Department
of Health

From the Lord Prior of Brampton
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Dr Lord Naseby,

Thank you for your oral question on 9 November about NHS costs. I agreed to write setting out clearly our position in relation to a number of points that were raised.

Baroness Walmsley asked whether the reference costs for hospitals discriminate between those that service PFI contracts and those that do not. There is a general principle which NHS hospital trusts follow when submitting their reference costs, which is that they should reflect ordinary ongoing revenue costs (including the annual PFI unitary charge) and exclude extraordinary one-off costs (such as those relating to setting up a PFI scheme from the initial business case stage to financial close).

Baroness Walmsley then asked whether the Department is appropriately funding hospital trusts with PFI contracts. Responsibility for the National Tariff, the principal means by which hospitals are funded using nationally agreed prices, transferred from the Department to Monitor and NHS England under the provisions of the Health and Social Care Act 2012. However, national prices are still informed by reference costs and therefore implicitly include the PFI unitary charge. The practice of adjusting prices for expected changes in costs associated with pay, drugs, and other operating and capital costs, will also remain an ongoing feature of the National Tariff.

I am concerned that I do not fully understand the reference made by Baroness Wall of New Barnet to a new system brought in by the Department to measure every activity that goes on in a hospital. As I noted during the debate, Baroness Wall may be referring to patient level information costing systems (PLICS), which identify and

record the costs of individual patients. Using PLICS, hospital trusts can tag events such as theatre minutes, diagnostic tests and prosthetics to the patient record. These systems provide trusts with the ability to understand their economic and financial drivers, benchmark their costs in detail against other providers, support meaningful engagement with clinicians, and improve the quality of national cost collections. The Department began encouraging trusts to implement PLICS about a decade ago and carries out a survey of uptake each year. The 2013-14 survey showed that 207 trusts (85%) have implemented, are implementing, or are planning to implement PLICS. The vast majority of trusts that have implemented PLICS are using the system to underpin their reference costs return. I hope this responds to Baroness Wall's question, but I am of course happy to write to her again if it does not and she is able to provide more detail.

Lord Ribeiro asked a question about the cost-effectiveness of independent sector treatment centres (ISTCs). The original contracts let under the ISTC programme under the previous Labour government were, on the whole, more expensive than National Tariff. Much of this was driven by under-used guaranteed minimum activity levels with associated payments and also retail price index linking of prices. As contracts have come to an end, the procurement of replacement contracts with potential providers has been on the basis of the NHS Standard Contract with pricing at National Tariff. Clinical commissioning groups also have the flexibility to negotiate different prices if it can be shown that the activities vary significantly, for example by having a simpler case mix, from those included in National Tariff.

In terms of whether NHS consultants should have greater access to ISTCs to help them deal with their elective cases, the policy principle is that patients have free choice of their provider when they are referred by their GP for consultant-led elective care. Patient choice is therefore determining how many referrals each hospital receives. It is also the case that some NHS hospitals subcontract some elective activity to local independent sector hospitals or ISTCs, to cope with peaks in demand or to make sure that patients do not have to face excessive waiting times. These decisions about whether to use independent sector capacity are rightly made at local level, in the light of local awareness of capacity and demand, and not at national level. However, I also do recognise that some hospital trusts are facing particular challenges with their waiting lists due to rising demand for NHS services, and nationally we are starting to work with local organisations to match and transfer patients to available independent sector capacity and to encourage changes in referral patterns.

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Finally, Baroness Farrington of Ribbleton raised concerns about patients with complications being referred to the NHS from private hospitals when the procedure gets too complicated for them to deal with. Some forms of surgery do involve recognised complications, which are likely to happen in a certain proportion of cases, through no fault of the surgeon. In some of these cases, it will be normal and necessary for such patients to be referred on to a more specialist centre. This would occur with patients from non-NHS providers, but also with patients treated in some NHS organisations that do not have adequate emergency facilities to meet such demands, such as district general hospitals. Patients from both independent sector and NHS organisations can end up being referred for specialist treatment in an NHS tertiary centre, to deal with a complication that has arisen.

NHS patients should expect to receive the same safe, high quality standards of care wherever they are treated and we have brought in tougher independent inspections for all hospitals so any service that is not providing the desired quality of care, whether it is run by the NHS or privately, will be forced to turn things around or be put into special measures. The Care Quality Commission has been applying its new approach to inspecting and rating private hospitals from 1 April 2015 and plans to have rated all private hospitals by the end of 2016. Moreover, a duty of candour means private hospitals are legally required to report and apologise for mistakes, increasing transparency for patients and families and commissioners can hold private providers to account when things go wrong, through the NHS Standard Contract.

I hope this covers all the outstanding questions. I will copy this letter to the other speakers in the debate and place it in the library.

Yours, L.

David

DAVID PRIOR