, the Strategic Health Authority agreed to extend the break-even period to five years to March 2006 to give the Trust time to put plans in place to make savings and improve efficiency.

The financial performance of the Trust since its inception is shown as follows:-

	2000/01	**2001/02**	**2002/03**	**2003/04**	**2004/05**
	£000	**£000**	**£000**	**£000**	**£000**
Surplus /(Deficit)	104	(4,153)	(4,040)	(8,968)	87
Cumulative Surplus/ (Deficit)	104	(4,049)	(8,089)	(17,057)	(16,970)

The table above shows that the Trust has a cumulative deficit since merger on 1 April 2000 of £16,970,000 to recover in 2005/06 in order to meet its statutory duty.

Maidstone and Tunbridge Wells NHS Trust claim the **local Health Economy has repaid in full the Trust's deficits arising from 2001/02, 2002/03, 2003/04.**

The cumulative deficit of £16.970m remains on the Balance Sheet as at 31 March 2005. The Trust is seeking a resolution of the cumulative deficit balance in discussions with the Strategic Health Authority and the Department of Health.

The NHS OSC would appreciate information on the outcome of these discussions.

4.1.2 The Finance Director of Maidstone and Tunbridge Wells NHS Trust (MTW) assured NHS OSC that, each year, deficits are deducted from the following year's Primary Care Trust Resource Allocation. The Primary Care Trust, in turn, then deducts this amount from the amount they pay in contract payments for the services they

commission. Maidstone Weald Primary Care Trust says in its 2004-5 annual report and accounts:-

> *The PCT was required to repay £2.4M support to the Strategic Health Authority, which it had received in 2003/04 and in addition itself provided a similar level of support to local health economy partners.*

This process of mutual support, although beneficial in enabling health economies to make the best of their funds to protect their statutory duties, does not demonstrate that health organisations, have, in fact, paid their debts.

4.1.3 The Department of Health in its Frequently Asked Questions[23] reiterates the principle:-

> ***Will Trusts be able to retain surpluses as a reward for efficiency? Will Trusts be allowed to benefit where costs are lower than the national average?***
>
> Yes. Under Resource Accounting and Budgeting there are already carry forward arrangements by which Trusts are able to retain surpluses. The net surplus or deficit made by each health economy is returned to SHAs the following year. SHAs are then responsible for passing these back to the organisations in their economy. We are reviewing these arrangements to see how we could provided greater certainty for organisations where surpluses originate.
>
> It is likely that Trusts will still face the statutory duty to breakeven. Trusts will need to ensure that they breakeven on the income and expenditure account, taking one year with another. This has been interpreted as a three year rolling average, and a five year average on an exceptional basis. On becoming Foundation Trusts, Trusts will no longer face this breakeven duty.

4.1.4 The Audit Commission offers this view:-[24]

> *'If a Trust makes a deficit in one year, this must be recovered through a corresponding surplus within the following financial years so that the cumulative position over the three-year period (or potentially five years) is breakeven.*
>
> *Under the current financial rules that operate within the NHS, income equal to the recorded deficit is deducted from a Trust in the year following the year in which a deficit is recorded. Trusts, consequently, must reduce the level of spending or increase levels of alternative income. To help manage this pressure, repayable support is generally provided by the NHS. The objective being to provide*

[23] Department of Health, Payments by Results, Frequently Asked Questions – http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/NHSFinancialReformsArticle

[24] Public Interest Report, Trafford Healthcare NHS Trust

temporary financial support to enable the Trust to meet its annual financial targets and to provide time to develop and implement effective recovery plans. When a Trust reports a deficit that is not covered by financial support, that deficit is also deducted from the following year's income. Trusts must also make a surplus in a subsequent year to offset the accumulated deficits shown in the accounts to the extent they are not covered by previous surpluses brought forward.'

However, as shown on the Maidstone NHS Trust balance sheets, that 'deduction of income' does not eradicate the deficit on the balance sheet.

A Public interest report written by the Trust's auditors is due soon and will comment on the deficit made in 2004/5 and determine whether the accumulated deficits have in fact been paid back.

4.1.5. The Chief Executive of Dartford and Gravesham NHS Trust told NHS OSC that under the regime of RAB (Resource allocation budgeting) the deficit had already been taken off his Trust's income. He did not think it was possible to achieve a surplus equivalent to the amount of accrued deficit still showing on Dartford and Gravesham NHS Trust's balance sheet in 2005/6.

4.1.6 MTW is in the final year of its extended five-year break even duty. Current financial plans do not generate a surplus equivalent to its accumulated post RAB deficit (£17m). The impact and resolutions of this situation are being reviewed with the Department and the Trusts auditors and is inherently linked to the development of the overall NHS financial strategy. This is a national issue and is being addressed by a group of experts.

Recommendations for the Department of Health:-

2. The Department of Health needs to clarify the confusion around Resource Allocation Budgeting and remove from the balance sheets of those NHS Trusts those deficits that have been repaid.

The NHS OSC welcomes regular up-dates on when this will happen.

3. Trusts should be made aware of a clear and realistic timescale within which they must repay their deficits.

4.2 Reaching Financial Balance in 2005/6

4.2.1 Maidstone and Tunbridge Wells NHS Trust

Why did Maidstone and Tunbridge Wells NHS Trust overspend in the first place, and why are there recurring problems? The Trust continues to have an underlying deficit (difference between recurring income and costs) of £17.5m, albeit reduced from £24.5m deficit at the end of 2004/5. In 2004/5 they received £9.7m assistance from Kent and Medway SHA, while managing to make £11m savings of their own, of which £5.5m was a recurrent saving.

The Trust believes that the answer lies, once again, in over-performance of Service Level Agreements. They calculate they will do £4.0m of work above the level of their SLA income budget with the Primary Care Trusts. Additionally, due to growing capacity within the hospital, there is likely to be another £2.3m worth of work for which PCT demand management schemes are not yet effective and thus GPs will refer patients and the work will be done.

4.2.2 Dartford and Gravesham NHS Trust

Their mid-year figures for 2005/06 show a deficit of £1.4million, but there are actions in place that will reduce this to an approximate deficit of £650k by the year's end. This will bring them towards the 0.5% of budget considered to be within break even distance for a NHS Trust. In addition new schemes for further reducing this deficit are still being considered. Dartford and Gravesham NHS Trust have a strong marketing ethos – they have the capacity to take on even more patients. Their new treatment centre is operating at approximately 80% capacity and this could be increased by additional elective throughput by around 10% without any change to staffing levels. Additionally they could introduce late night and weekend work.

4.2.3 Overall productivity at Darent Valley Hospital has increased, and they have projected additional income of £1.25million in their financial recovery plan. This has been achieved by an increase in the number of patients being treated from the Bexley and Crawley areas as well as an increase in the number of local patients. Dartford and Gravesham NHS Trust feel they are ideally situated to attract patients from wider areas of Kent, such as Sevenoaks, and also from Essex and Bromley. They have marketed in Lakeside Shopping Centre, Thurrock, Essex, to raise the public awareness of their services. Over performance by this hospital has been a difficulty for Dartford Gravesham and Swanley PCT so they realise that if they wish to improve the numbers of patients they treat, it is unlikely to be from their immediate area.

