

**NHS SELECT COMMITTEE – FINANCING  
OF THE HEALTH ECONOMY**

**INTERIM REPORT – DECEMBER 2002**

# **NHS SELECT COMMITTEE – FINANCING OF THE HEALTH ECONOMY**

## **1. INTRODUCTION**

## **2. SELECT COMMITTEE**

## **3. STRATEGIC CONTEXT**

## **4. FINANCING THE NHS**

- (a) Revenue Funding**
- (b) Capital Funding**
- (c) Reforming Financial Flows. Introducing Payment by Results**

## **5. KENT HEALTH ECONOMY**

- (a) Current Position**
- (b) Budget Pressures**
- (c) Recovery Plans**
- (d) Relationship between Health and Social Services**

## **6. CONCLUSIONS**

## **7. RECOMMENDATIONS**

## **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 established a Pilot NHS Overview and Scrutiny Committee in November 2001. The committee will become a legal entity once the local authority Overview and Scrutiny Committee's Health Scrutiny Functions Regulations 2003 are implemented on the 1<sup>st</sup> January 2003.

Protocols for local authority scrutiny of the NHS in Kent were agreed by the Kent Association of Local Authorities in November 2001, and will be updated in light of the regulations anticipated this week.

## **2. SELECT COMMITTEE**

The Select Committee is made up of seven Members of the County Council, to date the District/Borough or Community Health Councils have not nominated any representatives to this committee.

The Terms of Reference for this topic review are outlined below:

*“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”.*

The Select Committee agreed that this review would be undertaken in two phases. The first phase, which is the focus of this report, has concentrated on the funding mechanisms and current financial position of the health economy in Kent. The second phase of the review will build upon the foundations of this stage and address the Terms of Reference in full. This interim report is designed to summarise the findings of the first stage of this review, however, a full report will be prepared at the end of phase two which covers the totality of this topic.

The first stage of the review has focused on gaining an overview of the current financial position of the health economy in Kent. In order to do this written evidence was sought from the following organisations; the Strategic Health Authority, Acute Trusts, Mental Health Trusts, Kent Ambulance Trust, Primary Care Trusts and Kent County Council Social Services. In addition 3 hearings were held to which a selection of the above organisations were invited. Further details of the review are summarised in appendix 2 and copies of the written and oral evidence collated are available upon request.

### **3. STRATEGIC CONTEXT**

In April 2002 the NHS underwent significant organisational change. The previous Health Authorities were dissolved and many of their functions, including their commissioning role have been transferred to the Primary Care Trusts (PCTs). These changes place PCTs at the cornerstone of the NHS with the authority and power to develop the modern style of health service outlined in the NHS Plan.

Health Authorities have been replaced by a smaller number of Strategic Health Authorities (StHA), who are responsible for developing strategy and for the performance management of PCTs, NHS Trusts and Workforce Development Confederations.

The NHS plan, Shifting the Balance of Power, National Cancer Plan, Clinical Governance, National Service Frameworks, National Institute for Clinical Excellence are just some of the key components which are driving the modernisation of the health service. As a consequence of this funding is increasingly being concentrated on the achievement of nationally set targets, which are closely monitored and it is a Trusts performance against these targets which determines whether or not they are performing effectively. The priorities for health and social care are set out in 'Improvement, Expansion and Reform: The Next 3 Years', and specific targets underpin each of the following target areas:

- Improved access to all services through
  - better emergency care
  - reduced waiting, increased booking for appointments and admission and more choice for patients
- Focusing on improving services and outcomes in
  - cancer
  - coronary heart disease
  - mental health
  - older people
- Improving life chances for children
- Improving the overall experience of patients
- Reducing health inequalities
- Contributing to the cross-government drive to reduce drug misuse

### **4. FINANCING THE NHS**

NHS funding is agreed following negotiation between the Treasury and spending departments following a formal bidding process. It is also important to note that the Chancellor of the Exchequer announced in his April 2002 budget statement, that NHS funding will be increased year on year by an average of 7.4%. This will ensure that by 2007/08 the level of GDP allocated to healthcare will match that of European counterparts.

