MR. COOKE

NHS Management Executive

To: Regional General Managers
District General Managers
General Managers of the
London Postgraduate SHAs
FHSA General Managers

cc. Special Health Services Authority

Department of Health
Richmond House
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24 October 1990

EL(90)205

Dear General Manager

FUNDING AND CONTRACTING FOR THE LONDON POSTGRADUATE SPECIAL HEALTH AUTHORITIES

In May Ministers confirmed their decision that the London Postgraduate Special Health Authorities would continue to be centrally funded. In keeping with the reforms of the NHS, this central funding would be linked to contractual arrangements between the NHS Management Executive and each SHA.

The attached paper sets out the broad arrangements under which the SHAs' central funding will be managed in 1991/92. It has been discussed and agreed with both the SHAs themselves and Regional Directors of Finance, and it reflects the processes which have already been initiated between SHAs and purchasing authorities to define levels of workload. Detailed issues over the construction and monitoring of the SHAs' contracts are being considered in joint NHSME/NHS working groups.

Any questions about funding and contracting arrangements for SHAs should be addressed to Robert Creighton, Room 172, Richmond House, 79 Whitehall, London SW1A 2NS (Tel: 071-210 5687/8).

Yours sincerely
M.C. Malone-Lee

M C MALONE-LEE

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This letter will be cancelled on 31 October 1991.

FUNDING AND CONTRACTING FOR THE

LONDON POSTGRADUATE SPECIAL HEALTH AUTHORITIES

Introduction

1. The continued central funding of the SHAs was announced by Ministers on 21 May. Executive Letter EL(MB)90/101, which announced the decision, summarised the principles on which it was expected that central funding would be based. This paper describes the practical arrangements for operating the central funding of the SHAs in 1991/92 and, with modifications derived from experience, the years thereafter. Broadly, the arrangements are that the Management Executive (ME) will agree with each SHA the overall number and types of cases which it will treat, for which central funding will be provided. The SHA's capacity will then be apportioned between commissioning authorities in the form of indicative workload agreements, without separate financial contracts. Commissioning authorities will therefore not normally be expected to make any payment for referrals under the ME contract.

Objectives

2. Ministers decided to fund the SHAs centrally in recognition of their national role in postgraduate teaching, research, and development. Central funding will need to be linked into a clearer definition of each SHA's national role and objectives, to be developed in discussion with the ME (in particular the Director of Research and Development). This, in turn, will inform agreements on each SHA's range of services, workload and funding. The first step, to be achieved for 1991/92, is to establish contractual arrangements which reflect current understandings of the SHAs' tasks. For future years the contracts will be modified to reflect refinements in the SHAs' role and objectives.

3. We therefore propose that the operational arrangements for central funding should have the following main objectives:

(a) to provide a basis for more explicit service and workload agreements between SHAs on the one hand, and, on the other, the ME and RHAs/DHAs (as appropriate), acting as joint purchasers;

(b) to ensure that the SHAs receive adequate numbers of appropriate types of referrals to sustain their research, development and postgraduate teaching roles;

(c) to involve RHA/DHA purchasers directly in specifying 'quality' in service contracts.

But we also need one subsidiary objective:

(d) to ensure that the system has appropriate "signals" and safeguards against exploitation by both purchasers and providers - ie by purchasers seeking excessive use of SHA services which are to them free goods, and by SHAs seeking payment for services which properly fall within their contracts with the ME;

and two constraints:

(e) to ensure (as far as possible) that the new arrangements do not make it any more difficult for SHAs to control activity and expenditure within budget;

(f) to avoid introducing any extra instability which would interfere with "smooth take-off" for the service as a whole.

"Smooth take-off"

4. The emphasis on managing the introduction of the NHS reforms so as to limit initial instability has led the ME to make it clear that for 1991/92 at least it expects most purchasers and providers to enter into block contracts which identify:

(a) price;
(b) likely volume of services, or predicted range of volume;
(c) quality measures.

In such contracts it will be for provider units to manage the cost/activity equation as at present, and SHAs will be no different in this respect from other providers of services.

