THE SCOTTISH OFFICE
Department of Health

NHS
MEL(1999)4

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

22nd January 1999

Dear Colleague,

FUNDING ARRANGEMENTS FOR CROSS-BOUNDARY AND CROSS-BORDER PATIENT ACTIVITY

1. Summary

1. This MEL outlines the process for funding Cross-Border and Cross-Boundary patient activity from 1999-2000. Details are contained in Annex A attached.

2. The process of determining the allocation adjustments for Cross-Border flows has almost been completed following guidance issued previously.

3. The process for intra-Scotland activity is, briefly, as follows:

- Health Boards and Trusts agree Service Agreements (SAs) for the year ahead based on rolling forward the (current year) arrangements with the emphasis being on the cost rather than the price of activity.
- The SA will cover elective and non-elective, i.e. emergency activity.
- SAs may contain re-opener provisions to cater for substantial variations in referral activity or excess of low volume and high cost cases.
- The treatment of patients who present at Trusts where no Health Board/Trust SA exists will be classed as unplanned activity (UNPAC) and subject to a charge.

4. For 1999/00 high cost/low volume cases will need to be managed within the system outlined above. Health Boards are, however, encouraged to examine the feasibility of introducing consortia arrangements, on a regional basis, to manage high cost/low volume cases. For information Annex B gives details of the services currently funded on a national basis.

Addressees

For action:
General Managers, Health Boards
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For information:
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5. In the past, there have been problems over Health Boards responsibilities for certain categories of patients eg prisoners, boarding school pupils, or in particular circumstances such as emergency admissions, or when a patient changes address. Revised guidance on a number of residence issues is attached at Annex C. This guidance should be implemented with effect from 1 April 1999. Guidance on long-stay patients will be issued later.

Action

6. Health Board General Managers and Trusts Chief Executives should ensure that appropriate action is taken to:

- Complete the work required to identify Cross-Border allocation adjustments.
- Agree Service Agreements for 1999-2000.
- Absorb as much ECR activity into Service Agreements as possible
- Submit a report by 30 April 1999 (to Mr C Naldrett) on the amount of ECR activity absorbed into SAs.
- In the small number of instances where there are no Service Agreements send appropriate invoices on a quarterly basis.

7. The arrangements in this MEL will be reviewed in due course, and revised if necessary, to ensure they are effective.

DR PAUL A BRADY
Director of Finance

ANNEX A

FUNDING ARRANGEMENTS FOR CROSS BOUNDARY AND CROSS BORDER PATIENT ACTIVITY

Purpose

1. This Circular outlines the process for funding cross-Border and cross-boundary (intra-Scotland) patient activity from 1999/00.

Overview

2. The White Papers for both Scotland and England made commitments to abolish the 'internal market' and with it the process of extra contractual referrals (ECRs). This means that from April 1999 NHS Service Agreements (SAs) will replace annual contracts and wherever possible those Agreements will include current ECR provision.

3. The Department of Health in England (DH) have adopted a process where the ECRs that cannot be accommodated in a SA are classed as 'out of area treatments' (OATs) and will be funded by non-recurrent adjustments to Health Authorities' cash limited allocations. It follows that, because there is a cross Border flow of OAT activity, the adjustment process will apply to Health Boards too.

Cross-Border

4. The process of determining the allocation adjustments for cross Border flows is now well advanced in both England and Scotland. By necessity we have followed the English route which, in brief, rests on taking 1997/98 SA/OAT data and agreeing how much of the OAT activity can be subsumed into the SA totals. Thereafter the revised SA/OAT amounts will be up-rated to 1999/00 prices. The factor for up-rating and the methods by which the cross Border allocation adjustments will be effected have still to be determined.

Intra- Scotland

5. A joint Management Executive/NHSiS Working Group has considered the preferred arrangements for intra-Scotland activity flows. Additionally, the possibility of adopting the DH arrangement for intra-Scotland activity has been put more widely to the NHSiS in a draft Financial Issues paper.

