Affordability Update

December 2014

1 Introduction

The purpose of this paper is to provide an update to the Programme Board on the work undertaken to determine whether any scenarios on the longlist should be considered to be unaffordable.

The work has looked both at funding scenarios and at expenditure scenarios. The funding analysis identifies a range of possible scenarios and acknowledges the challenging current environment. The expenditure scenarios show some significant differences between scenarios but all of them are based on a range of broad assumptions that need further testing and refinement.

It is essential to note that the costings currently being undertaken take no account of any underlying financial deficits in Trusts or CCGs and does not take into account any potential year-end deficits that may be declared by the organisations between now and the end of this financial year.

2 Work undertaken so far

The work to determine whether any scenarios should be considered unaffordable at this stage comprised four main elements:

1. A review of the long term (2018/19) funding position and investment headroom for the CCGs
2. An examination of the revenue consequences of the Emergency Care Centre feasibility study capital costs
3. An estimate of the revenue costs of Urgent Care Centres
4. An assumption about the investment required in primary and community care

The remainder of this paper sets out the conclusions of the work in each area and summarises the overall position.

It should be noted that this paper and its conclusions describe the position that has been reached at a point in time. The work on affordability of options is not complete and will continue to be refined over the coming weeks and months and will continue into the options development phase.

3 Review of CCG funding and investment position

This analysis identified that the CCGs are above their capitation financial allocation target (Shropshire) or just above their allocation target (Telford and Wrekin). Both CCGs currently spend more than the West Midlands average on Acute and Community Care.

It is considered very unlikely that either CCG will receive any more than the national average funding increase for CCGs for the foreseeable future, given the national direction of travel in relation to reducing the "distance from target" of lower funded CCGs across England and giving them higher than average financial uplifts.

The publicly reported current financial position of Powys Health Board and the lack of detailed information on the longer term funding outlook for the NHS in Wales suggests that the Powys long term position will not be more favourable than that of the English CCGs.

The work then considered various scenarios of national funding growth, increases in the cost of care, and assumptions about the ability of providers to meet national efficiency requirements.

Various combinations of scenarios were tested. The worst case suggested that the CCGs would need to find an extra c£60m in efficiency savings over five years. The best case suggested that the CCGs would have c£50m to invest in new services.

3.1 Main issues with the analysis

- The range of outcomes is very broad and it was not possible to arrive at a "most likely" scenario with any confidence.
- As stated above, not all NHS providers and commissioners have a current underlying balanced financial position. Any assumptions about future affordability need to recognise any imbalance in the current overall financial position of the local health economy.

4 Revenue consequences of Emergency Care Centre Feasibility Study

This work attempted to identify the net revenue impact of the feasibility study for each of the longlisted scenarios. This meant adding two scenarios to the original feasibility study: Emergency Care Centre PRH/Treatment Centre RSH and Emergency Care Centre RSH/Treatment Centre (DTC) PRH.

It also attempted to identify the revenue cost of a do nothing scenario.

The work examined the capital costs of the added scenarios and the likely revenue consequences of the change in capital charges for all scenarios.

It also made assumptions about the potential savings to be achieved by the creation of a single site EC and a single site DTC.

The outcomes of this work suggest that:

- The capital cost of "do nothing" over a 25 year period will be significant as the current estate backlog issues are tackled and as further refurbishment is required. This capital cost could be as high as some of the other longlisted scenarios.
- The cost of greenfield scenarios were higher than the other scenarios.
- Scenarios siting services at PRH were generally lower cost than siting services at RSH

4.1 Main issues with the analysis

The confidence in this stream of work is limited by the following:

- The absence of detailed designs for the EC and DTC
- The absence of developed plans for the activities assumed to be continued on the existing sites under any scenario, such as outpatients, and the capital cost required to be spent on those services
- Uncertainty about the realisation of single site efficiency assumptions without further work being undertaken

5 Cost of Urgent Care Centres

This work attempted to identify the revenue costs of running four and seven Urgent Care Centres (UCCs). These numbers were chosen because they represent the smallest and largest number of UCCs envisaged in the long list of scenarios.

It required assumptions to be made about the number and type of patients who would present at UCCs and the number and type of staff who would be needed to treat those patients.

The work suggests that the gross cost of seven UCCs is some £14m while the gross cost of four UCCs is some £9m per annum. These costs would be offset by a reduction in the cost of A&E attendances, MIU attendances, and possible DAART and GP out of Hours attendances as activity is shifted into UCCs.

5.1 Main issues with the analysis

The confidence in this work is limited by the following:

- Assumptions have been made about the number and type of staff needed in UCCs before the detailed workforce and activity plans for UCCs have been developed.

- No formal assessment has been made of the need for capital investment for UCCs that are not on the PRH/RSH sites (on the PRH/RSH sites the capital cost is assumed to be included in the EC costings) but an element has been added for generic overheads.
- Further work is required to determine the extent to which UCCs would supplant the work of existing services such as Minor Injuries units and GP Out of Hours services

6 Investment in primary and Community Care

The FutureFit Programme, through the Activity and Capacity workstream has developed assumptions about the amount of work flowing to the acute sector in the future. To some degree this reduces activity to a level lower than it would otherwise have been in the absence of the Programme.

This stream of work assumed that whatever resources were released as a result of reducing acute activity would be used to create an investment pot for primary and community care to develop services that would reduce the reliance on acute care.

The work assumes that 100% of the cost released from the acute sector would be reinvested in primary and community care. Therefore in affordability terms for the whole health and care system it would have no impact.

6.1 Main issues with this analysis

- Further work is required to identify how much cost could be released from the Acute service
- Further work is required to develop firm proposals for investment in primary care and other community based health and care services

7 Conclusion

The financial outlook for the NHS (and local government) is challenging. All of the long listed scenarios could be considered to be affordable within the context of a benign view of long term funding. Within the context of a pessimistic view, all of the scenarios appear problematic.

The analysis undertaken so far has demonstrated that there is significant further work to be undertaken before greater confidence can be placed in an affordability analysis.

Given these uncertainties it would seem premature to rule out any of the longlisted scenarios on the grounds of unaffordability.

Further work on the development of shortlisted scenarios over the course of the next five months will need to address these uncertainties as far as possible before a view is taken on proceeding to public consultation.

All of the analysis is working on the assumption that the health economy is currently broadly in financial balance. This is unlikely to be the case.

The Programme Board is asked to accept the conclusions of this report.