

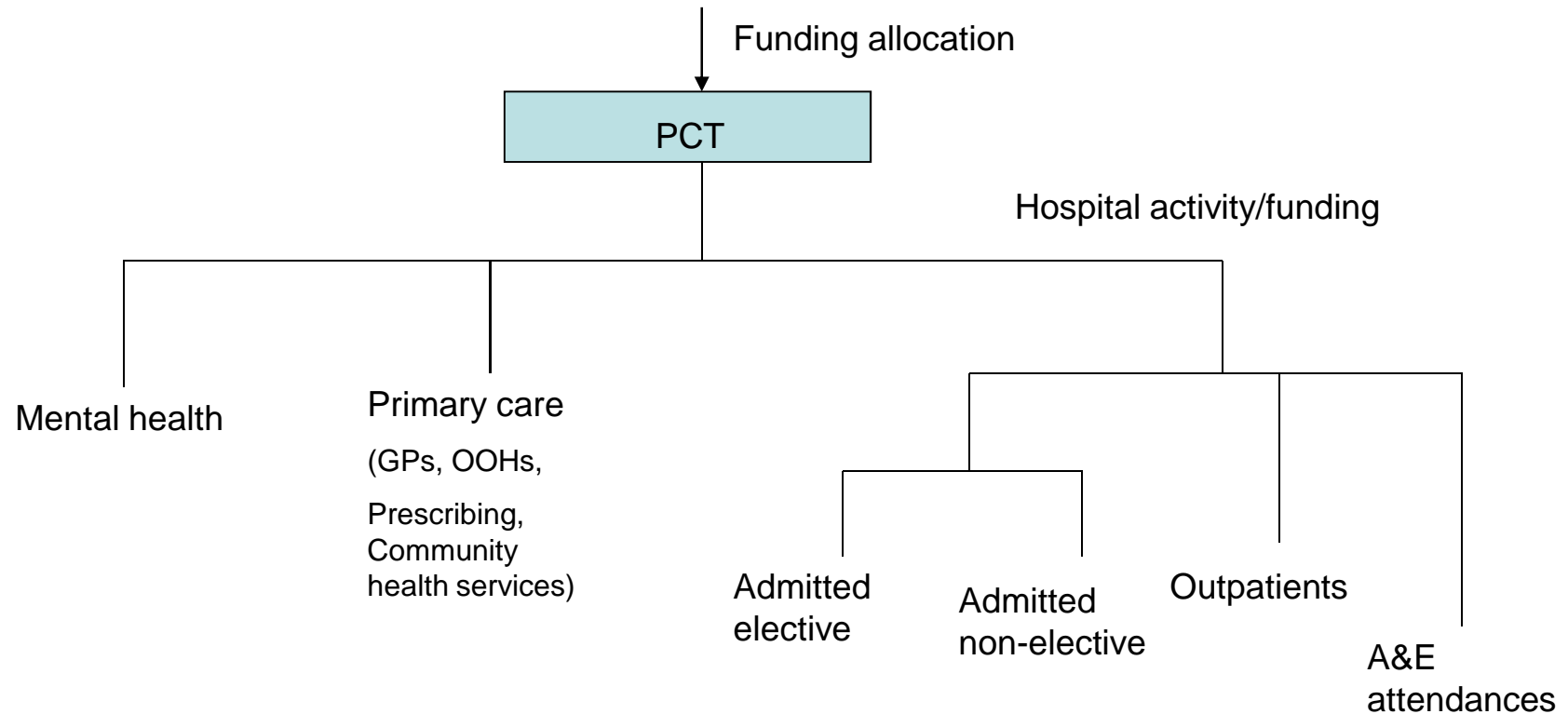
S E London Service Redesign and Sustainability Project