5. As part of the process of ensuring smooth take-off, Regions are expected to ensure both that Districts' purchasing intentions reflect GPs' wishes and that any changes they imply from existing flows make sense and can be managed across the Region as a whole. Similar considerations will apply to SHAs. They will need to ensure, as far as they reasonably can, that their contracting

expectations reflect DHAs' referral intentions and that their estimates of small flows, for which separate workload agreements would not be appropriate, are consistent with trends in the volumes of such flows. We would expect SHAs to obtain the agreement of Regions to all predictions of referrals, whether contracted or not, from their Districts.

Types of contract

6. The types of contracts which SHAs will be expected to enter into with the ME, and which will be reflected in the indicative workload agreements with HAs as joint commissioners, should be similar to those for provider units in general. The emphasis in 1991/92 on achieving "smooth take-off" implies that contracts with SHAs should generally be block contracts, as defined in paragraph 4 above. Using overall block contracts and indicative workload agreements in this way will leave the onus on SHAs (like other providers) to control activity and expenditure within the funds available. Over time, as all the parties involved gain more experience of contracting, it will be possible to move towards the cost and volume type of contract. To make these forms of contract work effectively, more detailed profiles of admissions throughout the year from specific authorities will be required than are currently available.

7. Indicative workload agreements linked to a central block contract will leave the onus on SHAs to continue to manage demand very much as now. These arrangements will not by themselves discourage commissioning HAs from sending more cases or more complex cases to SHAs than are covered by their agreements. SHAs will either have to reject such referrals outright, or put them on a waiting list, or accept them at the expense of patients from other commissioners. If numbers of referrals greatly exceed expectations, SHAs will have to place considerable reliance on the judgement of clinicians over priorities for admission.

8. Nevertheless rigid limits on numbers and types of cases in each workload agreement would not be sensible, given the likelihood of fluctuation from year to year in referrals from an individual commissioner. Referrals under SHAs' indicative workload agreements will need to be carefully monitored on a monthly basis, and as referrals from any individual commissioner approach their expected maximum, it will be necessary to start immediate consultations between the SHA and the commissioner concerned, informing the ME and Region and involving them as required. These consultations will need to take account of any under-referrals from other sources and the potential in-year effects of excess referrals on other commissioners whose referrals the SHA may not have the capacity to treat. They will also be used to prepare for the re-negotiation of indicative workload agreements and the overall contract for the following year. They should not normally be used to open financial negotiations between SHAs and commissioners, except under the terms set out in paragraph 16.

9. Most SHAs provide services for large numbers of referring HAs, but many of these only send small numbers of referrals in any one year. One option for 1991/92 might be - in such cases - to have a single indicative workload agreement between each SHA and each Region for the services provided to that Region's Districts. Where the numbers of referrals, or their nature, make it feasible, however, indicative workload agreements with DHAs will be more appropriate. SHAs should, however, be able to enter into direct discussions with Regions whenever they feel this would be desirable.

10. In some cases, even flows from Regions are relatively small. For such cases it will be simpler not to involve Regions (or Districts) in drawing up advance agreements, at least for 1991/92, but to allow a contingency for them in the overall volume for which the ME will contract with each SHA. The absence of a workload agreement should not preclude Regions or Districts referring relevant cases to SHAs. Such flows will be carefully monitored, and agreements will be established from 1992/93 (or whenever) if they increase significantly at any stage. Because the SHAs will be contracted centrally for overall volumes, which will include margins for small flows and individual referrals of this type, they will not be able to seek payment from HAs for such referrals.

11. When patients have to be referred on from an SHA for admission to a non-SHA hospital, even if temporarily, the costs of treatment at that hospital will be borne by the DHA in which the patient is resident as outlined in EL(90)194. In cases for which such onward referrals are regular and predictable features of treatment the SHA will ensure that referring DHAs are aware of the protocols for treatment.

Establishing and Monitoring Contracts and Workload Agreements

12. The SHAs have been asked to establish their present workload and referral patterns, and to agree these with commissioning HAs. SHAs are expected to have completed a first cut by the end of September at the latest, to fit in with the overall contracting implementation timetable. In planning for the future, depending on the volumes of referrals, SHAs may proceed to seek agreements with either DHAs or RHAs (on behalf of DHAs with small flows and GP Fund Holding practices - see paragraph 9 above).