4.2.4 Medway NHS Trust

Medway NHS told the Committee that they were showing an overspend of £1.6m at the half year point, but will aim to break even in 2005/6. They finished 2004/5 with a deficit within material limits (0.2%) after a hard year. They have an extensive, varied range of savings plans, including improving theatre efficiency, improving procurement, combined with performance management targets and negotiation on capital charges. They have involved the clinicians who are, of course the budget managers, fully in the plans. They also have contingency plans to use if these schemes do not yield sufficient savings.

Medway NHS Trust believes that managing over performance is:-

'An art, rather than a science'

They are undertaking collective planning with Medway and Swale PCTs and Social Services to take into account the interaction with primary care.

4.2.5 East Kent NHS Hospitals Trust

East Kent NHS Hospitals Trust is one of the largest hospital trusts in the country, with an annual turnover of £350m. This would place them, as a business, in the FTSE 100. They have achieved both their Access Targets and their Financial Targets over the last two years. At the same time, they have reduced their underlying deficit from £31.9m to £6.8m. They are now sharing their best practice with other NHS Hospital Trusts. They believe, like Medway, that strong relationships with the commissioning PCTs are the key to tackling over performance on service level agreements.

4.2.6 However, their Local Delivery Plan (LDP) settlement for 2005/06 added to their financial pressures. They need to make a £5.6m saving requirement because of the introduction of payments by results. This means there are cost pressures in excess of the national funding. The local cost base per activity is higher than the income they will receive under the tariffs.

They also have increases in clinical negligence insurance premiums, a reduction in income recharges from road traffic accidents, and increases in non-pay costs such as utilities. Although they need to align their costings to national reference costs, the delayed rollout of Payment by Results has also handicapped them because they remain reliant on block contracts with the Primary Care Trusts. They have also lost income through the revised Market Forces Factor. Because of the worsening national and local situation, they have also suffered a reduction in their expected financial support from the health economy of £4.5m. This gives them a total requirement of savings this financial year of £20.5m. Currently they are forecasting an end of year overspend of £4m.

4.2.7 East Kent Hospitals Trust are fighting this, like Medway, with a package of measures: increasing income and savings, seeking the reinstatement of financial support, and developing a plan for the underlying shortfall called “Fit for the Future”. This will hinge on ensuring the Trust receives full reimbursement for the treatments it provides and to ensure that its services are efficient and effective. Among a wide range of areas they are reviewing are:-

- The length of Stay and improving discharge management through closer links with Social Services.
- Like Medway, better theatre utilisation to maximise the efficiency of patient pathways.
- Exploring the possible movement of procedures from inpatient to day surgery.
- Substituting managed patient-initiated follow ups to make clinic utilisation more effective.

As this is a huge financial challenge their “Fit for the Future” Programme focuses on efficiency, to create financial sustainability through driving changes forward. However, they were clear to maintain:-

‘Financial Recovery cannot be a means to deliver sub standard care to patients’

Although there are challenges lying Ahead, East Kent Hospital Trust now feel confident that they are performing well compared to many organisations but they still have work to do to compete on price and quality.

4.2.8 The Audit Commission, in its national report 'Achieving first-class financial management in the NHS' (April 2004), discusses the concept of keeping in balance across a health economy: -

> *'NHS bodies **are increasingly required to work in partnership** with other bodies within their health economy. This can affect the financial management of organisations as the SHA may seek to encourage bodies to release resources to others within the community with deficits. Each SHA works towards keeping expenditure of the bodies in the health economy within a control total. While this helps all bodies achieve financial balance, **it can mask underlying financial problems** and results in **shifting the goal posts** for the NHS bodies involved, as well as risking compromising sound financial planning and budgeting. The resources received are usually repayable the following financial year and therefore **the financial problem is deferred to the following year, rather than being dealt with**. It could also be perceived that poorly controlled bodies receive a reward of additional funding at the year-end at the expense of the well-managed bodies, **creating a perverse incentive to aim not to achieve financial balance.'**[25]*

4.2.9 Auditors' experience shows that financial management failures tend to occur not because of insufficient income, but due to a combination of more basic financial management issues. These comprise:-

- A failure of basic financial controls.
- Ineffective financial monitoring systems.
- A lack of financial awareness among board members.
- Possible dysfunctional relationships between board members and senior managers.
- A lack of ability within the finance department and overstretched finance staff.
- A lack of financial awareness throughout the organisation.
- A lack of ownership of, and leadership on, financial issues.

4.2.10 The Audit Commission is very clear that the view that exists in some NHS bodies that central government targets are in direct competition with the achievement of financial balance is not a reason for failure to do this.[26]

---

[25] Achieving first-class financial management in the NHS – Audit Commission 2004
[26] Achieving first-class financial management in the NHS – Audit Commission 2004

The key to controlling over-performance on Service Level Agreements between PCTs and NHS Trusts lies in joint planning, including KCC Adult Services, and in retaining close relationships between commissioner and provider through the introduction of Payment by Results.

Recommendation: For NHS Hospital and Primary Care Trusts

4. While recognising that Payments by Results and Patient Choice are driving changes, it is essential for NHS Trusts and PCTs to plan jointly for a match between need and resources.

Recommendation for Kent County Council NHS Overview and Scrutiny Committee (NHS OSC):-

5. The NHS OSC is encouraged by Maidstone and Tunbridge Wells NHS Trust's success at reaching underlying balance, but are concerned at the deficit which remains. They support the search for the collection of more robust data to investigate the causes.

The NHS OSC will work in partnership with the Trust to support them in finding ways of reducing the underlying deficit.

4.3 Payments by Results 2006/7

4.3.1 It is planned that on 1 April 2006 emergency and outpatients' treatment will join elective treatment to be paid for on a cost and volume basis. At this point hospitals whose costs are more than the average will risk their costs rising above their income and they will slip into deficit. The table below shows the current situation in Kent and Medway:-

LAST PUBLISHED REFERENCE COSTS – KENT AND MEDWAY REFERRING TO 2003/4[27]			
ORGANISATION NAME	MARKET FORCES FACTOR[28]	ORGANISATION-WIDE INDEX INCLUDING EXCESS BED DAYS[29]	ORGANISATION-WIDE INDEX EXCLUDING EXCESS BED DAYS
DARTFORD AND GRAVESHAM NHS TRUST	1.021119	90	90
EAST KENT COMMUNITY NHS TRUST*	0.969089	98	98
EAST KENT HOSPITALS NHS TRUST	0.970842	104	103
KENT AMBULANCE NHS TRUST	0.992209	104	103
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	1.001986	94	94
MEDWAY NHS TRUST	0.997149	94	94
WEST KENT NHS AND SOCIAL CARE NHS TRUST*	1.009375	81	81

The Committee asked the health organisations about how they had prepared for these changes.

4.3.2 Medway NHS Trust has studied patient pathways through to discharge. They have looked at where the delays and bottlenecks are, to treat patients more efficiently. In Medway a project planning team is led by the CEOs of Medway NHS Trust, and Swale and Medway PCTs

4.3.3 East Kent NHS Hospitals Trust is working hard to analyse data. They have discovered that movement in treatment areas and out-patients treatment means information on activity is not captured so readily. They want to improve the gathering of this information to ensure the patient gets the correct treatment, and they charge the commissioners accurately.

