PRIME MINISTER

NHS REFORMS

Following the disappointing seminar on the NHS Reforms, Mr. Clarke has now provided a sheaf of papers setting out his plans for implementation in much greater detail.

At Flag A is a personal note from Mr. Clarke setting out the political case for going ahead with the reforms. At Flag B is a note covering the main papers (also copied to Treasury Ministers).

The important papers are at Flag C and Flag D; at Flag C is a thorough account of the proposed contracting system; at Flag D is a note which responds to the main criticisms made at the seminar. (There is also a host of background papers which Policy Unit are now considering.)

Assessment

The most interesting paper is at Flag C. It provides what should have been in the presentation by the NHS Management Team - a step-by-step account of how the contracting system will work in practice.

It brings out that in the first year the reforms are more an exercise in re-drawing the accounts than a radical shake-up of hospitals and health service management. They are a necessary first step that paves the way for more radical reforms and the introduction of a more market-based system in later years.

The papers present a more promising picture than previously of how the contracting system will be introduced in the first year. Nonetheless, the following issues seem to be the key to successful implementation: you may feel they require further consideration.

b

i) Preparedness: how ready are the regional health authorities (RHAs) and district health authorities (DHAs)? The papers quote health authorities which have already taken part in pilot exercises. (That does not of course cover all regions and districts.) At the seminar those with experience in London (Lord Rayner, Sir Robin Ibbs and Sir David Wolfson) expressed concern that health authorities were not ready. Others, Mr. Clarke himself and Howard Davis (Audit Commission) suggest that, drawing on evidence from a wider group of health authorities, most health authorities are ready to take on the changes. Mr. Clarke is proposing a further check on the state of readiness in September.

ii) Information: the key information requirements are on:

a) cross border flows - between regions, between districts, and within areas between units - and;

b) the speciality costing system, ie the unit costs of dealing with particular types of case episode.

Clearly a great deal of work has been done on cross border flows: some gaps remain; but, again, Mr. Clarke is proposing a further review of the position in September. The information on speciality unit costs is said to be satisfactory, though by no means precise: and there are questions of variance and referral stability considered below.

iii) Variance: there is year to year variance in patterns of illness (which is separate from patterns of referral) and differential growth in speciality unit costing. Also, the location of major accidents and incidence of flu epidemics varies from year to year. The extent of such variance and the significance of errors in speciality unit costing, could be important in determining the success of the contracting system. The paper is still not wholly persuasive on this aspect.

iv) Referral Stability: this was a major concern at the seminar and Mr. Clarke's officials have produced a fairly

thorough response to the points made. Paper D indicates there is a broad measure of stability; there is little evidence of doctors planning to change referral patterns quickly when the reforms are introduced; and there is a reserve capacity to cope with uncontracted referrals.

v) London: the paper at Flag C shows clearly how the new system would work. But it is based on a district health authority in Bristol. Moreover, even with a relatively stable pattern of referrals, the paper acknowledges there is still a 10 per cent uncertainty on the income side for units ie hospitals within the district. That level of uncertainty must be multiplied in areas like London, where there is a wider dispersal of patient, and therefore financial, flows; and, even under block contracts, the number of separate contracts would be large. The issue of London is really not addressed in the main papers - perhaps an indication that Mr. Clarke himself recognises special arrangements may be necessary there.

The Way Forward

The Policy Unit note (Flag E) suggests that the paper is more encouraging; that the reforms should go ahead in most areas on the basis proposed by Mr. Clarke; but that special arrangements are required in London.

Mr. Clarke has also made a powerful political case to you in his private note for continuing with the reforms. And you may well judge that these papers are much more reassuring about the modest nature and limited scale of the reforms in the first year. That said, you may nonetheless see attractions in a further exercise to check on the readiness of regional health authorities and district health authorities; and to check on the gaps in information and concerns about the variance in cost patterns.

Andrew Turnbull and I have considered who might undertake such an exercise: the best candidates would appear to be:

A

Bob Scholey }
Graham Day } on the NHS Management Board
Roy Griffiths }
Robin Ibbs

The Chief Secretary has suggested a further name - Christopher Bland, Chairman of LWT and a member of a London health authority.

Up to two or three of these could be asked to consider jointly or severally whether they believed the state of information and readiness within health authorities justified going ahead in all areas as Mr. Clarke plans. In view of time pressures they would have to report by no later than three weeks, ie Friday, July 20.

If you are to put these ideas to Mr. Clarke there are advantages in doing so on a personal basis early next week. I have arranged a provisional slot on Tuesday morning for you to speak to Mr. Clarke about the NHS reforms. However you also need to see him before E(LG) next Wednesday to explain that you, Mr. Patten and Treasury Ministers now all believe that the transfer of community care to LAs (except for the mental health proposals) should be postponed for two years. I do not think he will demur.

Conclusion

i) Content to see Mr. Clarke next Tuesday? Yes
and
ii) Content for him now to proceed with the reforms?
Or
iii) Do you wish to pursue the idea of a further exercise to check on the readiness of the health service for the reforms; and if so, which external experts might be asked to undertake the work? Yes pmd

BHP

BARRY H. POTTER
27 JUNE 1990 a:\economic\health.mrm

D

IMPLEMENTATION OF CONTRACTING FOR SERVICES

I. INTRODUCTION

1. Phase 1 The Management Executive's aim is to effect in April 1991 the basic practical change - resident-based funding - which will make securing the objectives of the Reforms possible over time. This is the first phase of implementing the Reforms. It is vital that it is introduced without disruption to patients' existing access to services. We do not expect GP referral patterns to change dramatically in the first year. GPs will generally be most concerned to agree quality standards with existing providers, though there will be some change at the margin. The Management Executive and RHAs are therefore concentrating on ensuring that accurate information on current patient flows is available this summer, and that DHAs discuss with GPs any planned changes. This will enable DHAs to let contracts which match expected patient flows based on the existing pattern and any variations which have been planned for and predicted.