Policy Issues

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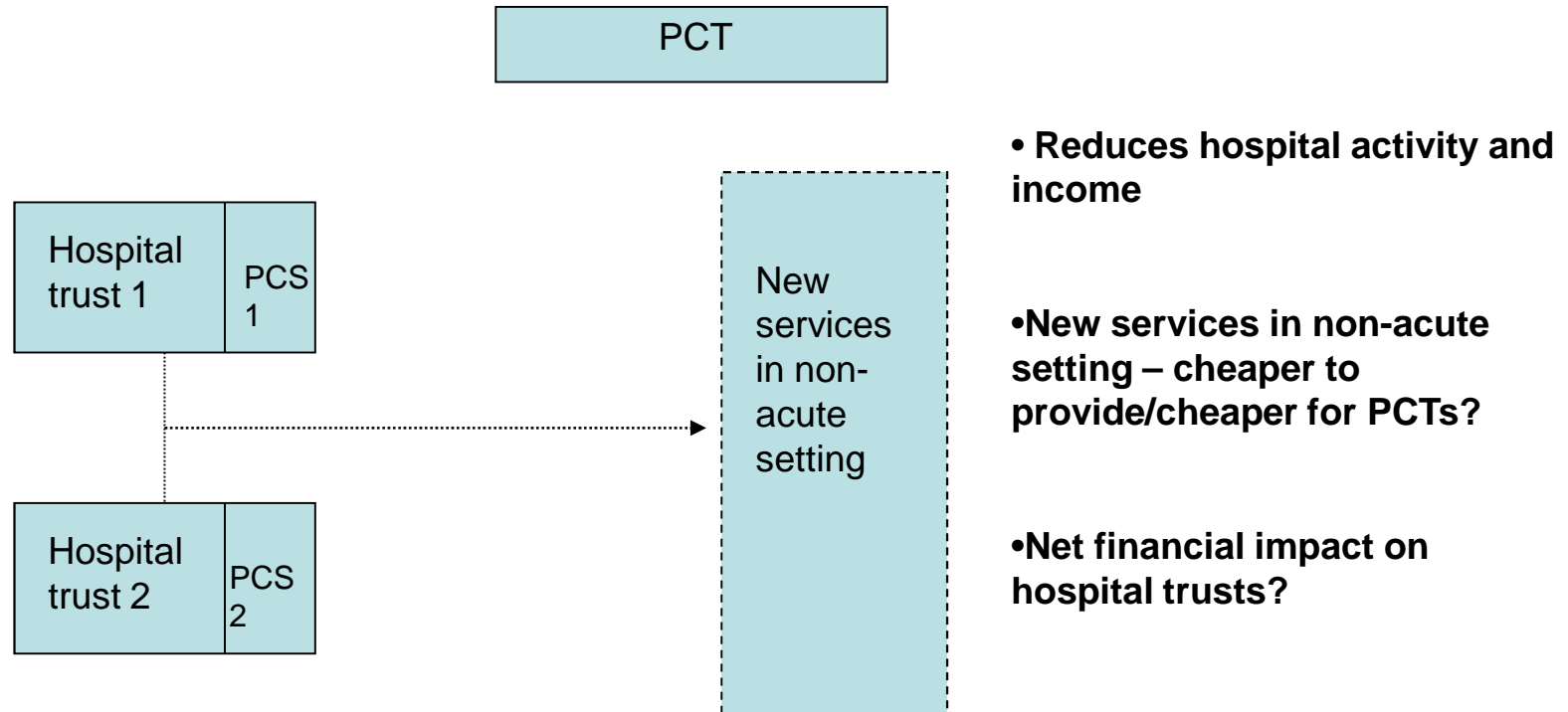
Activity and Financial Flows in SE London



A&E, Cardiac, Obstetrics/maternity, Pathology
Elective surgery, End of life care

Activity, average cost and average price at service level facilitates quantitative analysis
Evaluate reconfiguration options against baseline for service provision and finances
Impact evaluated for each PCT, each provider trust and SEL sector as a whole

Care in an appropriate setting



Can PCTs release funds from hospital providers to fund new services?

Will new services be cheaper than hospital services?

Need to finance set-up and parallel running costs

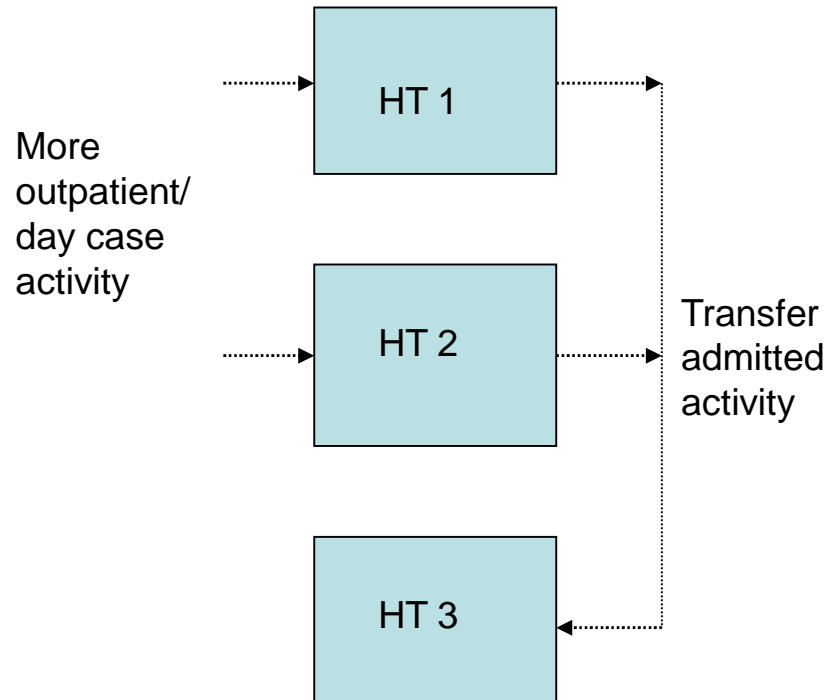
'Stranded' hospital fixed costs and I/E financial balance

An Example from the SE London SRS project

(Numbers are illustrative only)

PCT Action	Trust Action	PCT Position	Trust position
Case 1			
PCTs constrain demand to affordable levels (= lower than historic) but current pattern of services	100% of 2.5% annual efficiency target achieved	+£1m	-£89m
Case 2			
PCTs act to shift care from acute setting/ expanded community care (= Community Services Project)	100% of 2.5% annual efficiency target achieved	+£2m	-£138m

Acute Services Reconfiguration



- PCT activity/spend unchanged
- HT1 and 2 lose admitted activity to HT3 and gain more outpatient/day case activity
- Net financial 'winners' (HT3) and 'losers' (HT1 and 2)
- For sector result is lower total costs for providers

Planned service reconfiguration versus choice/supply side competition

Losers incur stranded fixed costs/financial deficits

Financing of parallel running costs?