4.3.4 Maidstone and Tunbridge Wells NHS Trust is confident that in overall terms, the Trust's unit costs are as expected. However, within this figure there is fluctuation based on the type of service. Their investigations have uncovered that emergency inpatients are 11% more expensive than expected, while Outpatients are 6% more expensive than expected, planned Inpatients and day cases are 2% cheaper than expected and critical Care and Intensive Care appears to be 21% cheaper than expected.

4.3.5 The Trust has not placed any assumptions that it will gain or lose from the full introduction of Payment by Results as it very much depends on the volume changes of the types of services currently and in the future. They also have doubts about the future value of National Tariffs in terms of inflation assumptions, the regional adjustment for prices (termed the Market Forces factor) and the degree to which new intervention/ new drugs/ new technology has been included.

---

[27] Reference Cost Index (page 24) - These indices are the last published indices and relate to the 2003/04 year. The Reference Costs for 2004/05 have been issued only in draft to health organizations, and although show further improvements for East Kent, still remain below the National Average of 100).

[28] Market forces factor has been 're-based' for 2005/6 and is now a factor of 1 and above.

[29] Excess bed days reflects statistics on the effect of delayed discharge on patients' stays in hospital.

4.3.6 Dartford and Gravesham NHS Trust has increased their coding of activity to approximately 95% and work is continuing to increase this rate, as from April 2006 all non-coded work will not receive funding. They believe that coding is extremely important in ensuring the accuracy of hospital records, and essential in creating a better understanding of payments under the fixed tariff scheme. Like Maidstone and Tunbridge Wells, they are aiming to identify which procedures exceed the funding that is, or will be after 1 April 2006, received for performing them. Robust and accurate coding systems should be implemented as soon as possible.

4.3.7 Across the County there were encouraging signs of preparation for Payments by Results. However, as Dartford and Gravesham NHS Trust pointed out, so much depends on the up-lift of the national tariffs to represent inflation, and the application of the market forces factor. Sandwell and West Birmingham Hospitals NHS Trust, with an average house price of £117,395 currently has a higher market forces factor than East Kent Hospitals Trust and the East Kent PCTs. Shepway has an average house price of £186,229.[30]

Recommendation for NHS OSC:-

6. With the difficulty in recruiting NHS staff, and high property prices throughout Kent, NHS OSC should campaign for Kent and Medway areas to have a higher market forces factor which more fairly represents high property costs

4.4 Foundation Status

4.4.1 Since the announcement of the rolling programme to convert all NHS Trusts to Foundation Hospitals by 2008[31], Kent and Medway NHS Hospital Trusts have begun to prepare for this eventuality. Kent and Medway Strategic Health authority, together with Monitor[32] are beginning an exercise to plan when all Kent and Medway NHS Hospitals Trust will be ready to apply for foundation status. One criterion is that NHS Trusts must be financially sound before they apply. However, three out of four Trusts ended the year with a deficit, and East Kent Hospitals Trust remains within its financial recovery plan after its £17m non-recurring revenue support[33] from the NHS Bank two years ago. Dartford and Gravesham NHS Trust, though, is likely to apply first for foundation status as they hold three stars for performance. Although the application process is lengthy, they could become a Foundation Trust by April 2007. Their audit letter for 2004/5 is clear

[30] BBC News average house prices
[31] Foundation hospitals – Appendix 2
[32] Monitor is the foundation hospitals regulatory body

[33] Non-recurring revenue support is financial support from the NHS Bank (funded by Department of Health) to enable health organizations to implement permanent changes, usually reorganization of services. Terms of repayment are subject to negotiation, both in timing and type of repayment (if applicable) and advances may be either a loan or abated to a grant.

that their financial position is the highest risk to the achievement of Foundation Trust status. As part of the process, NHS Trusts must prepare five-year business plans.

4.4.2 Medway expects to follow shortly afterwards, while East Kent Hospitals Trust sees foundation status as a challenge that lies ahead. Their financial recovery plan is due to end 31 March 2007.
So far there is insufficient evidence of the difficulties and advantages that lie ahead with foundation status. There is, as yet, no exit strategy from foundation status, even if they become financially insolvent. The Department of Health and Monitor are jointly working towards proposals for how a failure regime for Foundation Trusts will operate. Fortunately, Payments by Results will be fully in place and working before any of the Kent and Medway Hospital Trusts become Foundation Hospitals.

4.5 Implications of Patient Choice

4.5.1 Patient Choice is still in its early stages, and there is as yet no indication of how it will affect Kent and Medway NHS Trust income flows. Early information from pilot studies in London show movement of between 10 and 15% as patients choose different hospitals. However this is less likely in Kent and Medway because of the larger distances between hospitals.

4.5.2 Dartford and Gravesham NHS Trust are taking care in compiling their five year business plan, required in the foundation hospital application process, to project an accurate reflection of patient choice flows. This area is where the early foundation hospitals who have gone into financial deficit have failed to make realistic projections of numbers of patients. East Kent Hospital Trust see this as yet another challenge to their business planning process, while Maidstone and Tunbridge Wells NHS Trust anticipates no change, although it believes that it will probably lose income once the Treatment Centre is complete. There may be turbulence in the health economy as Hospital Trusts become Foundation Trusts and begin to 'market' their services more aggressively, and the full effects of the London hospitals gaining foundation status are not yet clear. It would be wise for the NHS Trusts that are further away from gaining this status to reflect this in their business plans. These business plans will of course be subject to assessment by Monitor, the NHS Foundation Trust Regulatory Body.

Recommendation for NHS Hospital Trusts:-

7. NHS Hospital Trusts should show that they include in their business plans: -

- **The effect of Patient Choice**
- **Future Financial Capacity (Marketing)**
- **The impact of the London Foundation Hospitals**
- **The impact of their own foundation status**

Recommendation for NHS OSC:-

8. The NHS OSC should investigate the impact of London Hospitals gaining foundation status.

5. Challenges Ahead for Primary Care Trusts

5.0 With impending reconfiguration, Primary Care Trusts have already begun to work more closely together. Currently the Chief Executive of Ashford also manages Swale PCT, the Chief Executive of Shepway also leads East Kent Coastal PCT, and there has been one Chief Executive appointed for Maidstone Weald and South West Kent.

Primary Care Trusts have many challenges ahead in the remaining days of financial year 2005/6, plus reconfiguration by 1 October 2006. They are still expected to meet their statutory duty to achieve financial balance for 2005/6, and this is a big challenge for some.

5.1 Achieving Financial Balance in 2005/6

5.1.1 In their November 2005 board paper, the Strategic Health Authority (SHA) projected a forecast overall deficit position at outturn (31/3/2006) for the whole Kent and Medway health economy of £3.755m. This is after they have contributed their own under spend of £5.6m[34]. The SHA's task is to performance manage the overall economy to break even at the year end while achieving all other key targets for 2005/06.

5.1.2 Half-year actual positions across the economy demonstrated increasing financial pressure, caused by slipped delivery of Financial Recovery Plans and, once again, activity over planned performance by local and tertiary providers. At the end of September, month 6, actual performance across all organisations showed an aggregate deficit of £12.2m, which represented a deterioration compared with the month 5 position. The SHA reported that although no PCT planned to breach its statutory financial duty, Canterbury and Coastal and Swale PCTs were currently projecting deficits for the end of the financial year.