6. The outcome is a strong call for a different approach in Scotland. Comment was also made about the fact that a considerable degree of 'simplification' had already been achieved over the last 12 months. This was partly in response to the Management Executive's calls to reduce bureaucracy and internal market activity, but also from substantial reductions in the invoice activity around GP fund holding (once its demise was announced). The result is that now most Board and GP fund holder contracts are on a block basis and the ECR position is relatively low volume and well managed.

7. Nevertheless, it is accepted that further improvements in the system can still be achieved. In addition, given the substantial amount of operational change that the NHSiS is facing, the Service is keen to retain some financial flexibility.

Summary of Arrangements

8. In summary the process is:

- Health Boards and Trusts agree Service Agreements (SAs) for the year ahead based on rolling forward the existing (current year) arrangements with the emphasis being on the cost rather than the price of activity.

- The SA will cover elective and non-elective, i.e. emergency activity.

- SAs will contain re-opener provisions to cater for substantial variations in referral activity or excess of low volume and high cost cases.

- The treatment of patients who present at Trusts where no Health Board/Trust SA exists will be classed as unplanned activity (UNPAC) and subject to a charge.

9. For 1999/00 high cost/low volume cases will need to be managed within the system outlined above. Health Boards are, however, encouraged to examine the feasibility of introducing consortia arrangements, on a regional basis, to manage high cost/low volume cases. For information, Annex B gives details of the services currently funded on a national basis.

Cross Boundary Service Agreements for 1999/00

10. A wide range of Service Agreements (SAs) between Health Boards and Trusts already exist for cross boundary activity, albeit they may currently be referred to as 'contracts'. The intention is that the existing SAs should be rolled forward with the minimum of adjustment, i.e. the aim is to avoid old style 'contract negotiations' and to ensure for this year that the SAs are in place well before 1 April 1999. Consequently the discussions for this year should centre on:

- changes in activity levels based on strategic service developments (per the HIP);

- absorbing the current GP fund holder SAs into the Board's 1999/00 SA;

- transferring provision for current ECR/emergency activity into a 1999/00 SA (Note: where there is no existing SA the process at paragraph 14 will apply);

- cost adjustments/uplifts and efficiencies;

- SAs should include re-opener clauses, if appropriate.

11. Health Board allocations will not be subject to adjustment for SAs. The expectation is that resources to cover the SAs will be paid directly by Health Board to the relevant Trusts as equal or periodic payments.

Unplanned Activity (UNPAC)

12. Where a Trust has no SA with a Health Board but receives and treats a patient from that Health Board's area it may charge for the treatment provided. It is expected that cases falling into this category will be relatively few, i.e. most treatments will be covered by a SA. Unplanned activity will be charged and settled retrospectively on a quarterly basis. The basis for the charge should be based broadly on speciality costs or other appropriate charges.

Payment Arrangements

13. As indicated above, the need for payments (SA re-openers and UNPACs) outside the main SA process should be relatively limited. Unlike the OATs arrangements for cross-Border activity with English Health Authorities and Trusts, where the funding flows will be effected by a charge to Health Boards, the re-opener and UNPAC adjustments will be by cash payments from Health Boards to individual Trusts.

Control and Review Requirements

14. Whilst the new arrangements will reduce the need for invoicing and minimise regular cross-charging between all Boards and Trusts, it will remain necessary for Trusts to track, monitor and report on patient activity. Essentially this is for two reasons. Firstly, to prevent, or at least address, significant variations to what is expected under the SA and OAT arrangements. Trusts will want to develop local protocols with their clinicians on the arrangements for authorising referrals in and out of the Health Board area. And secondly, the process of agreeing SAs and charges for OATs will be subject to annual review and revision as appropriate.

Finance Directorate
18 January 1999

ANNEX B

List of Nationally Funded Services (as of April 1999)

The services listed below, at the locations listed below, are funded at an "all Scotland" or "all UK" level and no separate charge should be levied for Scottish residents referred to these specific services from 1 April 1999.