2. Subsequent phases in future years will continue this policy of a managed approach to taking advantage of the opportunities of the Reforms. New and more effective referrals, increasingly challenging quality specification and greater competition between Units for VFM will come on stream at the pace of growing managerial and financial expertise and improved information systems. It is likely that this speed of change will vary between Districts in line with management capacity and their room for growth.

II. BASIC INITIAL CHANGE FOR PHASE 1

3. The approach to implementing phase 1 of the Reform process has a number of implications both for the characteristics of contracting in the first year, and for the management of the process by the Management Executive and RHAs.

4. Implications for contracting

a. All DHAs move to resident-based funding. It is not possible to manage the NHS on the basis that some DHAs are funded for their residents and others for the catchment areas of their local Units.

b. Block contracts will be in the majority. These will specify cost, quality of service and volume of activity. They differ from cost and volume contracts in that fluctuations in actual volumes will have to be managed by providers within the original price agreed for the contract. This minimises the risk of loss of financial control while a firmer information base is developed on case complexity, trends in referral patterns etc. Explicit specification of the key elements of service in the block contract is itself an improvement on current

arrangements. It also provides an effective basis for developing the information and expertise needed for more sophisticated contracts which will deliver the longer term objectives of the Reforms (point vii of the Note).

c. Prices will generally be based on specialty costs. Given that block contracts will cover the range of services which a DHA requires of an individual provider, this is feasible. There is no requirement for patient-based costing yet, but there will be incentives for providers to develop this as their information base allows.

[**Note:** see Paper B: "Contract Pricing: Cost Allocation Principles". See also Paper C: a report on practical work carried out in SE Staffordshire, as an example of the approach to developing prices].

d. Contracts in year 1 should include realistic and achievable quality terms which can, above all, be monitored. Future renegotiation will build on this.

5. Implications for the process of implementation:

a. RHAs are leading the work of sorting out cross-boundary flows in their regions. Decisions were made last year on inter-regional flows; these will be incorporated.

[**Note:** see Paper D: "cross-boundary flows" and DH revenue allocations].

b. Since the introduction of resident-based funding will be universal, there is no place for "piloting" in one or two regions/districts. This approach would not be illuminating, because artificial, and susceptible to wrecking. Instead the lessons from demonstration projects will be disseminated. (Point (viii) of the Note).

c. Heavy emphasis needs to be placed on DHAs and Units maintaining financial control. This means that DHAs contractual commitments must be reconcilable with cash limits; and providers expenditure reconcilable with contract income. This is a complicated field which the ME is ensuring is grasped fully by the NHS.

(Management Executive=ME)

[**Note:** see Paper A: "Financial Management in DHAs" for a description of how this will work in practice].

d. The NHS needs to ensure that a basic minimum of information flows under contracts to allow performance to be monitored. A contract "minimum data set" has been devised in agreement with the NHS to achieve this.

[**Note:** see Paper E: "Framework for Information Systems: Next Steps"].

e. RHAs will be required to ensure that DHAs contract to meet existing referral patterns, and desired changes whose effects can be planned for and predicted.

f. The Management Executive is securing a measured pace of change by:

- monitoring each RHA's timetable and essential tasks up to April 1991.

- requiring position statements on achievement of essential tasks in September and December for all DHAs and Units.

- ensuring that information on patient flows is fully quantified by September.

g. The Policy Board reviews progress at each of its monthly meetings.

III EXPECTED PRACTICAL ACHIEVEMENTS OF FIRST YEAR

6. a. Putting in place the structure of the new system, which will allow individual DHAs and Units to move forward thereafter at a differential pace ie, in line with management capacity, financial skills, and quality of their data.

b. Securing beneficial change in referral patterns where they can be planned and their effects predicted.

c. Huge increase in the quality of information on which decisions are based, particularly on patient flows (in diagnostic and post coding of residents).

d. Basic quality standards, including waiting times, specified in contracts. They will be capable of being monitored, compared and informing future renegotiation to improve them.

e. Entrenching incentives for both providers and purchasers to take advantage of the new opportunities.

IV. RISKS IN FIRST YEAR (AND CONTAINMENT)

7. a) "Making complex change [cannot] be achieved without extra money to smooth transition and accommodate the changes". (Points (i) and (vi) of Prime Minister's Private Secretary's Note of 15 June)

- Certainly extra money would allow a faster pace of change. But, am ensuring that speed of change is in line with available resources for implementation and with management capacity. Confident that can achieve phase 1 for 1991 with resources available. Concentrating on ensuring that resources are available for securing essential tasks: understanding patient flows of DHA residents.

[Note: see Paper F: resources obtained for implementing WP in PES settlement]

b) What if referral patterns are inaccurately predicted? (points (iii) and (x) of the Note).

- Concentrating above all on this task. RHAs working closely with all DHAs and Units to quantify and validate information on patient flows throughout Summer. Already greatly improved accuracy. Will make a comprehensive review of the position at end September. Confident that NHS can achieve sufficient accuracy.

c) What if all hospitals expect increased referrals than in past? (point (iii) of the Note).

- Don't believe many hospitals believe that they can secure greater proportion of referrals in first year; view only of more aggressive (e.g., City and Hackney DHA). Clearly not a sensible expectation across the board, unless hospitals achieve greater efficiency. However, DHAs hold purse-strings, and will start by contracting largely for existing referral pattern under RHA supervision. Of course, hospitals competing to increase activity is beneficial, as long as DHAs respond in a controlled fashion

d) What if GPs decide they wish to change their referral patterns radically (particularly "shire" GPs who want more local treatment)? (point ix of the Note).

- Crucial for DHAs to consult local GPs closely. RHAs ensuring this happens. If GPs want change DHAs will need to work with them to ensure change is at speed which can sensibly be planned.