5.1.3 Swale PCT calculates that by July 2005, if no savings had been made they would have been heading for a £12.5m deficit by the end of the financial year. This has been reduced to a £6.8m overspend, and after a loan of £3m from the Strategic Health Authority, to £3.8m. The Trust believes that they have stemmed the flow of overspend and have a substantial financial recovery plan to save £12.2m.

The up-date of the financial recovery plan has been updated to include:-

- A review of Community Hospital usage – there are only 20 community hospital beds in Ashford and alternative strategies are already in place there. There may be good practice which can be spread to Swale.

- A freeze of Local Delivery Plan proposals for development.

[34] Resulting from the retention of specific allocations made available to the SHA (£4.1m) and unplanned slippage on minor aspects of workforce development (£1.5m).

- The implementation of admission avoidance schemes.

- The review of all Placement expenditure.

It is the review of community hospital usage which is now becoming an issue for consultation with stakeholders. This issue is complicated by the continuing review of eligibility criteria for NHS continuing care, which is being undertaken to provide a national framework for eligibility.[35]

5.1. 4 Canterbury and Coastal Primary Care Trust

Canterbury and Coastal PCT's recovery plan aims to save £5.5m on a recurrent basis. The year end projection is currently £1.6m which is a £0.5m improvement on earlier projections. They now seek additional savings to achieve a break even year end position.

The PCT recognises that previous risk share arrangements between PCTs for acute services have been to its financial disadvantage. As part of its recovery plan it has therefore entered cost per case contracts ensuring that it pays only for its residents. This strategy must raise questions

This strategy must raise questions:-

- have other Primary Care Trusts been paying less than they should for their block contracts? or

- has the Primary Care Trust been contributing more than it should to the finances of East Kent Hospitals Trust?

The discussion will become largely academic after October 2006 when this PCT merges with others, in whichever configuration is agreed. However the Primary Care Trusts are forced into adopting this strategy – 'squeezing' the expenditure into another part of the health economy – because of their statutory requirement to break even each financial year.

5.1.5 South West Kent PCT has experienced significant over performance at Acute Trusts but is able to tackle the problem. They have estimated this will cost £2m extra by 2005/6 year end. Although support has been negotiated with the Strategic Health Authority to cover this in 2005/6, it will cause a further financial pressure for the PCT in 2006/07. The PCT must achieve its financial target in 2005/06 as well as repaying the SHA support in 2006/07, while remaining in recurrent balance.

5.1.6 In 2005/06 South West Kent are heading for a deficit of potentially £4-5m. They are suffering similar pressures as in previous years. Their patients are being treated by non-local providers, often in London, and there is a greater use of Bromley Hospital as it is more accessible for some Sevenoaks patients.

[35] Strategic Context para. 2.5.2.

However, they are currently going through a process to validate their data. Activity looks higher than they expected in maternity, neo-natal care and outpatients. They aim to ensure the charges are legitimate and will dispute payment where there is no data to support charges from London and Bromley hospitals.

5.1.7 Maidstone Weald PCT is already reporting an overspend in 2005/6 of £1m and forecasts this will rise to £3m by 31 March 2006. Financial pressures remain of funding non-local providers and private sector placements. Maidstone Weald PCT pays Maidstone and Tunbridge Wells NHS Trust 33.2% of its £242.4m budget**.** [36]

5.1.8 Shepway PCT Shepway PCT still expects to break-even in 2005/6, and the surplus of £410,000 recorded in 2004/5 has been re-invested in health and care services in Shepway in the current year.

The Trust have set their activity levels at a level that they understood and also allocated a contingency figure in case the activity figure was above their expectations. It was a statutory requirement not to overspend.

5.1.9 East Kent Coastal PCT. The PCT is anticipating a break-even position in 2005/6, which includes the achievement of a £5.3m Recovery Plan.

The Recovery Plan was necessary to offset underlying cost pressures that had arisen in 2004/5. These were mainly relating to placements and external service level agreements. Also included in the Recovery Plan was the repayment of £1.89m financial assistance which the PCT had negotiated from other members of the health economy in order to report a break-even position in 2004/05.

The Financial Recovery Plan includes "Invest to Save" schemes. Prescribing Advisors and Placement Managers have been employed and they have been successful in reducing expenditure on drugs and on patients treated outside of East Kent.

5.1.10 Dartford, Gravesham and Swanley PCT is still able to predict break even for this financial year, but there are still considerable risks. They have received £2m support from the Strategic Health Authority this year which they will have to repay in 2006/7.

5.1.11 Medway PCT is still forecasting a balanced position [37] at the end of the financial year, which depends on the delivery of their £3.4m financial recovery plan. However, there is a further £5.0m of potential risk in their action plans, which are currently being developed in the Directorates by the budget managers. They are holding fortnightly meetings to discuss and monitor progress against the required savings to ensure that the necessary savings are met.

5.1.12 Ashford PCT still feels they are under funded by approximately £3m as their population continues to grow at about 2% each year. Additionally, there have been changes in financing between East Kent PCTs, which have been adverse for Ashford by £1.5m. They are still able to project break even by the end of the financial year. Current

[36] Maidstone Weald PCT annual report and accounts.
[37] Minutes of the Meeting of the Medway Board Held on Wednesday 21 September 2005

activity is in line with budgets, due to a close relationship with East Kent NHS Hospital Trust and there is no over performance on the planned levels.

5.1.13 The Resource Allocation formula in 2006/7 and 2007/8 has had elements of its formula changed to benefit areas of expanding population. From 2006-07 a recalculation of the resource allocations will mean that their growing population will now be more accurately reflected. However, despite this, the increase for 2006-7 looks conservative – compared to the increase in GP lists that they hold. Their funding for 2006/7 shows:

	£m
TARGET 2006/07	126.4
ACTUAL FUNDING 2006/07	123.7
SHORTFALL	**2.7**

5.1.14 The Strategic Health Authority is involved in planning health services for increases in population and lobbying for more sensitive instruments for measuring population growth. However accurate the method, funding growth still remains a function of the amount of money available and this may still not be as much as Ashford needs. The SHA will continue to push, comparing local views of population growth which do not always reconcile to those of the Office of National Statistics. They are also urging that those PCTs which are not yet at target funding should move more quickly[38].

The SHA has also undertaken work to assess the effects of population moves and the way that this impacts on both health and social care organisations. This is a dynamic exercise, as patient pathways change, as health services develop. They are working with KCC Planners and Social Services Department.

Recommendation for NHS OSC:-

9. The NHS OSC must work with the Strategic Health Authority in providing evidence to reflect population growth in order to attract additional funding to Kent.

The Kent and Medway Strategic Health Authority, in its role as performance manager, continues to reinforce the message across all organisations of the absolute requirement to achieve financial balance at the year-end. This remains a significant challenge in 2005/6.

The statutory requirement for individual Primary Care Trusts to break even was introduced for sound financial reasons. This has become harder to achieve during the transition towards Payments by Results. Reconfiguration into much larger bodies is designed to bring greater flexibility and financial resilience. The statutory requirement for each PCT to break even by 31 March 2006 remains, even though the organisations cease to exist on 30 September 2006. This places an even greater burden on hard pressed managers. It is important that for taxpayers to receive value for money in

[38] Appendix 3

2005/6, business continuity to secure health services for Kent and Medway residents should take priority.