On the 11<sup>th</sup> December Alan Milburn, Secretary of State for Health, announced in Parliament an increase in funding to PCTs;

*“The average PCT budget will grow over the next three years by almost £42 million – in real terms, an increase of 22%, in cash terms, of over 30%. No PCT will receive an increase in funding over the next three years of less than 28%. For the information of members on both sides of the House, the real-terms increase in resources for local health services in this Parliament will average almost 7%.”*

The detailed information regarding allocations to Kent PCTs will be available in the very near future.

### **(a) Revenue Funding**

From April 2003 PCTs will control 75% of NHS funding and revenue funding will flow direct to PCTs from the Department of Health, rather than as in the past via the Health Authorities. As the current year has been one of transition, funding was allocated to the Health Authorities and then in April distributed by the StHA to the PCTs. These allocations cover the commissioning and provision of services managed in the secondary and tertiary sectors or by the PCT itself, as well as PCT administration costs. This allocation also covers expenditure relating to issues such as general practice infrastructure and prescribing. However, GP and Dentists fees are funded directly by the Department of Health.

NHS funding is designed to be flexible to enable resources to be managed to meet local needs, as such PCTs are given a single allocation and there is limited hypothecation although some earmarked funding is allocated. Currently allocations are identified on an annual basis but from 2003 funding allocations will be made on a three-year cycle, to enable PCTs to plan for the longer term.

A single resource allocation formula underpins all NHS expenditure and unified allocations are made on the following basis:-

- (i) Weighted capitation targets – set according to the national weighted capitation formula which calculates PCTs fair share of available resources based on the age distribution of the population, additional need and the unavoidable variations in the cost of providing services.
- (ii) Baselines – represent the actual current allocation which PCTs receive. For each allocation year the recurrent baseline is the previous year’s actual allocation, plus any adjustments made within the financial year.
- (iii) Distance from target – this is the difference between (i) and (ii) above. If (i) is greater than (ii), a PCT is said to be under target. If (i) is smaller than (ii), a PCT is said to be over target.
- (iv) Pace of change policy – this is the speed at which PCTs are moved closer to their weighted capitation targets. The pace of change policy is set annually by Ministers and attempts to balance two objectives; 1) to maintain continuity and stability in the service and make progress nationally in priority areas; and 2) to move as quickly as practical to fair shares.

On the 11<sup>th</sup> December, the Secretary of State for Health, Alan Milburn, announced significant changes to the weighted capitation allocation formula. These include a greater focus on poverty and deprivation, access, the cost of living and updated population information from the 2001 census. The details of these changes have not yet been made available as such it is unclear what the impact will be on the South East.

### **(b) Capital Funding**

There are two areas of Capital funding in the NHS; block and discretionary funding. Block funding is allocated directly to NHS organisations and its use is under the control of that organisation, within overall delegated limits set by the department of health. Discretionary funding is held by the StHA, who will approve capital schemes on the basis of local strategic planning priorities and the merits of the outline and full business cases submitted. These arrangements are in transition and will not be fully in place until 2003/04. The Department of Health also reserves some capital funding to cover national projects or initiatives.

### **c) Reforming Financial Flows. Introducing Payment by Results**

‘Reforming Financial Flows. Introducing Payment by Results’ sets out fundamental changes to commissioning in the NHS, initially the focus is on acute care but it will eventually cover all financial transactions within the NHS. Currently most services are commissioned in block contracts but in future a greater emphasis will be placed on ‘cost and volume’ and ‘cost per case contracting’. The vision being that services will be purchased from a diversity of providers who will be paid for the activity that they undertake. Another important element of these proposals is that a national tariff will be introduced, the aim being to enable PCTs to focus on improving quality and increasing service volume, free from the distraction of negotiating costs.