Name	Hospital
Adult Cystic Fibrosis	Aberdeen Royal Hospital Western General Hospital, Edinburgh (includes outreach service in Dundee) Western Infirmary, Glasgow
Cardiothoracic Transplantation: - Heart Transplantation - Heart, Heart /Lung and Lung Transplantation	Glasgow Royal Infirmary (Adult) Freeman Hospital, Newcastle (Adult and child) Papworth Hospital, Cambridge (Adult) Harefield Hospital, London (Adult) Great Ormond Street Hospital, London (Child)
Choriocarcinoma: - Diagnosis of Hydatidiform Moles/AFP - Treatment	Dundee Teaching Hospital *Charing Cross Hospital, London* *Weston Park Hospital, Sheffield*
Clinical Chemistry	Victoria Infirmary, Glasgow
Clinical Scientists Training Schemes	Dundee Teaching Hospital (Molecular Geneticists, Biochemists, Cytogeneticists) Royal Infirmary of Edinburgh (Audiologists, Microbiologists) Aberdeen Royal Hospital (Medical Physicists)
Cochlear Implantation	Crosshouse Hospital, Kilmarnock (Adult and Child) Royal Infirmary, Edinburgh (Adult)
Craniofacial Surgery	*Great Ormond Street Hospital, London* *Radcliffe Infirmary, Oxford* *Birmingham Children's Hospital* *Royal Liverpool Children's Hospital, Alder Hey*

Name	Hospital
Cystic Fibrosis Audit Database	University of Dundee
Endoprosthetic Replacement for Primary Bone Tumours	*Royal Orthopaedic Hospital, Birmingham* *London Bone Tumour Service (Middlesex Hospital, London and Royal National Orthopaedic Hospital, London)*
Gaucher's Disease (Diagnosis and management)	* Addenbroke's Hospital, London (Adults) * Great Ormond Street Hospital, London (Child) * Royal Manchester Children's Hospital (Child)
Gynaecological Reconstruction	*Hammersmith Hospital, London
Henderson Model for Severe Personality Disorders	*The Henderson Hospital, Carshalton, Surrey
High dependency ventilation care at home for spinal injuries	Southern General Hospital, Glasgow
Hyperbaric Medicine	Aberdeen Royal Hospital
Inpatient Psychiatric Service for Deaf Children and Adolescents	*Springfield Hospital, London
Intestinal Failure (Specialist Service)	*St Mark's Hospital, London *Hope Hospital, Salford
Liver Transplantation	Royal Infirmary, Edinburgh (Adult) *St James Hospital, Leeds (Adult)* *University Hospitals, Birmingham (Adult)* *Birmingham Children's hospital (Child)* *King's College Hospital, London (Child)* *Royal Free, London (Adult)* *Addenbrokes Hospital, Cambridge (Adult)* *Freeman Hospital, Newcastle (Adult)*
Molecular Genetics	Aberdeen Royal Hospital Dundee Teaching Hospital Western General Hospital, Edinburgh Yorkhill Hospital, Glasgow
Ophthalmic Oncology (includes proton beam treatment where necessary)	Western Infirmary, Glasgow (proton beam at Clatterbridge Hospital, Liverpool)
Paediatric Cardiac Surgery	Edinburgh Hospital for Sick Children Yorkhill Hospital, Glasgow
Pancreatic transplantation (for those also requiring kidney transplantation)	Royal Infirmary, Edinburgh
Photobiology	Dundee Teaching Hospital