13. The ME has set up working groups to discuss and agree with SHAs firstly the best ways of moving from data on past flows to predictions of future workload, and secondly detailed means of monitoring referrals and case mix during 1991/92 and thereafter. The ME will also consult commissioning HAs on the levels of efficiency improvements which they would wish to seek from SHAs, taking into account the levels which they will seek from other

providers, and will aim to reflect efficiency improvements agreed with SHAs in their indicative workload agreements. By these means the ME intends to make explicit to all concerned the steps by which the overall contract and individual workload agreements are derived.

14. On the basis of agreements about present workloads and taking into account both revenue allocations when known and efficiency improvements, the ME will determine the overall capacity for which it will contract with each SHA. Capacity will be expressed in terms of indicative volumes of various types of cases representing various ranges of costs (for instance, high cost tertiary referrals). Baselines will take account of current estimates of SHAs' casemix. If the review of an SHA's function causes changes in the desired casemix, this may affect the overall capacity for which it is contracted. Whatever the casemix, the ME intends that the overall capacity for which it contracts with each SHA will cover the SHA's full likely workload. When efficiency improvements increase capacity, that increase will be taken into account in negotiating the next year's contract.

15. Arrangements for monitoring both the contracts between the ME and SHAs and the indicative workload agreements between commissioners and SHAs will be determined as part of the process of agreeing contracts. The intention will be to ensure that they are comparable with arrangements proposed for monitoring contracts in the NHS as a whole.

Spare capacity

16. When continued central funding was announced, it was made clear that the SHAs would be able to "market" any spare capacity over and above that for which they received central funding. SHAs are not to be treated differently from other providers, and they will be able to market spare capacity (which effectively means space, facilities and services) at marginal cost. The application of block contracts and workload agreements as set out in this paper means that SHAs will be very unlikely to have spare working capacity immediately available within their contracted workloads. As for other provider units, marginal cost contracts can only be for short periods (eg. to clear a waiting list) and certainly for less than 12 months. As with their indicative workload agreements, SHAs will be expected to ensure that any such contracts with Districts are agreed with relevant Regions and the ME.

Local Acute Services

17. In the exceptional cases where an SHA is considering, with the agreement of the ME and the RHA, a contract as the supplier of basic secondary care for a local DHA additional to provision already covered in the main contract with the ME, the price of the contract will need to be determined as for normal NHS contracts. The price will need to be calculated in conformity with the cost allocation principles applied generally throughout the NHS as set out in the booklet "Cost Allocation Principles" sent out under EL(90)MB/173.

18. The ME will wish to take an interest in such contracts in the context of an SHA's research, teaching and service priorities. For example, we would not think it right for an SHA greatly to expand its routine workload through separate contracts unless this had been agreed to be consistent with the SHA's teaching, research, and development role.

GP Fund Holders

19. Some SHAs may receive patients referred directly by GP Fund Holding practices. These referrals will be made under the same arrangements as for DHAs/RHAs, ie. the practices will not be expected to pay for any cases which form part of an SHA's overall workload as agreed with the ME. Unless the volume is high enough to justify a specific workload agreement, such referrals will be included in wider agreements between SHAs and RHAs, or within an SHA's contingency margin. When calculating the level of each practice fund, Regions will need to take into account the use made by fundholders' patients of the services provided by SHAs.

Supra-Regional Services

20. Supra-Regional Services which are provided by SHAs will be funded in the same way as such services provided in any other hospital. Separate guidance will be issued on detailed ways of operating these arrangements.

Patients from outside England

21. Treatment of patients from other UK countries, from the EEC, and from countries with which the UK has reciprocal health agreements will fall within the overall ME contract or, if appropriate, under the separate contract for Supra-Regional Services. If flows from other UK countries are significant, discussions with the Health Authorities/Boards concerned, on a similar basis to that proposed for England, may be appropriate. The ME should be consulted when such discussions are initiated. Monitoring arrangements will need to be able to identify patients from these sources.