## **5. KENT HEALTH ECONOMY**

### **(a) Current Position**

Cumulative allocations to the Kent and Medway health economy for 2002/03 amount to £1.3 billion, and currently a deficit of £27.1 million (as of Month 6) is being predicted unless further action is taken. This is a significant deficit but is under 2% of the overall budget. Acute Trusts are projecting overspends totalling £21.8 million; PCTs overspends of £7.3 million and the StHA a surplus of £2 million which will be driven back into the Kent and Medway health economy. In the current financial year it is clear that it will be extremely challenging for the Kent and Medway Health Economy to achieve financial balance.

The table, shown in appendix 1, clearly illustrates the scale of the difficulties being faced by local NHS bodies in striving to achieve financial balance. The table demonstrates that most of the NHS bodies who provided information to the Select Committee, are currently overspending against their budgets, this ranges from £0.5 million to £11.3 million.

It is important to note the split between primary and acute care, the highest overspends being linked to acute care as illustrated in the table in appendix 1. This pattern of expenditure is repeated across the country in spite of the fact that the majority of healthcare is delivered by the primary sector. This is not an issue per se, however, when the acute sector is consistently in deficit it has a significant impact upon investment and development in primary care. This is a concern Canterbury and Thanet Community Health Council raised,

*“Historically particular services in this area have suffered at the expense of the acute sector, with the majority of investment going to the hospital services.”*

PCTs have a legal requirement to balance the books. In the past deficits have been managed through brokerage arrangements (loans from other parts of the health economy who have under spent), however, as resources become ever more restricted the flexibility to broker is reduced. The message from the Department of Health is that no brokerage will be available this year, however, similar messages have been articulated in the past and brokerage has been made available nearer to the end of the financial year. In the absence of brokerage it is unclear what the implications would be for a PCT who failed to balance the books, as this has not yet been tested. However, the pressure to balance the books through mechanisms such as brokerage does appear in some ways to reduce transparency and can to a certain degree mask an organisation’s financial problems.

#### **(b) Budget Pressures**

The evidence collated by the committee points to several common reasons that have resulted in overspends. These range from the impact of managing historic deficits to increased activity, along with problems which are exacerbated in the South East due to the high cost of living such as the high cost of placements, agency staff and recruitment and retention difficulties. Other significant budget pressure such as prescribing are a more national problem.

The main reasons for overspends are identified below:-

- i) Historical debt – The East and West Kent Health Authorities and 3 PCTs which existed before April 2002 accrued deficits in 2001/02. Following the removal of the health authorities on the 31<sup>st</sup> March 2002 these deficits were shared amongst their successors, those PCTs coming into being in April 2002. The deficits carried over from 2001/02 range from £850k to £4.1million. As a consequence of this a number of trusts (but not all) have operated within their 2002/03 budgets but have failed to repay their debts. Lord Hunt of Kings Heath made the position on this issue clear in the following statement;

*“I am quite clear that the liabilities of restructured NHS organisations must be passed on to their successor organisations. That principle has been adopted through any number of reorganisations and restructurings and must apply to primary care trusts. Primary care trusts must operate in financial discipline.” Hansard, 11<sup>th</sup> December 2002, Column 276.*

These historic debts must be dealt with as quickly as possible, which is the express intent of these trusts, in order to ensure the business of investing in and improving services can be undertaken. In future years as new processes bed down it will become more apparent how effectively PCTs are operating.