- Ultimately, if GPs insist on referring outside contracts, it will be handled with extra-contractual mechanism (see (e) below). But there is considerable inertia in GP referral preferences. Will not quickly abandon the particular consultants, and local specialist hospitals they have been using.

- Recent reports from District surveys suggest that existing GP referral patterns will remain largely unchanged in the short term as GPs take on commitments under the new contract and take stock of services offered, particularly in terms of quality of care for their patients.

- We are requiring all districts to establish referral patterns by the Autumn but some districts have already done a good deal of work. For example Eastbourne Health Authority has strong links with its GPs and Family Health Service Authority and has been able to establish that its services in 1991 will be based very largely on current referral patterns; South Lincolnshire Health Authority already has a picture of referral patterns by its GPs both within and outside the Trent Region - the majority of these are predictable and will involve local hospitals. St Helens Health Authority has reached the stage of discussing and agreeing the proposed content of contract specifications with local GP representatives, particularly as it relates to service standards and quality requirements. A number of other districts, whilst surveying current information on their GPs' referrals, are also engaged on special exercises to analyse future activity, particularly by practices on district boundaries and GP fundholder applicants.

e) What if GPs make large scale use of the extra-contractual referral mechanism?

- DHA's clear objective is to work with the grain of local GP preference. But guidance made clear ("Operational Principles") that DHA has to consider overall needs of residents and cannot be mere cypher. Emergency extra-contractual referrals will always be funded. Do not believe GPs will pursue perverse objectives in this area. Non-emergency extra-contractual referrals unlikely to be refused by DHA, but release of funds to hospital will have to take its place with other priorities. Therefore,

a capacity and waiting list issue as now. However, do not believe a significant issue, given inertia of present referral patterns.

[Note: see also Paper G: Contracts for Health Services: Operational Principles]

f) What if DHAs, particularly in the Shires, decide to switch contracts from distant (particularly London) hospitals to local Units?

- Do not believe it is likely to occur. Most referrals to major London Hospitals, and similar Units, are justified on clinical grounds. Both local GPs and clinicians will want them to continue. However, the Management Executive will have a clear idea of DHAs contracting intentions by end September. RHAs will step in if there is any evidence of plans to switch contracts to local hospitals to a degree that would cause substantial financial turbulence. They will ensure such contracts are phased in to avoid uncontrollable instability in the first year of the reforms. If necessary, Secretary of State has reserve legal powers to make Directions to DHAs. However, some beneficial change in referral patterns, in favour of Shire counties, which has been planned and predicted, is likely to occur deliberately, so as to improve services.

g) What if DHAs hold "contingency funds" in case of unexpected demand and therefore reduce activity levels (point x of the Note)?

- DHAs will be expected to commit all their resources under contracts initially, except for those needed to meet expected extra contractual payments for small patient flows. Providers will therefore have a large measure of certainty. These small reserves will allow flexibility to meet unpredictable flows and emergency demand. DHAs will not be expected to set up contingency reserves beyond those needed for extracontractual referrals and emergency admissions. RHAs will need to consider whether this provides adequate certainty or whether some standby arrangements are needed.

  [See Paper A: "Financial Management in DHAs" for further discussion of the approach in practice, particularly sections 7 and 8. The worked example suggests that variations in the level of uncontracted activity in a Unit are likely to have

small effects. In the teaching hospital example (Unit 1) a 10% variation only amounts to a £0.7m shortfall. (Paragraph 7.7)

h) What if DHAs have to manage 1,000s of contracts? Could they cope?

- Much of this concern is based on a misunderstanding of what a contract is. Generally, it will cover all the services that a DHA requires from a particular provider. Therefore, a large number of specialties will be wrapped up in a single contract.

  [Note: see specimen contracts in Paper H: "Operating Contracts].

- For most DHAs, the great majority of services will be obtained from a few local providers, and they will not need many contracts at all. Particular concerns have been expressed about teaching hospitals and other centres of excellence which attract referrals from all over the country. Further examination has however shown that although the total number of purchasers is large, the great majority, by volume, of treatment is carried out for a manageably small number of DHAs. [see for example paragraph 6.4 of Paper B: Unit 1 a teaching hospital will enter into four contracts]. The other small flows can be managed on a "cost per case" basis as they arise.

- The London Health Planning Consortium (LHPC) Table C4 discussed at the seminar shows that, though the position is more complex in London than elsewhere and more contracts would be required, the numbers would not be enormous.

- More recent figures are not available on an exactly comparable basis, but in 1985, 89% of Guys local acute patients came from 10 district health authorities, 91% of Kings patients were from 10 DHAs, as were 81% of City and Hackney patients.

- Furthermore, most work will go into establishing the contract (including quality specification) between the "primary" purchaser and provider - typically between the district and its local district general hospital. This will serve as a basis for negotiation with other purchasers. There will be some room for variation in the terms, but major differences in the kind/quality of services offered to different clients within the same hospital would be neither practicable nor desirable.

- RHAs are ensuring that all Units, including hospitals with a national catchment, have identified their purchasers, by volume, by end September. A review of the position will be undertaken then.

i) What if there is no information on usage of out-patient facilities? How can contracts be agreed?

- It is recognised that inadequate information will prevent DHAS from securing improvements in quality and efficiency though contract negotiation as quickly as for acute services. But an important benefit of the Reforms is the priority being given by the NHS to developing a minimum data set for out-patient care which will be passed by Units to contracting DHAs. Work is in hand to develop computer-based facilities at Unit level. This will bring the quality of out-patient information up to the level of in-patient information, and allow similar sophistication in contracts.

- Such facilities will not be universally available in 1991/2. However, a large part of the usage of out-patients departments can be integrated with contracts for the in-patient services to which it leads. Out-patient departments can be maintained by DHAs at existing levels through block contracts.

j) What if a hospital runs out of money in mid-year?