Name	Hospital
Pulmonary Vascular Service	Western Infirmary, Glasgow
Recombinant Factors VIII and IX	# Glasgow Royal Infirmary # Royal Infirmary, Edinburgh
Reference Laboratory Services	Royal Infirmary of Edinburgh (Mycobacteria, Neisseria Gonnorhoea) Aberdeen Royal Hospital (E-coli 0157, Campylobacter) Stobhill Hospital, Glasgow (Legionella, Meningococcus, Pneumococcus, Parasitology, Salmonella, Screening of inborn errors) Glasgow Royal Infirmary (MRSA, Trace elements) Raigmore Hospital (Toxoplasma) Public Health Laboratory Service, Colindale, London, (Specialist reference services not provided in Scotland.)
Retinoblastoma	*St Bartholomew's Hospital, London*
Scottish Poisons and Information Bureau	Royal Infirmary of Edinburgh
evere Combined Immunodeficiency and Related Disorders (SCIDS)	* Newcastle General Hospital * Great Ormond Street Hospital, London
Small Bowel Transplantation (service evaluation)	* St James Hospital, Leeds (Adult) * Addenbroke's Hospital, Cambridge (Adult) * Birmingham Children's Hospital (Child)
Specialist Paediatric Liver Disease Service	*King's College Hospital, London* *Birmingham Children's Hospital*
Spinal Injuries	Southern General Hospital, Glasgow
Total Anorectal Reconstruction (TAR) (service evaluation)	* Royal London Hospital

Normal type – services funded at listed locations for Scottish residents by National Services Division. These are the designated national specialist services for Scottish residents.

Locations in Italics – services funded on UK basis by Department of Health in England (open to Scottish residents)

* Service previously funded on ECR basis – from 1 April 1999 funded via National Services Division from pooled Health Board funds

Service funded via National Services Division from pooled Health Board funds

Out-patients

Where patients who are undergoing a course of treatment as out-patients, change their home address during that course of treatment, financial responsibility will immediately transfer to their new Health Board of residence, from the date the patients take up residence within that Health Board's area.

Where patients move whilst waiting for out-patient treatment, the Health Board in whose area they are resident on the date that treatment commences, will be responsible for meeting the cost of their out-patient treatment.

In such cases, the patient's GP and the hospital where treatment is being provided, will be jointly responsible for advising the new Health Board of residence of the change in circumstances, and the Health Board's responsibility for the remainder of the out-patient course of treatment.

For patients who normally reside in England and move to Scotland while undergoing a course of treatment as out-patients, they shall be treated as residents of an English Health Authority until such time as the appropiate period has elapsed. Details of trigger dates etc are shown in the following paragraph and are the same as those which apply to Scottish residents moving to England.

Where patients who normally reside in Scotland move to England while undergoing a course of treatment as out-patients, they shall be treated as usually resident at the address at which they were usually resident when the course of treatment began until a trigger date is reached. The trigger dates are :-

* three months after the change of address, or

* the beginning of the financial year following the change of address, or

* the course of treatment is completed,

whichever comes first.

PRISONERS

From 1 April 1999 patients who have been in the prison system for six months or more will be the responsibility of the Health Board in which the prison is located. Prisoners (or those on remand) who have been in the system for less than six months will be regarded as being resident in the area in which they lived before they were remanded or sentenced, but if the previous address cannot be determined, they should be regarded as residents of the area in which the prison is situated.

SELF REFERRALS

For certain categories of service where patients self refer, the patient's wish for complete anonymity warrants departure from the principle of charging the patient's Health Board of residence. The services falling into this category are those provided in genito-urinary medicine and similar clinics and services for those with or testing for HIV or with AIDS.

ANNEX C

ESTABLISHING RESIDENCE

Article 2 of the Functions of Health Boards (Scotland) Order 1991 states that where it is unclear where a person resides, he/she shall be treated as ordinarily residing at the address which he/she gives to the Health Board. It goes on to say that where there is no evidence of his/her present address, he/she shall be treated as ordinarily residing at his/her most recent address and where there is any doubt as to this, he/she shall be treated as ordinarily residing at the address which he/she gives to that Health Board as his/her most recent address. If the address still cannot be established, he/she shall be treated as residing in the area in which he/she is at present.

As a result, it has always been accepted that the patient is the arbiter of where he/she is resident except where the Secretary of State has directed that exceptions should be made for particular cases. The following guidance covers

- Patients who move address
- Prisoners
- Self Referrals
- Emergency Admissions
- Boarding school pupils
- Schools for children with special educational needs
- Patients transferred from the State Hospital

This guidance should be implemented by Health Boards and NHS Trusts with effect from 1 April 1999.