NHS continuing care criteria must be reviewed in the light of the Health Ombudsman's report and the current Department of Health Review. This review will establish a **national framework of eligibility** for patients who need long term nursing care. At the same time, other agencies can contribute by ensuring that there are other options rather than long term residential care for as many patients as possible.

Recommendation for KCC and District and Borough Councils:-

10. Every effort must be made to ensure discharge plans are in place to enable patients to be discharged from Community Hospitals by ensuring the full range of Intermediate Care, Primary Health Care, Social care and housing options are available.

5.2 Payments by Results and Commissioning

5.2.1 The Primary Care Trusts are now beginning to see the effects of the implementation of Payments by Results. When they held a block contract for services from their providers, they could plan their expenditure and it was known within limits from the beginning of the year. The gradual move to cost and volume contracts is having an effect. Unless they bring demand management strategies into play, they have no control over the volume of patients who are treated in secondary care. However, the block contract system was not without its problems, and this has also led to problems this financial year.

5.2.2 Shepway PCT welcomes Payments by Results, as they feel it provides an opportunity to study the cost effectiveness of the patient pathway and to look at the best way to provide services in terms of quality and price.

However, the burden of financial risk swings over from NHS Hospital Trusts towards Primary Care Trusts as Payments by Results takes over. Fortunately the slowing down of its implementation gives Primary Care Trusts longer to change over and develop demand control strategies. In its report 'Early Lessons from Payments by Results'[39] the Audit Commission recommended that Primary Care Trusts should review their arrangements for planning and organisational development.

5.2.3 The areas of the Kent and Medway Health Economy that were most successful were those that demonstrated joint planning between all agencies.

The Audit Commission advises that there should be a common set of expectations across the health economy locally, based on joint planning, agreement on high-level clinical pathways and a clear understanding of the arrangements for reporting, monitoring and dispute resolution.

[39] Audit Commission October 2005

It is clear that although great efforts have been made to improve the accuracy of coding, monitoring and billing, there is still a long way to go. Early results from Payments by results show that it takes much longer to implement and is more expensive of administrative time than was previously considered. Although Primary Care Trusts will not spend time agreeing block contracts with their providers, they will possibly take just as much time in checking charges.

5.2.4 The transitional period will have many difficulties as there remains the vestiges of block contracts plus the introduction of payments by results. This may strain relationships between commissioners and providers and there could be a role for the Strategic Health Authority in smoothing the way and settling disputes informally before they need to go to arbitration, while helping the development of the organisations and supporting health economy wide demand management and service redesign initiatives. The financial risks of the end of financial year 2005/6 will demand all the skill of the Strategic Health Authority to help the health organisations achieve their statutory obligations.

5.3 IT Issues – Choose and Book

The introduction of Patient Choice has been complicated by the delays in the Information Technology system 'Choose and Book'. From 1 January 2006, Patient Choice should offer patients four alternatives when they are referred by their GP to a hospital. They should be able to book their appointment while at their GP's surgery directly with the Hospital Trust of their choice. However, so far GPs are not all using the system, and Hospital Trusts booking systems are not yet accessible on line. The Chief Executive of Ashford and Swale is leading on the implementation of the system for Kent and Medway.

There is an element of risk in the implementation of Patient Choice. Financial monitoring will need to be done manually until the IT systems become universal, and this may mean that where patients are offered a choice, the financial implications of this may take longer to be reflected in financial monitoring. In practice, although Choose and Book should have begun by January 1, it is unlikely to have much effect until the IT problems are solved and it is straightforward for GPs to use.

6. Mental Health in Kent and Medway

6.1.1 East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust will merge on 1 April 2006. They stressed to NHS OSC that their merge represented a managerial merger only, and the services would not be reconfigured or merged. Erville Millar, currently Chief Executive of the Camden and Islington Mental Health and Social Care Trust has been appointed as Chief Executive.

6.1.2 Both Trusts broke even in 2004/5, after contributing efficiency savings. In **East Kent**, from the outset 2004/05 was always going to be a big financial challenge for the Trust. To cover cost pressures that had built up over recent years, including the recovery of the previous year's £225,000 overspend, the Trust needed to find approximately £2.0m of in year savings. This represented a **4.8%** efficiency saving.

In 2005/6, East Kent has a 1.7% cash and efficiency savings target imposed, but they are not aware of any further requirements to support the local health economy. East Kent will break even in 2005/6 and although they have had to introduce saving plans, they have identified 94% of the savings required and will meet their targets.

6.1.3 In **West Kent** the Trust has been asked to make a large efficiency saving of £2.9m which it has achieved through non-recurring savings, some reduction to non-clinical staff and some re-organisation. The Trust tried to protect its resources and maintained financial balance. One of the main problems for the West Kent Trust has always been recruiting staff. This is still an issue because patients now need increased staffing support - and the lack of permanent recruits means that it has to use bank and agency staff. A 10% recruitment premium introduced in 2004/5 had not gone far enough in closing the gap between NHS and private pay. The Trust had to recruit domestic staff from out of the area as it could not compete with private rates in the affluent Tunbridge Wells/Sevenoaks area.

6.1.4 West Kent Trust supplies specialist services for eating disorders, Children and Adolescents, and for personality disorders across East and West Kent, as well as further across the South East as well as in the Channel Islands. Many of these specialist services simply do not exist in East Kent. The merger should not affect the financial position of this service delivery, but public expectation and demand may change when they are served by one Trust.

The Trust felt that despite its success, it had not been successful in arguing a case for any more money for developments, although new services, such as the Crisis Resolution Teams, have attracted existing staff from other parts of the NHS. In West Kent, developments within the community could help to improve the quality of mental health – for instance:-

- More supported housing would help avoid admissions to in-patient services.
- Increased investment in children's and adolescent mental health services (CAMHS) within Kent could save the £10m cost of providing outside Kent.
- More permanent arrangements for secondment of staff between the Trust and the County Council to bring stability to the service.

6.1.5 West Kent Trust has maximised the use of its resources to full capacity, but an extract from "The 2004/05 National Survey of Investment in Mental Health Services"[40] shows that the ability to do this further is now exhausted. Kent and Medway now shows the lowest amount of investment in England, at £109 per head. Both Trusts assured the NHS OSC that this was because investment in West Kent was actually less than this at around £95 per head, whereas in East Kent investment was more like £134 per head.

There is no doubt that merging the two Mental Health Trusts will bring managerial economies. With a larger and more financially resilient organisation, there will be a chance for improvement and the reduction of inequalities across the County.

[40] - Prepared by Mental Health Strategies for the Department of Health.

Recommendation for the Kent and Medway Health Organisations:-

11. The NHS OSC supports the merger of the Kent and Medway Mental Health Trusts. Particularly in West Kent, it is essential that greater investment is made into the services, before surpluses are used elsewhere.

7. Reconfiguration - Opportunities and Threats

The merger of the two Mental Health Trusts, although technically separate from the reconfiguration of the other health organisations,[41] will be the first visible change in the structure of Kent health organisations. This will be followed by the Strategic Health Authority and the Primary Care Trusts.

7.1 Strategic Health Authorities

7.1.1 Strategic Health Authorities hope to reorganise ahead of Primary Care Trusts so they can continue with their performance management duties. However, if Primary Care Trusts in Kent and Medway reduced in number to one or two, these larger and more financially resilient organisations should have the management capability to negotiate directly with the Department of Health. Consultation begins on 14 December for the reconfiguration. Kent and Medway hope to merge with Surrey and Sussex SHA, one of the largest in the country. Candy Morris, who was CEO of Kent and Medway SHA, has been seconded as Chief Executive of Surrey and Sussex from 21 November 2005.