- The arrangements we envisage will ensure that this is no more likely in future than now. Most services will be secured through "block" contracts which will specify that a price will be paid in regular instalments throughout the year for access to facilities. Hospitals, as now, will manage the workload to ensure that expenditure does not outstrip contractual income.

  [**Note:** see Paper A: on "Financial Management of DHAs", particularly sections 6 and 7).

k) What if DHAs are late in paying bills for services delivered? How will hospitals cope?

- The ME is developing NHS wide arrangements to secure prompt payment of invoices. In essence, RHAs will be able to pass money to Units directly if DHAs are dilatory in payment.

  [Note: see Paper A: Financial Management in DHAs, para 10.4; and Paper I: "Framework of Rules for Contract Billing and Settlement")

l) What if a high occupation of hospital beds by geriatrics prevents Units coping with new inflows of patients. (Point iv of the Note).

- This is not a problem for the implementation of contractual funding, since DHAs will largely contract on the basis of existing services. The real solution lies in the effective implementation of "Caring for People" so that people who can live in the community are enabled to move back there.

V RISKS AVOIDED BY PHASED APPROACH

8. The strategy discussed above avoids the dangers of too rapid change, particularly:

a higher costs of implementing change due to need to develop sophisticated contracting skills for 1 April 1991.

b disruption in the NHS due to uncontrolled shifts in referral patterns.

c wasted resources due to purchasing precise volumes of services on the basis of inadequate information from providers where demand does not materialise.

d threat to the viability of Units due to uncontrolled change in demands for services by DHAs.

VI NHS RESPONSE TO IMPLEMENTATION OF CONTRACTING

9. RHAs are responding to the challenge. Attached are two reports showing how the implementation process is happening on the ground:

Paper J:	NW RHA:	"A New Way of Thinking"
Paper K:	SW RHA:	"Service Contracts Proposals 1991/2"

VII ANNEXES

10. a. Annex 1 lists the points in the Prime Minister's Private Secretary's minute of 15 June and the relevant paragraph of these papers.

b. Annex 2 lists the additional papers referred to.

Annex 1

Points in Note of 15 June	Paragraph which covers
(i) Start Up Costs	7(a)
(ii) Introduce Trusts and Practice Funds alone	Secretary of State's cover letter
(iii) Patients flow forecasts - accuracy	7(b), 7(c)
(iv) Bed blocking	7(l)
(v) Getting existing Management Systems right	Secretary of State's cover letter
(vi) Start Up Costs	7(a)
(vii) Block Contracts	Secretary of State's cover letter and 1, 2 and 4(b)
(viii) Pilots, Partial Implementation	Secretary of State's cover letter and 5(b)
(ix) Referral patterns - stability	7d) (e) (f)
(x) Referral patterns - forecasts	7(b), (g)
(xi) Contingency Reserves	7(g)

ANNEX 2

Paper A: "Financial Management in DHAs"

Paper B: "Contract Pricing: Cost Allocation Principles".

Paper C: A report on practical work carried out in SE Staffordshire, as an example of the approach to developing prices.

Paper D: (D1) "cross-boundary flows"; (D2) DHA revenue allocations

Paper E: "Framework for Information Systems: Next Steps".

Paper F: Resources obtained for implementing WP in PES settlement.

Paper G: Contracts for Health Services: Operational Principles (particularly paragraph 3.5)

Paper H: "Operating Contracts.

Paper I: "Framework of Rules for Contract Billing and Settlement"

Paper J: NW RHA: "A New Way of Thinking"

Paper K: SW RHA: "Service Contracts Proposals 1991/2"

PAPER A

FINANCIAL MANAGEMENT IN HEALTH AUTHORITIES

The attached note explains the calculations which underpin moving from the existing funding system (funding of managed facilities) to the funding of hospitals via contracts held by purchasing authorities. The calculations are based on a model district health authority. The calculations can appear complex and the following table summarises the key steps and shows how the system is self balancing and designed to minimise risk.

	Model DHA		Other DHAs
	Purchaser £m	Provider £m	£m
The current cash limit for the DHA		114.3	-
Add: capital charges (new cost introduced)		22.4	
Revised baseline		136.7	
Transfer to other DHAs of cash currently spent on treating their residents		(25.7)	25.7
Transfer from other DHAs of cash currently spent by them on treating Model DHA's residents		13.3	(13.3)
Revised cash limit for DHA		124.3	
Purchase allocation for DHA	124.3		
Expenditure on contracts with own provider units	(109.1)	109.1	
Expenditure on own residents treated in other districts			
- contracted	(9.4)		} 13.3
- extra contractual	(3.9)*		}
Income from other DHAs for treatment of their residents			
- contracted		17.8	} (25.7)
- extra contractual		7.9*	}
Net Position	1.9	134.8	-
Expenditure as at present		136.7	

* These items are the true risk items in respect of the purchaser needing to pay for uncontracted flows or the provider not receiving all of the income expected.

FINANCIAL MANAGEMENT IN DISTRICT HEALTH AUTHORITIES

1. Background

1.1 This note explains how:

(a) financial allocations will move from the current basis to resident population funding;

(b) districts and units will operate financial control and management from 1 April 1991.

1.2 The principles involved are illustrated by reference to a model District Health Authority. The figures used are drawn from those of a DHA which is more complex than average; it is a teaching district and is in an urban area and hence has higher than average cross boundary flows. Whilst some simplifying assumptions have been made, the problems illustrated are not understated in respect of the majority of the country. London districts are more complex than shown but raise no new issues of principle.

2. Basic Principles

2.1 DHAs are currently funded for the facilities that they manage. From 1 April 1991 they will be funded for their resident populations. Section 4 explains how Regions establish the funding basis.

2.2 Having been funded for their resident populations DHAs enter into contracts with provider units for health care for their resident populations. Sections 5 and 6 explain how this is done and how the process will be managed from the perspectives of the DHAs as purchasers and units as providers.