- ii) Increased activity – Due to the very nature of healthcare provision it is extremely difficult to accurately predict activity levels. A number of the bodies who have provided evidence to the committee have specified increased levels of activity as a cause of the current budget pressures. It should be noted that increases have occurred in specific specialities such as emergency care but there has not been an overall increase in activity.
- iii) Prescribing – The development and increasing costs of new drugs are both locally and nationally creating budget pressures. National Service Frameworks (NSFs) and the National Institute for Clinical Excellence (NICE) are recommending the adoption of new drugs to improve patient care but there is often a significant cost in implementing this advice. As in many areas of the NHS high costs are justifiable when they can be explained and clearly lead to improved outcomes for patients, which is the case in many areas of prescribing. However, on the basis of the evidence collated it is equally clear that there are areas of wastage, for instance, repeat prescriptions if unchecked can lead to patients collecting but not taking medication. Each of the organisations who provided information demonstrated that they are being proactive in targeting this problem area, for instance, through the use of prescribing advisors, reviewing repeat prescribing or increasing the percentage of generic products.
- iv) Staffing – Changes such as the restructuring of junior doctors working hours, development of nurse consultants have all led to cost pressures and imminent changes to National Insurance and GP contracts will lead to further pressures next year. In addition recruitment difficulties within the NHS, which are exacerbated in the South East due to the high cost of living, are leading to an increasing use of agency staff and the high costs associated with this. It should be noted that it is anticipated that the development of NHS Professionals will help to ease this problem.
- v) Referral patterns – It is entirely appropriate for patients to be referred out of county for some highly specialist treatments. However, due to Kent's proximity to London referral patterns have developed overtime which have led to some patients being referred to London who could be treated locally in Kent. As would be expected the cost of out of county referrals is significantly higher and furthermore can, if not managed, impact upon investment in local services. This issue is Kent wide, although unsurprisingly to a greater degree in the West, as such plans are currently being implemented to repatriate patients.
- vi) Placements – Specialist placements for continuing care or for instance for patients with a mental illness or learning or physical difficulties are extremely high cost. The cost of living within the South East has a significant knock on effect on the cost of placements, and an adult mental health placement can cost



between 150k and 200k per annum. It should be emphasised that these are 'specialist' placements and therefore relatively uncommon but clearly 1 or 2 additional placements in a year can have a significant impact on budgets. The costs of placements are significant irrespective of whether they are provided by the public or private sector. However, private sector placements are by far the most expensive and on the basis of the evidence heard it appears that there is currently an over-reliance on such placements. Measures to address this situation are currently being pursued, increasingly through joint arrangements between Health and Social Services.

- vii) Delayed Discharges - This is a complex area that involves all sectors of health including Social Services. The problems and possible solutions have been well rehearsed and are covered in some detail in a previous Select Committee Report by the Social Care and Community Health Policy Overview Committee on Nursing Care.

### **(c) Recovery Plan**

In order to overcome the current financial pressures each of the NHS bodies in Kent, in liaison with the StHA, are implementing recovery plans and performance improvement plans. It is important to note that none of the organisations contacted as part of this review have identified cutting services as a means of achieving financial balance.

The recovery plans focus on housekeeping and savings measures such as reviewing unused reserves, freezing non critical posts/training/maintenance, deferring developments, identifying capital to revenue transfers, reviewing activity and waiting list targets and expenditure.

Committees have been established in a number of Trusts to oversee Performance Improvement Plans in particular areas of budget pressure, such as prescribing.

In some instances site rationalisation or renegotiating PFI arrangements are also proving to be mechanisms to improve individual Trusts financial situations.

In the longer term all of the Trusts are working to ensure that wherever it is appropriate, patients are treated locally and not referred out of county. Similarly new ways of working which improve the quality and efficiency of patient care and offer better value for money are also being pursued, such as, the use of nurse consultants.

It is clear that a wide range of mechanisms to tackle current overspends are being utilised and all bodies are striving to achieve financial balance. Several of the health bodies consulted believe that this will be achievable but others are clear that this will not be possible in the current financial year. It is important to note that all of these health bodies are planning to improve upon the situation currently being predicted and the StHA have identified that progress towards this end is being made. The forecast out-turn in Month 6 of £27.1 million showed an improvement of £2.7 million from the previous month. However, it will only become clear as months 7 to 12 unfold whether the current financial situation can be improved upon. It cannot be confidently assumed that all 14 organisations will be able to implement their recovery

plans and achieve complete success, especially when these plans are so dependent on a number of factors many of which, such as activity levels, are not totally controllable.