7.1.2 The new organisation will face financial challenges as there were three significant deficits amongst the NHS Hospital Trusts at the end of 2004/5:-

- Brighton and Sussex University Hospitals NHS Trust of £10m.
- East Sussex Hospitals NHS Trust with £4.9m.
- Surrey and Sussex healthcare NHS Trust with a deficit of £30.6m.
- At month 6 of 2005/6, Surrey and Sussex Healthcare NHS Trust now shows a projected deficit of £41.2m, which is 33.1% of its total budget. [42]

There were also significant deficits in 2004/5 amongst the Primary Care Trusts, including:-

- Adur, Arun and Worthing with a deficit of £3.6m;
- East Elmbridge and Mid Surrey PCT with a deficit of £2.5m;

[41] Reconfiguration of PCTs and SHAs is part of the Commissioning a Patient Led NHS initiative.
[42] Deficits at month 6 – DoH 2 December 2005

- Guildford and Waverley PCT with a deficit of £5.9m; and
- Sussex Downs and Weald PCT with a deficit of £1.8m.

Recommendation for the Strategic Health Authority:-

12. The NHS OSC is yet to be convinced of the purpose of the SHA and would like to see evidence of the added value of the proposed merger with Surrey and Sussex.

7.2 PCTs

7.2.1 The shape of the organisation after reconfiguration of Primary Care Trusts is less clear cut, but will bring benefits if it brings greater financial resilience and management capability. However the Audit Commission found[43] that there has been a lack of focus on financial management issues during periods of restructuring. In particular there has been insufficient prioritisation of funding to support an organisation's organisational aims and objectives. It will be particularly difficult in Kent as there are areas of deprivation with greater needs to be met if they merge with areas with lesser deprivation and therefore lesser health demands. An example of this is the suggested option where Dartford and Gravesham would become part of West Kent together with its wealthier neighbours in South West Kent.

7.2.2 Another challenge, unless there is just one Primary Care Trust, will be the unpicking of lead roles and inter-organisation dependencies. This will be particularly difficult if, as is mooted, Swale becomes part of a predominantly East Kent area and Ashford becomes part of a separate PCT. This will be a time consuming managerial task while continuing to preserve the level of service to patients.

One benefit of reconfiguration is that inter-organisational transactions are complex in Kent and Medway and the unpicking of this will make the introduction of Payments by results more straight forward. The constant re-allocation of funding around the health economy to preserve the break even position for every organisation can mask underlying financial problems within an individual body and undermines sound financial management.[44] This at least, with one or two Primary Care Trusts, will be reduced.

7.2.3 Although the Department of Health anticipates that boundary changes and a new focus on commissioning for Primary Care Trusts will enable local NHS organisations to make substantial savings by reducing management costs by £250m, the Audit Commission has found that one of the early results of Payments by Results is the added cost of administration. Coupled with the time spent on reconfiguration and possible managerial redundancies, it is uncertain when the savings will occur.

[43] Achieving first-class financial management in the NHS – Audit Commission 2004
[44] Achieving first-class financial management in the NHS – Audit Commission 2004

7.3 Ambulance Trust

Kent Ambulance Trust is also planning a merger with Surrey Ambulance Service and Sussex Ambulance Service. Although the current organisation works well, holding three stars, it has been made clear to the ambulance services by the Department of Health that the current configuration is no longer an option.

The Reconfiguration of Primary Care Trusts should improve their financial resilience they need to manage Payments by Results. However the emphasis on saving administrative costs may prevent them from preparing as thoroughly as they need and this will jeopardise the financial standing of the new organisations

Recommendation for the Department of Health:-

13. Service provision is more important to the residents of Kent and Medway than reconfiguration.

The Department of Health is urged to phase requirements to reconfigure health organisations so that undue turbulence does not jeopardise the delivery of health services.

CONCLUSION

The health organisations face a difficult period over the next year. They have the challenge of reconfiguration as well as the extension of Payments by Results. If they are well supported by the Strategic Health Authority and build on the best practice that they demonstrated to NHS Overview and Scrutiny Committee they will be successful in their tasks. The difficulties now suffered by the rest of the health organisations across the country demonstrate the size of the challenges ahead. This period of turbulence will only be worthwhile is at the end of this period of transition health services for the ordinary Kent resident have improved.

RECOMMENDATIONS *(Paragraph number shown in brackets)*

Recommendation for the Primary Care Trusts:-

1. The Strategic Health Authority and Primary Care Trusts must show how the £8.5m saved during reconfiguration is redirected to front line services.

The NHS OSC will monitor this. (2.2)

Recommendations for the Department of Health:-

2. The Department of Health needs to clarify the confusion around Resource Allocation Budgeting and remove from the balance sheets of those NHS Trusts those deficits that have been repaid.

The NHS OSC welcomes regular up-dates on when this will happen.

3. Trusts should be made aware of a clear and realistic timescale within which they must repay their deficits. (4.1)

Recommendation for NHS Hospital and Primary Care Trusts:-

4. While recognising that Payments by Results and Patient Choice are driving changes, it is essential for NHS Trusts and PCTs to plan jointly for a match between need and resources. (4.2)

Recommendations for NHS OSC:-

5. The NHS OSC is encouraged by Maidstone and Tunbridge Wells NHS Trust's success at reaching underlying balance, but are concerned at the deficit which remains. They support the search for the collection of more robust data to investigate the causes.

They will establish working groups to support the Trust in its quest. (4.2)

6. With the difficulty in recruiting NHS staff, and high property prices throughout Kent, NHS OSC should campaign for Kent and Medway areas to have a higher market forces factor which more fairly represents high property costs (4.3)

Recommendation for NHS Hospital Trusts:-

7. NHS Hospital Trusts should show that they include in their business plans:-

- **The effect of Patient Choice**
- **Future Financial Capacity (Marketing)**
- **The impact of the London Foundation Hospitals**
- **The impact of their own foundation status**

Recommendation for NHS OSC:-

8. The NHS OSC should investigate the impact of London Hospitals gaining foundation status. (4.5)

Recommendation for NHS OSC:-

9. The NHS OSC must work with the Strategic Health Authority in providing evidence to reflect population growth in order to attract additional funding to Kent. (5.1)

Recommendation for KCC and District and Borough Councils:-

10. Every effort must be made to ensure discharge plans are in place to enable patients to be discharged from Community Hospitals by ensuring the full range of Intermediate Care, Primary Health Care, Social care and housing options are available. (5.1)

Recommendation for the Kent and Medway Health Organisations:-

11. The NHS OSC supports the merger of the Kent and Medway Mental Health Trusts. Particularly in West Kent, it is essential that greater investment is made into the services, before surpluses are used elsewhere. (6)

Recommendation for the Strategic Health Authority: -

12. The NHS OSC is yet to be convinced of the purpose of the SHA and would like to see evidence of the added value of the proposed merger with Surrey and Sussex. (7.1)

Recommendation for the Department of Health:-

13. Service provision is more important to the residents of Kent and Medway than reconfiguration.

The Department of Health is urged to phase requirements to reconfigure health organisations so that undue turbulence does not jeopardise the delivery of health services. (7.2/3)