Financing restructuring and rationalisation

Examples from SE London SRSP (I)

Emergency care reconfiguration

Actions

Emergency care centres treat A&E minors, minor injuries and integrate OOH GP services

PCTs act to reduce emergency admissions by 5% by pro-active case management of frequent flyers

Consolidate A&E majors, emergency surgery/medicine on fewer sites

	Change in PCT Position	Change in Trusts position
2004/5 margin	Baseline	Baseline
2009/10 margin	- £8m	+ £8m
2009/10 effect of PCT action	+ £12m – costs	- £12m
2009/10 effect of EWTD	--	- £2m
Consolidate A&E majors	--	+ £20-25m

Net overall gain from reconfiguration highly skewed across acute trusts

Winners and losers caused in large part by stranded fixed costs

Examples from SE London SRSP (I)

Elective surgery reconfiguration

Actions

New independent treatment centre opens 2008

Shift of minor elective surgery to community setting

Consolidation of high throughput and complex surgery on fewer sites

	Change in PCY Position	Change in Trusts Position
2004/5 Margin	Baseline	Baseline
2009/10 Margin	- £4m	+ £4m
ITC opens	?	?
2009/10 effect of PCT actions	+ £3m – costs	- £3m
2009/10 effect of consolidation	--	+ £8m

Net overall gain from reconfiguration is highly skewed across acute trusts

Winners and losers caused in large part by stranded fixed costs

Commissioner issues (I)

The Issue

- Limited ability of PCTs to manage hospital demand
- PCTs pay full tariff for all elective hospital services – result is resources sucked into hospital care and out of primary/mental health services
- Risk that new community services induce greater hospital demand
- Cannot afford to contract for alternative services provided in non-acute setting
- Even if they could - would incur parallel running costs in short term

The solution?

- Collective commissioning by PCTs
- Limits on hospital activity paid at full tariff specified at service level?
- Medium term volume contracts at service level – changes in contracted volumes signal to providers the need for reconfiguration
- Term financing of parallel running costs from SHA/NHS Bank

Commissioner issues (II)

The Issue

- PCTs must pay the same tariff for same HRG wherever services provided
- Even if care in non-acute setting is cheaper, PCTs pay the same and the benefit goes to the provider
- No financial benefit to PCTs or increase in affordability of services for patients

The Solution

- For some new services, maximum prices but actual prices set by tender process in which all providers allowed to make offers (incl GPs, Foundation/NHS trusts)?

Commissioner/provider issues (III)

The Issue

- Currently PbR disadvantages providers that act to reduce inappropriate hospital admissions

The Solution

- Redesign of PbR tariffs for patients with long term conditions to strengthen incentives for care in an appropriate setting
- PCTs contract certain services across the acute/primary care divide. Requires contracting for programmes of care and volume caps on care in an acute setting paid at full tariff

Provider issues (I)

The Issue

- Reconfiguration generally creates financial winners and losers
- With independent trusts and annual trust-specific financial balance targets potential losers are unlikely to agree to reconfiguration – even where good for patients and cheaper overall

The Solution

- SHA agrees transitional planned deficit and term financing of deficit
- SHA agrees recapitalisation of trusts where planned reconfiguration results in permanent diminution in (monetary) value of public assets and liabilities
- SHA agrees term financing for restructuring costs as part of overall reconfiguration that benefits patients and saves money overall
- Strong penalties on trusts that fail to deliver promised reconfiguration plans
- Need for clear rules about whether and on what terms trusts can access restructuring support

Provider issues (II)

The Issue

- Can reconfiguration be achieved without some institutional restructuring?
 - Acute services networks of care (A&E, cancer, cardiac etc)
 - Integrated primary/acute care providers
 - 'Takeovers' of failing trusts by other NHS providers?
- What sort of institutional restructurings (eg mergers, franchising, strategic alliances etc) are to be permitted and what are the rules with which they must comply?

The Solution

- DH must clarify the 'rules of engagement' to facilitate local discussions about 'voluntary' service and institutional restructuring

Conclusions

- Reconfiguration raises major policy issues that need to be resolved before reconfiguration plans can be implemented
- PCTs do not currently have the commissioning 'teeth' they need to bring about the shift in services required by the White Paper
- PbR in its current form and specification acts to inhibit the development of services in a non-acute setting and reconfiguration of acute services
- Reconfiguration will cause some trusts to incur transitional deficits. They will need to be allowed to incur transitional deficits if they are to volunteer for reconfiguration
- Reconfiguration will require transitional financial support from SHAs or the NHS Bank (to finance parallel running and restructuring costs) and some may need to be recapitalised to reflect their different portfolio of services
- In some cases successful reconfiguration may require institutional restructuring if the potential benefits are to be realised in practice