#### **(d) Earmarked Funding**

NHS finances are not restricted by high levels of hypothecation as local government is. Within the NHS some funding is 'earmarked' for specific activities, however, this is only subject to normal audit processes and not the specific scrutiny associated with hypothecated funding which is designed to ensure funds are only spent on the specific area they were intended for. For instance, in East Kent earmarked funding was concentrated on 4 main areas; building capacity, cancer, coronary heart disease and resetting the primary care budget. However, this was at the expense of investment in learning disabilities, children's services, mental health and information technology, although at a later stage some non-recurrent funding was identified to support mental health and information technology.

It is also important to note that health bodies and local authorities have different responsibilities and as such prioritise funding differently. As such the expenditure of allocated funding such as that for building capacity can be a cause for concern. As from a local authority perspective delayed discharges, a joint responsibility for Health and Social Services, should have been a significant beneficiary of this funding. However, whilst delayed discharges are a recognised priority area for health, and as such have benefited from some funding, it is not an area covered by national targets. As such the majority of building capacity funding was concentrated on acute hospitals and the ambulance trust, with significantly smaller sums funding community initiatives.

#### **(e) Relationship between Health and Social Services**

Both health bodies and Social Services indicated that good progress is being made towards joined up working. This is particularly clear in the area of mental health where Social Services have transferred their functions and associated budget to the two mental health trusts. Numerous examples of effective joint working were highlighted, which were in many cases leading to both improved patient care and reduced transactional costs.

However, both Health and Social Services highlighted that the current partnership arrangements can and should be built and improved upon. This is an approach that the committee would strongly endorse, particularly where joint working can improve patient outcomes and minimise costs.

## **6. CONCLUSION**

The majority of Trusts in Kent are currently reporting overspends. This is due to a number of factors, such as increased levels of activity, higher costs of living associated with the South East and the responsibility for the historic deficits of the old health authorities and PCTs which existed prior to 2002. Of those who are still aiming to balance the books at the end of the financial year, a number will be

dependent on factors outside of their control. It is clear that the current financial position of the health economy in Kent is extremely challenging.

However, in relation to this review it is the impact of the current financial situation on health, social care and the community, which is of most importance. The Secretary of State for Health summarised the purpose of the increased allocations to PCTs in the following statement;

*“The allocations to PCTs include resources to finance the costs of pay reform, new drugs and treatments and additional NHS capacity. They include commitments that we set out in the NHS plan. However, none of the growth money has been identified for specific purposes. PCTs will be able to use these extra resources to deliver on both national and local priorities. PCTs are about shifting the balance of power in the health service so that while standards are national, control is local.” (Hansard, 11<sup>th</sup> December 2002, Column 270)*

It is clear from the above statement that the emphasis is being placed on local control, yet the financially constrained environment of the Kent health economy is unlikely to be conducive to supporting local control. Once national targets, core services and cost increases are resourced there will be limited resources available to fund local initiatives, consequently financial control will be limited to decisions regarding how money is spent and not on what it is spent.

Increased levels of funding have been announced for 2003/06 but it is not clear whether this will be sufficient to overcome the current financial situation and fund new developments. If this is the case it is likely that it will be activities which are not covered by national targets that will be most affected, and also could reinforce the tendency towards investing in acute care at the expense of other areas. If financial balance cannot be achieved this year, as is predicted, then these deficits will have to be cleared in 2003/06. A reduced ability to invest in services will clearly impact upon the growth and modernisation of health services and may also affect Social Services, particularly if Health's ability to invest in joint priorities such as delayed discharges is restricted. This could have more far-reaching consequences for Social Services if cross-charging is introduced next year. It is clear that the current financial challenges will also be a feature of the next financial year for both Health and Social Services.