2.3 Individual provider units have to manage their financial affairs each year to live within their contract income. Section 7 explains this.

2.4 DHAs have a duty to ensure that they do not overspend against allocated funds. This means that:

(a) as purchasers they must not overspend their funds in purchasing health care;

(b) as managers of provider units they must ensure that provider units balance their expenditure with income;

(c) their administration budgets are not overspent.

The tensions within the systems are managed in this framework. Section 8 explains the techniques.

2.5 In due course Regions will change DHA allocations to move them to weighted capitation. This could be more or less than the current resident population based allocation (ascertained as described in Section 4) and this move will be managed by Regions as explained in Section 9.

3. The Model DHA

3.1 The model DHA is a teaching district in an urban area. It has a resident population of 367,000. It has 10 acute sites organised and managed geographically into 2 units, with 800 and 600 beds respectively. It has a further unit which manages 12 sites covering largely mental illness and mental handicap. Its other activities comprise community services and it runs an ambulance service largely for its own hospitals.

3.2 The current revenue allocation and expenditure of the DHA is £114 million analysed as follows:

	£m
Acute Unit 1	51.7
Acute Unit 2	21.8
MI/MH Unit 3	13.6
Total units	87.1
Community services	17.8
Patient transport	5.4
Headquarters	4.0
	114.3

3.3 Over 20% of the patients in the 2 acute units come from outside the district. About 15% of the model DHA's residents are treated outside the District.

4. Resident Population Funding

4.1 Regions are required to commence resident population funding in 1991/92 for each DHA by reference to the cost of patient care currently received by their residents. The preliminary steps involved are:

(a) analyse own hospitals' 1989/90 data into:
  (i) residents treated;
  (ii) non-residents treated by district of residence.
  This, for in patients, is available from Korner activity statistics maintained by all authorities. Outpatients can be more complex and may need to be estimated for 1991/92;

(b) cost the activity data in (a). This is done using Korner specialty costs already produced routinely by health authorities;

(c) obtain from other districts/regions information about costed flows relating to a DHA's own residents not treated in the home district. This is handled through a clearing house in Mersey RHA. If all districts/regions submit their activity data by end June 1990, all districts and regions will have access to costed activity data by the end of July 1990.

4.2 In the case of the model DHA the DHA's own data show the following patterns:

	Own residents	Other DHAs	Total
Activity:			
In patient episodes	50,800(74%)	17,500(26%)	68,300
Outpatient attendances	507,000(85%)	76,000(15%)	583,000
	£m	£m	£m
Costs:			
In patients	38.6	13.1	51.7
Out patients	12.0	1.8	13.8
	50.6	14.9	55.5
Unallocated costs			21.6
			87.1

4.3 Costs have been calculated for all activity on an average specialty cost basis for each unit; data are already collected at that level. Unallocated costs are "general services" costs which cover management costs, record keeping, portering, cleaning, estate maintainance and other non-direct patient treatment costs. In order to cost the activity properly these costs will have to be apportioned to the specialty costs, probably on the basis of percentage uplifts. In this case unallocated costs are 33% of the allocated costs and all costs would be uplifted by 33%. This gives a revised pattern of costs:

	£m
Own residents	67.3
Other DHAs	19.8
	87.1

4.4 Regions and districts will also need to ensure that the cost base is in line with that actually being used in 1991/92. There are two principal factors here:

(a) devolution of health authority functions to unit level in line with "Working for Patients" and recharging of some ambulance services and common services. This will tend to increase unit level costs and hence the costs of patient activity. Estimates of this should be made by July 1990;

(b) capital charges which will be introduced from 1991/92 and will arise principally at unit level. First estimates of these are due at the end of June 1990 with definitive estimates by the end of September 1990.

4.5 The model DHA estimates that capital charges are £22.4 million making total costs:

	£m
DHA costs (para 3.2)	114.3
Capital charges	22.4
	136.7

4.6 After taking account of devolution of DHA functions and recharging transport services to units, the following cost pattern emerges:

	£m
Units 1 to 3 - Own residents	86.6
Other DHAs	25.7
	112.3
Community	20.0
Transport	2.5
HQ	1.9
	136.7

An analysis of the link between these figures and those shown at paragraph 3.2 is set out in Annex A.

4.7 The steps outlined above give a preliminary total for 1989/90 activity costed on 1991/92 bases. The figures also need to be adjusted by:

(a) estimated changes in 1990/91, both cost and volumes for example from service developments. The principal source here will be the Short Term Programmes (prepared March 1990) and Planning Statements (to be prepared by July 1990). Changes in activity as seen by each DHA needs to be analysed further into own residents and other

residents. Significant changes in respect of the latter category need to be notified to the other regions/districts involved;

(b) a factor to get to 1991/92 cost levels. This will not be done definitively until after the Autumn Statement though calculations can be made on the basis of existing inflation estimates;

(c) likely changes in referral patterns in 1990/91. If districts are to be funded to allow them to purchase at least the same amount as their residents currently receive, the impact of changed patient flows also needs to be considered. This would be particularly important in the context of known major changes - for example the opening of a new hospital. Simple shifts from hospital A to hospital B are unlikely to be a major problem in arriving at resident population based funding unless there are significant cost effects.

4.8 In the model DHA very few changes are anticipated and no adjustments are being made; for simplicity 1991/92 cost levels (paragraph 4.7(b)) are ignored. Hence the resident population funding is drawn up from the districts residents' use of its own facilities plus its residents' use of other districts facilities on a fully costed basis. This gives:

	£m
District funding (para 4.5)	136.7
Less: portion attributable to other districts' residents (para 4.6)	(25.7)
	111.0
Add: Cost of treating residents in other districts	13.3
	124.3

4.9 The costs of treating residents in other districts are ascertained by Regions from data held by other districts within the Region or, in respect of patient flows outside the Region, from other Regions based on the data exercise described at paragraph 4.1 above. The figures quoted at paragraph 4.8 include all relevant costs; these might not be available fully initially and Regions will probably carry out preliminary calculations based on figures excluding capital charges, leaving the capital charges effect to be added on separately when the final estimates for 1991/92 capital charges are known (September 1990).