APPENDIX I – The Review Process

Financing the Health Economy Meeting 1-11 November 2005
Bob Alexander, Director of Investment, Kent and Medway Strategic Health Authority
East Kent Coastal Primary Care Teaching Trust and Shepway Primary Care Trust
Ann Sutton, Chief Executive, Bill Jones, Deputy Chief Executive, Shepway PCT and Brian Allpress, Director of Finance, East Kent Coastal PCT
Kent Ambulance Trust
Hayden Newton, Chief Executive and Pam Fairclough, Acting Finance Director
Dartford and Gravesham NHS Trust
Mark Devlin, Chief Executive and Paul Traynor, Finance Director
South West Kent Primary Care Trust and Maidstone Weald PCT
Reg Middleton, Director of Finance and Information, South West Kent PCT, David Meikle, Joint Chief Executive and David Price, Director of Finance, Maidstone Weald PCT
Medway NHS Trust
Andrew Horne, Chief Executive and Jeremy Moon, Director of Finance
Financing the Health Economy Meeting 2- 23 November 2005
Dartford, Gravesham and Swanley Primary Care Trust
Bill Gillespie, Joint Chief Executive
Ashford Primary Care Trust and Swale Primary Care Trust
Marion Dinwoodie, Joint Chief Executive and Jonathan Bates, Director of Finance, Ashford PCT
Maidstone and Tunbridge Wells NHS Trust
Rose Gibb, Chief Executive
West Kent NHS and Social Care Trust
Jon Wilkes OBE, Chief Executive and Ian Davis, Director of Finance
Canterbury and Coastal Primary Care Trust
Wilf Williams, Chief Executive
East Kent NHS and Social Care Partnership Trust
Sue Hunt, Chief Executive and Brian Allpress, Director of Finance
East Kent Hospitals NHS Trust
David Astley, Chief Executive and Rupert Egginton, Finance Director

APPENDIX II – Foundation Hospitals

What are foundation hospitals?

Foundation hospitals are a new form of hospital being introduced by the Government as part of its programme of reforms in the NHS. They will be independent legal entities, and will be owned by their members who will include patients, staff and local people. Foundation hospitals will be granted a licence to operate by an Independent Regulator (Monitor) and will not be under Government control.

Foundation hospitals will have greater powers and flexibilities than traditional NHS hospitals. In particular they will be able to:-

- borrow from the private sector;
- retain their surpluses;
- keep hold of all money from the sale of land and assets; and
- exercise a greater degree of flexibility in setting pay and benefits packages.

Foundation hospitals will be controlled by a Board of Governors who will be elected annually by their members.

On 6 May 2003 the Health Secretary Alan Milburn published details of an NHS Improvement programme to raise standards across the NHS, including £200 million of financial support, to help all hospitals achieve NHS Foundation status within four or five years. Currently Strategic Health Authority and Monitor, the Regulatory Body for foundation hospitals, are charged with formulating an action plan for each NHS Hospital Trust to implement foundation status by 2008. To do this, they are using a diagnostic tool which helps the Hospital Trust assess its business needs in planning and preparation before they apply for Foundation Trust status

The ability to apply for foundation status was limited to three star Trusts – i.e. In Kent and Medway only Dartford and Gravesham NHS Trust could apply. However, now, all NHS Hospital Trust will be fitted into an improvement programme that will fit them for foundation status.

APPENDIX III – Resource Allocation Formula

1. Resource Allocations

1.1 What they pay for

Recurrent revenue allocations to Primary Care Trusts (PCTs) cover:-

- hospital and community health services (HCHS);
- prescribing (the drugs bill);
- primary medical services; and
- HIV/AIDS.

1.2 How they are calculated – components of the formula

The first three components are made calculated using factors for:-

- age related need;
- additional needs, over and above that accounted for by age; and
- Geographic variations in the unavoidable cost of providing healthcare (market forces factor and emergency ambulance cost adjustment).

1.3 Weighted capitation is age related need

A principal cause of variation in the level of demand for health services is the age structure of the population. The very young and the elderly, whose populations are not evenly distributed throughout the country, tend to make more use of health services than the rest of the population. The purpose of the age weighting is to allow for varying elements of health need associated with the age structure of local populations.

Average 2000-2003 age/cost weights[45] used in HCHS							
Age band	**0-4**	**5-15**	**16-44**	**45-64**	**65-74**	**75-84**	**85+**
Weighting (£)	542.04	269.01	525.78	655.41	1,245.37	1,976.50	2,799.22

1. 4 Extras - Supplements to the formula

There are two monetary supplements to the formula:-

- **English Language Difficulties Adjustment (ELDA)**
  The English language difficulties adjustment is based on calculations of those people of ethnic origin who have difficulty with the English language. In 2006/7 it will be worth £34.67 per person.

- **Office of the Deputy Prime Minister (ODPM) Growth Area Adjustment**
  In conjunction with the Office of the Deputy Prime Minister (ODPM), the Department of Health agreed to include a Growth Area adjustment for PCTs in ODPM Growth Areas in 2006/07 to 2007/08 allocations. There are 44 PCTs in four Growth Areas: **Ashford**, London-Stansted-Cambridge-

[45] Resource allocation: Weighted capitation formula

Peterborough, Milton Keynes and South Midlands, and **Thames Gateway**. In Kent and Medway these PCTs will receive this allowance: **Ashford, Canterbury and Coastal, Dartford Gravesham and Swanley, Medway and Swale**

Growth area policy aims to build significant additional homes in the Growth Areas by 2016, so population projections have been produced which estimate the impact of the additional Growth Area dwellings on the population of the Growth Area Local Authorities. This is a much requested change from Kent and Medway, particularly from Ashford PCT where population increases are already occurring.

2. The Size of the Resource Allocation in Kent and Medway

The Department of Health announced the national 2006/07 and 2007/08 allocations totalling £135 billion in February 2005. The table attached shows how the amounts in Kent and Medway have increased over the five years 2003-2008, but it must be stressed that:-

- Over this period PCTs' responsibilities have also increased to cover a large part of General Medical Services (Cost of GPs) which were previously reimbursed as a non cash-limited item – GMSNCL.

- These primary medical services allocations, covering general medical services (GMS) and personal medical services (PMS) were integrated into revenue allocations in 2005/06.

- The 'distance from target' allocations are shown below – Swale, Medway and Ashford still remain under funded.