PCTs are charged with an important role to modernise the NHS from the bottom up, yet whilst the health economy is so financially constrained it is difficult to see how this vision can be realised in a meaningful way. From April 2002 PCTs fully assumed their roles as the main commissioners in the NHS, however, the combination of their size and inexperience may limit their commissioning powers. In particular PCTs relationships with larger, more experienced acute trusts will significantly impact upon their commissioning powers.

8 PCTs were established in Kent to ensure these bodies had close links with their local communities but clearly this arrangement has a price tag. In order to achieve economies of scale it will be important that PCTs work closely together in large enough groupings to effectively co-ordinate commissioning and keep transactional costs to a minimum. Co-ordination arrangements are already in place with PCTs taking the lead on commissioning specific services for a wider group of PCTs but it is

important that such arrangements are built upon and strengthened over the longer term. It should be remembered that as new organisations PCTs are still developing and that it will take time for these new processes to bed down.

National announcements regarding increased levels of funding raise public expectations and these expectations must be carefully managed. The financing of the NHS is complex and constantly changing with additional funding often rapidly being taken up by new developments and treatments. High but realistic expectations must be met with solutions fitting a modern health service, and to do this transparency and honesty regarding issues of finance will be imperative. In a financially constrained environment it will undoubtedly be more difficult to modernise and improve services and health bodies must be able to clearly demonstrate that service changes are driven by the need to improve services and not to make savings. The support of the StHA and partners such as Social Services will be key in ensuring that the health economy can continue to embrace innovation in its pursuit to improve services.

It is important to reiterate that all of the Trusts have expressed a clear commitment not to cut services, however, it is clear that actions to reduce current overspends will impact upon the development of health services.

## **7. RECOMMENDATIONS**

The Select Committee's Terms of Reference 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”.*

The first stage of the review has addressed part (a) of the Terms of Reference and it is recommended that the knowledge built up during this part of the review is built upon in the next phase.

It is recommended that a review programme for phase two with timescales appropriate to the scale of the review is developed early next year, and that the following issues are given further consideration in the second phase.

- How are the demographic and cost issues of the South East of England reflected in the formula allocations to the NHS?
- How do allocations to Kent PCTs compare to the rest of the Country?
- What impact will the recent amendments to the weighted capitation formula have on the Kent health economy?
- To gain an understanding of financial flows and transactional costs in the NHS, considering the affect numerous commissioners will have on this area and what the impact of ‘Reforming Financial Flows. Payment by Results’ will be?

- To consider 2003/2006 allocations and Local Delivery Plans for their expenditure?
- Links to future planning framework and regeneration.
- Consider how demographic data is used locally to allocate funding?
- To consider how commissioning and joint commissioning arrangements are co-ordinated?
- To consider what implications the proposed PFI schemes may have on the health economy.
- Consider new service models or ways of working which make use of the new health flexibilities and/or deliver improved services and offer better value for money, for instance the whole health economy approach to planning emergency services.
- Consider plans to invest in and promote local services in order to reduce the number of unnecessary out of county referrals.
- To look more closely at actions being taken to tackle high costs in relation to specialist placements, staffing and agency costs.
- To consider the review of continuing care criteria in light of the Coughlan Judgement.