5. Contracts: the DHA perspective

5.1 All of the activity costing steps described in Section 4 provide background data to districts and units for contracting as well as providing the data for ascertaining revenue allocations to districts. There is an in built symmetry in the system: districts are funded to purchase on the basis of the actual costs of current patient activity in the units with which they deal leading to contracts on the same basis.

5.2 From the model DHA's perspective, the basic revenue allocation will be £124.3 million (paragraph 4.8). £1.9 million needs to be kept back for HQ expenses (after allowing for devolution of functions) leaving £122.4 million to be contracted.

5.3 The DHA will have considered likely changes in referral patterns as part of its contribution to the exercise of establishing the baseline for resident population funding (paragraph 4.7) and at present considers that no account need be taken of changes. This is a key assumption and DHAs are required to have carried out detailed enquiries of their local GPs; this process needs to be completed by September 1990.

5.4 Assuming that the assumption of no significant change in referral patterns holds, the DHA will want to enter into firm contracts with as many units as possible so as to ensure that its residents have access to the treatments etc. that they need. For significant patient flows the norm is block contracts which specify:

(a) price;
(b) likely volume; and
(c) quality measures (e.g. waiting times).

5.5 Each DHA is required to fund Accident and Emergency Services within its district for all comers (i.e. the district of residence is not relevant). These are provided at a cost of £3.2 million in two of the units and hence two contracts would be placed for these.

5.6 Other patient activity within the district is significant. Activity can currently be categorised nationally over 21 specialties (plus 12 very specialised areas handled on a supra-regional or supra-district basis) though not all are carried out at each unit. Contracts could be entered into for each unit and each specialty or could be specified on a unit basis with detailed schedules analysing individual specialties. Within the model DHA this could result in 37 individual specialty based contracts or three contracts each containing specialty details (the largest number of specialties within a single unit being 19). As simplicity is the order of the day, the district will probably enter into three main and two A&E contracts covering the £86.6 million of costed activity for its residents (paragraph 4.6) as follows:

	Total £m	Main £m	A&E £m
Unit 1	48.6	46.6	2.0
Unit 2	22.2	21.0	1.2
Unit 3	15.8	15.8	-
	86.6	83.4	3.2

Likely volumes will be specified (see paragraph 4.2 for overall numbers) and allocated to the individual specialties.

5.7 For other activity, the DHA will enter into contracts with the community unit (£20.0 million) and patient transport (£2.5 million).

5.8 The out of district treatment of patients is all in respect of acute specialties. An analysis of the £13.3 million of costed activity relating to residents treated outside the district (paragraph 4.8) shows:

	Total £m	In patients £m	Episodes	Outpatients £m	Attend-ances
Hospitals in district A	3.7	3.1	3,100	0.6	15,500
Hospitals in district B	5.7	4.9	5,000	0.7	20,000
Major flows	9.4	8.0	8,100	1.3	35,500
Minor flows 85 districts	3.9	3.3	3,600	0.6	15,200
Total	13.3	11.3	11,700	1.9	50,700

5.9 Districts A and B represent 3% and 4.5% of the DHA's total expenditure (and 3.7% and 5.6% of total specialty based activity contracted for). The activity is spread over 15 specialties (6 in District A and 9 in District B). The DHA regards these flows as significant enough to enter into contracts in advance and will probably want contracts similar to those drawn up for its own units (i.e. two contracts supported by specialty-specific data).

5.10 None of the remaining patient flows is very significant and the range is from 5 patient episodes (one-off tertiary referrals and emergency admissions) to in excess of 100 episodes in other districts within the region. The DHA decides that the nature and incidence of the referrals makes it impractical to contract in advance and hence will hold in its budget £3.9 million of uncontracted sums to meet the costs of the referrals when they arise. Having discussed referrals with local GPs (paragraph 5.3) the model DHA

considers that there is no reason to believe that this will be materially incorrect.

6. Contracts: The unit perspective

6.1 The DHA has three main units plus a community unit. Unit 3 deals with mentally ill and handicapped patients largely and does not have patients from other DHAs. It will thus expect to contract for all of its activity with the DHA, as will the community unit.

6.2 The two large units will, however, need to enter into a number of contracts to reflect their complex flows. Disregarding Accident and Emergency facilities, the number of districts and specialties involved is potentially:

	Unit 1	Unit 2
No. of specialties	17	14
No. of districts involved	120	30
Potential number of contracts	2,040	420

6.3 In practice this will not be necessary provided that major patient flows are covered by the kind of broad block contracts used by the units' own district. A fuller analysis of activity shows:

	Total £m	In patients £m	In patients Episodes	Outpatients £m	Outpatients Attend-ances
Unit 1					
Own DHA	48.6	36.3	30,700	12.4	300,000
District A	6.3	5.1	4,300	0.9	19,100
B	3.7	3.3	2,200	0.5	10,600
C	3.0	2.8	2,100	0.3	9,400
116 districts	7.0	6.2	3,900	0.8	16,400
	68.6	53.7	43,200	14.9	355,500
Unit 2					
Own DHA	22.2	16.1	17,500	6.1	172,200
District A	2.2	1.8	1,800	0.4	9,000
C	2.6	2.2	2,100	0.4	10,000
27 districts	0.9	0.9	1,000	-	-
	27.9	21.0	22,400	6.9	191,200

6.4 Thus Unit 1 will expect to enter into four major contracts and Unit 2 will expect to enter into three. Unit 2's extra activity is largely derived from emergency admissions which will be billed to districts of residence on an ad hoc basis. Unit 1 is more complex with a mixture of tertiary referrals and emergency admissions accounting for 70% of the £7 million uncontracted patient flows; the remaining 30% comprises one-off referrals from GPs who trained at the medical school. Again, none of these will be covered by contracts placed in advance.