PATIENTS WHO MOVE ADDRESS

In-patients

Where patients who are undergoing a course of treatment as in-patients change their home address during that course of treatment, they shall be treated as usually resident at the address at which they were usually resident when the course of treatment began until they are discharged.

Where patients move whilst waiting for in-patient treatment, the Health Board in whose area they are resident on the date they are admitted to hospital, will be responsible for meeting the cost of their in-patient treatment and care.

As with Accident & Emergency services (A&E), the cost of initial treatment will be met by the NHS Trust`s host Health Board irrespective of the patient's area of residence. Any subsequent inpatient or outpatient treatment will be charged to the patient's Board of residence as for other services

EMERGENCY ADMISSIONS AND ADMISSIONS TO AN ACCIDENT AND EMERGENCY (A&E) DEPARTMENT

Article 2(3) of The Functions of Health Boards (Scotland) Order defines references to accident and emergency services as being

> "health care provided for a person who after an accident, or in an emergency, requires immediate treatment at a hospital where that treatment is provided in a department of a hospital which administers accident or emergency services excluding any in- patient or out-patient treatment provided subsequently for such a person and connected with the provision of those services."

Host Health Boards are responsible only for treatment provided in the A&E Department up to a period not exceeding 24 hours. Treatment provided outwith the A&E Department, (or if the patient was still in A&E 24 hours after time of admission) will then be the responsibility of the patient`s Health Board. If a hospital does not have beds in its A&E Department any subsequent overnight observation is regarded as being outwith A&E, and a charge may therefore be made to the patient`s Health Board of residence. This may be either through the agreements included in their Health Improvement Programmes or under the UNPAC system, if a service agreement does not exist.

BOARDING SCHOOL PUPILS

In order to produce consistency with the way in which population estimates are calculated for use in determining weighted capitation shares, it was decided that, with effect from 4 July 1994, Health Boards should regard pupils at boarding school as being resident in the area in which the school is located.

SCHOOLS FOR CHILDREN WITH SPECIAL EDUCATIONAL NEEDS

These may be residential or day schools taking substantial numbers of children with special educational needs from a wide area. These children often have complex healthcare and therapy needs involving a range of professional staff and high cost equipment. Unlike boarding schools, the child's "home" Health Board should be responsible for funding in such cases. Where the school is "independent", the school is responsible for providing general school medical services, but the child's Health Board of residence is responsible for the purchase of the specialised care that is needed.

PATIENTS TRANSFERRED FROM THE STATE HOSPITAL

In some cases, establishing the Health Board of residence for patients being repatriated from the the State Hospital may not be straightforward, but if delays occur in establishing residence two major problems occur. The first is that patients are being denied the treatment to which they are entitled and the second is that the State Hospital continues to detain patients who no longer need the treatment and security provided at Carstairs. To ensure that are no delays when a State Hospital patient is transferred or discharged, the Health Board of residence must be known, and in the case of new patients this must be established no later than three months after admission to the State Hospital.

This approach will ensure that the State Hospital will be able to identify at an early stage which Health Board is responsible for the patient, and there should be no doubt or disagreement when the time comes for the patient to be discharged or transferred to another hospital. Health Boards and the State Hospital must liaise to ensure that the relevant Health Board for all patients is known at any given time. At the beginning of each financial year Health Board Directors of Public Health (or other senior official) must confirm with the State Hospital, the patients for whom they may have to accept responsibility if patients are repatriated. The Local Authority of Residence should also be established to eliminate possible later difficulties.

If the patient was admitted to the State Hospital from prison and is being returned to prison, he/she will be the responsibility of the Health Board which has responsibility for the prison. If the patient was a prisoner prior to being admitted to the State Hospital but is not being returned to prison he/she will, on discharge from the State Hospital, revert to the Health Board which was responsible for him/her before being sent to prison.

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