### Appendix 1 – Overview of the Current and Forecast Position of the Kent Health Economy

Organisation	Debt carried over 2001/02	Base budget 2002/03	Position at Month 7	Forecast position at year end
Dartford, Gravesham and Swanley PCT	£2,036,000	£186,351,000	£606,000	£1,617,000
South West Kent PCT	£458,000	£134,000,000	£189,000	Break even
Maidstone Weald PCT	£2,960,000	£169,223,000	£161,300	Break even in respect to current financial year. But will be unable to repay brokerage of £2,960,000
Swale PCT	£200,000	£75,860	£1,400,000	£1,700,000
Canterbury & Coastal	£228,000	£142,880,000	£500,000	Break even
East Kent Coastal PCT	£356,000	£213,332,000	£1,100,000	Break even
Shepway PCT	£145,000	£86,656,000	£600,000	£300,000
Ashford PCT	£128,000	£78,127,000	-	Break even
Dartford & Gravesham NHS Trust	£1,798,000	£80,800,000	£1,995,000	£1,490,000
Maidstone & Tunbridge Wells NHS Trust	£4,100,000	£157,448,000	£2,500,000	£2,500,000 to £5,500,000
East Kent NHS Trust	£2,000,000	£273,000,000	£11,300,000	£14,500,000
East Kent NHS and Social Care Partnership trust	N/A	£55,950,000	-	£0.8m
West Kent NHS and Social Care Trust	N/A	£100,000,000	Break even	Break even
Kent Ambulance Trust	£850,000	£26,000,000	10,000 surplus	Break even

**N.B. This year achieving financial balance is proving to be extremely challenging but all of the above bodies are striving to achieve this. Recovery plans are in place and in most cases are expected to deliver the savings to achieve a break even position, however, it must be stressed that that this will be highly dependent on issues such as activity levels and the successful delivery of the recovery plans. Similarly it is also possible that those bodies forecasting an overspend may be able to improve the situation currently being predicted, by taking further action.**

**SUMMARY OF THE REVIEW PROCESS**

The Select Committee requested written evidence from each of the health bodies in Kent and from Social Services, these bodies included:-

- The Strategic Health Authority
- Acute Trusts:- Dartford & Gravesham NHS Trust, Maidstone & Tunbridge Wells NHS Trust and the East Kent Hospitals NHS Trust.
- West Kent NHS and Social Care Trust and East Kent NHS and Social Care Partnership Trust.
- Kent Ambulance Trust
- PCTS:- Dartford, Gravesham & Swanley PCT, South West Kent PCT, Maidstone Weald PCT, Swale PCT, Canterbury & Coastal PCT, Ashford PCT, East Kent Coastal PCT and Shepway PCT.
- Kent County Council Social Services.

In order to complement the written evidence sought three hearings were also held during December.

**Hearing One – 3<sup>rd</sup> December 2002**

- Dartford, Gravesham & Swanley PCT
- Maidstone Weald PCT

**Hearing Two – 6<sup>th</sup> December 2002**

- Swale PCT
- East Kent Coastal PCT
- Social Services

**Hearing Three – 9<sup>th</sup> December 2002**

- Strategic Health Authority

## **BACKGROUND MATERIAL**

Shifting the Balance of Power: The Next Steps, Department of Health

Reforming NHS Financial Flows, introducing payment by results (October 2002), Department of Health.

Improvement, Expansion and Reform: The Next 3 Years. Priorities and Planning Framework 2003 – 2006, Department of Health.

Resource Allocation Weighted Capitation Formulas (June 1999), Department of Health.

Report of the Advisory Committee on Resource Allocation 1998 (July 1999), Department of Health.

Health Authority Revenue Resource Limits 2002/03, Health Service Circular 2001/024 (December 2001), Department of Health

History of the Staff MFF, RAWP 1, Department of Health

Population Data for Allocations, RAWP 2, Department of Health

The years of life lost index and the health inequalities adjustment, Department of Health.

Kent County Council Response to consultation on proposals to introduce a system of reimbursement around discharge from hospital 18/09/02.

Report to Social Care and Community Health Policy Overview Committee – 21 November 2002. A Preliminary review of the Social Services budget position for 2003-04.

Procurement and Support (May 2002), Audit Commission

New NHS Resources, Secretary of State for Health announces new allocations. Hansard, 11<sup>th</sup> December 2002.

NHS Resources, Lord Hunt of Kings Heath announces changes to the allocation formula. Hansard, 11<sup>th</sup> December 2002.

West Kent Health Improvement Programme 2000 – 2003.

Securing our Future Health: Taking a Long-Term View. Derek Wanless, April 2002.

Kent and Medway Strategic Health Authority Board Papers, 27 November 2002.