7. Provider unit financial management

7.1 Those units whose income is covered wholly by block contracts have a financial management task which is approximately equal to the current task, viz. living within their budgets. Hence if costs rise ahead of forecast for any reason, countervailing management action would need to be taken to increase efficiency and/or reduce cost levels. Contracting adds no further pressures. This would cover Unit 3 and the community unit (and would also apply to management of the HQ budget and the patient transport services).

7.2 Units 1 and 2 will be operating in a slightly different environment. Health authorities have been told to calculate their costings on the basis of expected activity levels and hence it is not open to them to cover all of their costs in their known contracts. This makes the provider units vulnerable as to contract income as follows:

	Total expected income	Uncontracted	
	£m	£m	%
Unit 1	68.6	7.0	10.2
Unit 2	27.9	0.9	3.2

7.3 A large proportion of provider unit costs is fixed in the short term (probably 95% or more) and scattered volume shortfalls result in an inability to cover fixed costs without a corresponding ability to reduce staff etc. to reduce the fixed costs. Furthermore, some fixed costs cannot be reduced even in the medium term; for example, capital charges which will account for about 20% of provider units' costs will only be saved if buildings are closed and sold.

7.4 Provider units will also be facing risks related to their activity covered by block contracts. If the units fail to control activity and activity runs ahead of the volumes specified in the contracts, they will not generally expect to receive payment. It is for units to manage the cost/activity equation as at present. Indeed, provider units will be expected to be efficient and provide higher levels of activity each year as has been the case in the past. If, on the other hand, referrals fall short of those for which contract income has been received, the unit will have spare capacity for which it has already covered its costs. It can

thus market its spare capacity at marginal cost and attract more income.

7.5 The picture is thus of complex interactions between activity levels and costs with both advantages and disadvantages to the units. These can be broadly summarised:

	Advantages	Disadvantages
Advance contracts	Certain source of income.	Need to control activity within specified totals.
	Under referrals create marginal capacity which can be marketed.	
One-off contracts	Ability to charge for every patient. No need to control activity.	No certainty as to income.

In all cases, the provider units will need to manage their cost levels.

7.6 Unit 2 is not regarded as being particularly vulnerable. If it manages cost and activity well it will remain vulnerable as to the £0.9 million of uncontracted flows but as most of these are emergency admissions, there seems to be no major problem. A 10% shortfall in this area amounts to only £0.1 million.

7.7 Prima facie unit 1 has a higher level of uncertainty at 10.2%. If there have been no major consultant changes, tertiary and one-off referral levels would be regarded as reasonably reliable. A 10% shortfall, however, would result in a £0.7 income shortfall.

7.8 Regions will have to look at the potential income shortfalls across the units in the Region to see if some form of underpinning is required. In the private sector some sort of standby facilities would be arranged for projects or businesses which are fundamentally sound but subject to the possibility of income shortfall. One possibility is a Regional bridging fund to cover, say, up to a 10% shortfall in vulnerable (i.e. uncontracted) income. This would need to be linked to a management action plan to counter the impact of income shortfall. Taking the country as a whole a shortfall in one unit is almost certainly balanced by extra activity in another unit but the cost effect in different units has to be considered, in particular the effect of fixed costs in provider units. Regions will need to be analyse this total vulnerability when resident population funding is complete and matched with contracting intentions. This exercise is expected to be complete regionally by the end of September.

8. DHA financial management

8.1 Districts have to manage their budgets as purchasers of health care and ensure that their provider units balance their books so far as possible. In addition they have to manage their HQ budgets. There will be one cash limit (or allocation) to each DHA covering all of its purchaser, provider and HQ activities and it is the legal responsibility of the DHAs and their senior executives to manage this.

8.2 The purchaser budgets of DHAs are largely managed through block contracts. The advantages and disadvantages of these contracts are the reverse of those for provider units (paragraph 7.5). They leave activity pressures to be managed by provider units where contracts are held while leaving the DHA vulnerable if referral patterns suddenly shift away from the units where block contracts are held. In addition DHAs need to be able to cover the costs of out-of-district emergency admissions of their residents, the incidence of which might change.

8.3 The model DHA has let block contracts as follows:

	£m
Unit 1 (para 5.6)	48.6
Unit 2 (para 5.6)	22.2
Unit 3 (para 5.6)	15.8
Community (para 5.7)	20.0
Patient transport (para 5.7)	2.5
District A's units (para 5.8)	3.7
District B's units (para 5.8)	5.7
	118.5

8.4 Its minor flows have been costed at £3.9 million (paragraph 5.8) - 3.2% of total purchaser expenditure. If there were a 10% increase in this non-contracted activity that would amount to only £0.4 million (0.3% of the cash limit). There is, however, no corresponding cost reduction in the units (because of the incidence of fixed costs - paragraph 7.3) if this results in referrals switching from those units.

8.5 Just as Regions need to consider some form of standby facilities to help provider units whose activity forecasts prove to be incorrect (paragraph 7.8) it may well be efficient for Regions to offer similar schemes for DHAs whose referral experience changes from that anticipated. Again Regions need to ascertain the size of the potential problem in September.

8.6 Districts will need to exercise financial oversight of their DMUs to ensure that in particular their budgets are drawn up on realistic bases and that costs are properly managed. Standby bridging finance should not be available in respect of poor cost management as the managers of provider units should bear the full responsibility for this.

9. Weighted Capitation

9.1 When Regions have calculated the resident population based allocations (Section 4) they also need to calculate the weighted capitation position. This is likely to show many districts being above or below their target in terms of weighted capitation. The impact of capital charges may affect this radically.

9.2 All Regions should be in receipt of full weighted capitation by 1992/93 in respect of revenue. Capital charges equalisation will be appraised in October 1990 when firm estimates of 1990/91 capital charges have been received.