Kent and Medway Primary Care Trusts – Distance from Target

PCT	2006/07 recurrent allocation	2006/07 closing target	2006/07 closing DFT		2007/08 opening baseline	2007/08 closing DFT	
	£000s	£000s	£000s	%	£000s	£000s	%
Ashford	123,752	126,425	-2,673	-2.1	123,752	-2,707	-1.9
Canterbury and Coastal	211,688	210,658	1,030	0.5	211,688	113	0.0
Dartford, Gravesham and Swanley	273,269	273,288	-19	-0.0	273,269	278	0.1
East Kent Coastal	330,340	332,282	-1,942	-0.6	330,340	-1,442	-0.4
Maidstone Weald	266,650	268,091	-1,442	-0.5	266,650	-1,253	-0.4
Medway	304,301	320,488	-16,187	-5.1	304,301	-12,357	-3.5
Shepway	134,799	135,131	-332	-0.2	134,799	-82	-0.1
South West Kent	200,604	199,339	1,265	0.6	200,604	689	0.3
Swale	116,872	125,133	-8,261	-6.6	116,872	-4,840	-3.5

Kent and Medway StHA: PCT Allocations: 2003/04 - to 2007/8

	2003/04 Baseline Allocation	2003/04 Actual Allocation[1]	2004/05 Allocation	2005/06 Allocation	Three Year Increase 2003-2006		2006-07 allocation	2006-07 increase		2007-08 allocation	2007-08 increase		Five year increase 2003-2008	
	£000s	£000s	£000s	£000s	£000s	%	£000s	£000s	%	£000s	£000s	%	£000s	%
Ashford	78,097	85,546	93,528	102,199	24,102	30.86	123,752	10,288	9.1	137,086	13,335	10.8	58,989	75.53
Canterbury and Coastal	137,636	150,208	163,549	177,927	40,291	29.27	211,688	16,547	8.5	231,695	20,006	9.5	94,059	68.34
Dartford, Gravesham and Swanley	179,977	196,417	214,153	233,267	53,290	29.61	273,269	22,730	9.1	298,896	25,627	9.4	118,919	66.07
East Kent Coastal	213,242	234,126	256,544	280,660	67,418	31.62	330,340	27,411	9	362,480	32,140	9.7	149,238	69.99
Maidstone Weald	166,017	182,029	199,462	218,377	52,360	31.54	266,650	22,314	9.1	292,733	26,084	9.8	126,716	76.33
Medway	189,363	208,169	228,675	250,623	61,260	32.35	304,301	30,834	11.3	340,701	36,400	12	151,338	79.92
Shepway	87,073	95,502	104,546	114,328	27,255	31.3	134,799	11,181	9	148,623	13,824	10.3	61,550	70.69
South West Kent	130,095	141,986	154,808	168,529	38,434	29.54	200,604	15,718	8.5	218,687	18,083	9	88,592	68.10
Swale	71,234	78,399	86,218	94,536	23,302	32.71	116,872	15,524	15.3	133,446	16,574	14.2	62,212	87.33
Totals	**1,252,734**	**1,372,381**	**1,501,484**	**1,640,446**	**387,712**	**30.94**	**1,962,275**	**172,547**	**8.79**	**2,164,347**	**202,073**	**9.34**	**911,613**	**72.77**

[1] These allocations have been uplifted to reflect growth and increase in capacity.

APPENDIX IV - Financing the Health Economy – 2003

Recommendations – Outcomes

(References to paragraphs in original volume in brackets – this is available on request)

Comments in italics after each recommendation give an up-date on progress since the recommendation was made.

For the Strategic Health Authority and All Health Organisations in Kent

All parts of the health economy should recognise the changes in the financial regime, which now require them to:-

1. Continue to take seriously the fact that they must balance their budgets, live within their means and not overspend. (6.5.7)
(Partly achieved - overall deficits in the Kent and Medway health economy have reduced)

2 Monitor the realism of savings plans and their implementation whilst maintaining high quality care and access targets. (6.5.7)
(Partly achieved - Health organisations have produced good evidence of successful savings plans while star ratings have risen – but problems remain)

3. Maintain the level of capital investment that is sufficient to maintain the value and quality of the estate and equipment. (6.5.7)
(Achieved - There is good evidence of capital investment from a variety of sources including treatment centres, PFI funding and partnerships)

4. Keep a tight control on budget management in view of the high level of savings targets set in 2003/4. Savings at this level have never previously been achieved. (5.4.3)
(Achieved - Innovative ways of working, analysis of patient pathways, reorganisation of services, reviews of procurement have made savings)

For the Strategic Health Authority

5. Stabilise the whole of the Kent and Medway health economy, using the flexible terms of the £17m loan from the NHS bank. (5.4.1)
(Achieved, despite problems from other parts of the health economy)

6. To provide consistent and transparent information on Financial Strategies and in the monitoring of outcomes within the Health Economy in Kent and Medway.
(Achieved in part - Health organisation accounts are now clearer and the Department of Health has begun to provide more information on a national basis. See main report for further comments)

7. The Strategic Health Authority to offer help as required in understanding financial information from other parts of the health economy in Kent and to provide the information in a mutually agreed format to the NHS Overview and Scrutiny Committee on a regular basis.
(SHA, NHS Trusts and PCTS have all supplied the NHS OSC with board papers, accounts, and verbal and written evidence each financial year)

8. Promote the revision of the market forces factor (the cost of providing services between one area to another) so that it properly reflects the costs of providing services in Kent and Medway. (5.3.8)
(This remains a contentious issue for Kent and Medway – see recommendation in main report)

For the Strategic Health Authority and Primary Care Trusts

9. Continue to lobby, with Kent County Council, the Department of Health regarding favourable transitional support for Ashford and the Thames Gateway, as the resource allocation formula will only reflect population change retrospectively. (10.3)
(Achieved - this has been successful – see main report)

10. Continue to develop the options for a Business case for the establishment of a Cardiac Centre in Kent. (5.3.8)
(Angioplasty unit has opened at William Harvey Hospital Ashford and will open in Medway Maritime)

For the Primary Care Trusts

11. Devolve prescribing budgets to GP Practices to match accountability with responsibility for prescribing. (5.3.4)
(Progress with controlling prescribing budgets has been made by the employment of prescribing advisers working closely with GPs; Practice based commissioning is to be introduced to introduce accountability with responsibility)

12. Work with other Primary Care Trusts to capitalise the efficiencies that can be achieved my making best use of scarce resources, while still retaining a local focus. (10.6)
(Achieved - Primary Care Trusts are to be reconfigured)

13. Commission services for as many patients as possible within Kent and Medway who are currently being referred to London hospitals. (5.3.8)
(Achieved in part - Repatriation of some services has been possible but more is possible)

For NHS Hospital Trusts

14. For Trusts with above average reference costs:-

    Reduce local costs to the national average while maintaining the highest standards of quality and safety thus using the national tariff as a lever for

eliminating unnecessary variation in levels of cost and quality and boost the use of local health facilities when patient choice is extended in December 2005. (9.3)
(Partly achieved - work continues on improving reference costs)

For the Mental Health Trusts

15. The two Mental Health Trusts should work much closer together across Kent and Medway, for the benefit of all the patients in Kent, to make management more cost effective and make best use of scarce resources. (5.3.6)
(Achieved – Mental Health Trusts merge on 1/4/2006)

For Primary Care, Mental Health, Social Services and Ambulance Trusts

16. Encourage initiatives in partnership innovations where they provide a better service for patients and expand those services which give best value for money. (11.6)
(Achieved where development money has been available)

For the NHS Overview and Scrutiny Committee

17. Actively support the formulation of options for a Business case for the Kent Cardiac Centre. (5.3.8)
(Situation altered when decision to improve and extend other cardiac procedures in Kent – e.g. angioplasty - showed to be better value for money/more suitable for critical patient mass)

18. The NHS Overview and Scrutiny Committee Manager to obtain the Strategic Health Authority and all Trusts Board meeting papers.
(Achieved)

19. To request the Directors of the Strategic Health Authority to continue to attend open meetings of the NHS Overview and Scrutiny Committee on a regular basis in order to answer questions on the financial position of all parts of the health economy in Kent and Medway. (5.4.4)
(Achieved)