9.3 It is for each Region to produce a strategy by the end of September 1990 to move districts' basic revenue allocations to weighted capitation. No end point has yet been set for Regions to achieve this but some Regions may need five years or more. In particular Regions with relatively small amounts of real growth in resources will find it hard to make progress except in the context of defined strategic moves (for example, the physical rationalisation of services which reduce the size and cost of local facilities). Others with average growth may be able to adopt a rising tide approach - leaving the "losers" where they are in real terms while allocating extra resources to the "gainers". Regions with growth in excess of average growth have the greatest flexibility and should require only two or three years to complete the task. Most of the losing districts are in urban areas and the gaining districts in the surrounding non-urban areas.

9.4 Weighted capitation is not a major issue for the model DHA as it is reasonably close to its target income and its Region is receiving average real growth. It can be seen, however, that a reduction in allocations to the DHA would require a reduction in amounts committed to contracts (or held for other referrals and admissions). This would only be practicable - in terms of at least maintaining the current levels of patient care - if one or more of the units were able to reduce its average cost per case through additional efficiency. This position is thus much as at present when allocations to districts change.

10. Other matters

10.1 This section briefly considers the impact of:

(a) NHS Trusts;
(b) GP fund holders;
(c) cash flow issues;
(d) how to deal with additional real allocations made as a result of the 1990 Public Expenditure Survey.

10.2 The only real impact of NHS Trusts is that they cease to be the direct financial responsibility of their district and become directly responsible to the Secretary of State via

the NHS Management Executive. Hence the NHSME, rather than Regions, has the task of ascertaining the financial vulnerability inherent in their contracts and budgets. Each potential NHS Trust is being comprehensively appraised (by external consultants) by September 1990. Comprehensive data will hence be available to the NHSME to assist in recommending to the Secretary of State that an NHS Trust should be set up (average or less financial risks) or not (more than average). If Unit 1 applied to become an NHS Trust, the NHSME would have to decide how realistic its income forecasting is, how vulnerable it is on its 10% uncontracted income and how well it has demonstrated its ability in the past to control cost and activity.

10.3 GP fund holders are not particularly more complex from a district's view point. Some of the district's own allocation will be transferred to a GPFH and the GPFH will contract direct. Districts will remain responsible for the costs of patients in excess of £5,000 in any one year. The average episode cost in the model DHA for the procedures which GPFHs are expected to contract for direct is around £1,150 and more refined costing may well produce a lower figure; hence the risk for the DHA is unlikely to be very great. From a provider unit's perspective, they are likely to see an increase in the amount of activity covered by contracts <u>not</u> let in advance though GPFHs will be encouraged to contract for as much as possible. The number of GPFHs is critical here. The standby facilities for provider units (paragraph 7.8) apply here. At worst a provider unit would see an additional 3% or 4% of its income appear less secure in not being contracted at the start of the year and even if, say, 10% of that was referred elsewhere the residual problem becomes only 0.3 or 0.4%.

10.4 Cash flows undoubtedly become more complex from 1 April 1991 but not unmanageably so. Guidance has already been issued to authorities that block contracts should be paid for on a monthly or similar basis to match the underlying expenditure; this minimises the leads and lags in the system. For activity not covered by contracts in advance there will be a payment lag of up to two and a half months (maximum one month to issue the invoice, then maximum of one month to settle and in default of that payment made almost automatically 2 weeks after that by the RHA). The effect of this on the model DHA is:

<u>DHA</u>	£m	£m
Block contracts	118.5	
Uncontracted	3.9	
	122.4	
Potential lag: 2 1/2 months re £3.9 million (cash not paid until maximum 2 1/2 months later).		(0.8)

Unit 1		
Block contracts	61.6	
Uncontracted	7.0	
	68.6	
Potential lag: 2 1/2 months x £7 million		1.5
Unit 2		
Block contracts	27.0	
Uncontracted	0.9	
	27.9	
Potential lag: 2 1/2 months x £0.9 million		0.2
Other units - all block contracts		-
		0.9
Net cash lag in receipt of funds within the District. (0.7% of cash limit)		

All of these lags will net out in the NHS and Regions will need to make marginal changes to allocations in 1991/92 so that net importing districts are compensated for the lag in receiving payment and that net exporters do not gain an unexpected increase in their cash purchasing power. After 1991/92 only changes in the net position will have an effect i.e. this is largely a one-off cash effect.

10.5 Additional real allocations made for 1991/92 will be allocated to Regions in accordance with bases which are already established by reference to achieving weighted capitation at Regional level by 1992/93. Those districts in receipt of extra allocations will be expected to ensure that the vast majority is covered by block contracts. Additional resources are associated with increased demographic pressures and hence most units which have contracts will expect to receive additional funds. The funds would not necessarily be distributed evenly to all units and would depend on the specialties involved (for example, geriatric specialties for aging populations, maternity and paediatrics for high birth rates). Districts should approach this exercise realistically in the light of the anticipated increase in underlying activity pressures. Districts would not be expected to keep extra sums unallocated against contingencies.

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ANNEX A

RECONCILIATION BETWEEN UNIT LEVEL COSTS

	Total	Unit 1	Unit 2	Unit 3	Community	Patient Transport	HQ
	£m	£m	£m	£m	£m	£m	£m
Costs per para 3.2	114.3	51.7	21.8	13.6	17.8	5.4	4.0
Capital Charges	22.4	13.7	4.6	2.0	1.8	0.3	-
Transport costs charged to units	-	2.1	1.1	-	-	(3.2)	-
HQ devolution/ recharge of costs	-	1.1	0.4	0.2	0.4	-	(2.1)
Revised costs per sections 4 and 5	136.7	68.6*	27.9*	15.8*	20.0	2.5	1.9

* = These three units total £112.3 per paragraph 4.6

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