

**Getting the money right matters most to patients, by John Murray
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The arcane nature of NHS finances tends to deter all but the most intrepid. In recent years, we have seen a series of substantial underspends being largely returned to the Treasury. In 2013-14 there is panic about a real, or maybe imagined, overspend on specialised services. In both cases, the result has inevitably been detrimental to patient care.

The confused state of funding for specialised services is particularly disappointing, as more robust arrangements remain one of the central purposes of the reforms introduced under the 2012 Health and Social Care Act.

Patchwork of provision

Until April, all money flowed to primary care trusts – with £500m being topsliced for highly specialised services, just over £5bn being voluntarily pooled through regional specialised commissioning groups and about £4.5bn being retained for specialised services that PCTs commissioned directly. The result was a patchwork of provision, with different standards and access depending on where someone happened to live.

The 2012 act brings responsibility and budget for specialised commissioning together in a single place for the first time under the auspices of NHS England. The funding flow has also been changed so that NHS England is in a position to retain the money it needs for specialised commissioning rather than being beholden to local commissioners. Policies are then drawn up once nationally for implementation at local level through 10 area teams responsible for managing provider contracts in relation to the treatment of patients from any part of England.

The purpose of this reform is to use the NHS's unique position as a national risk share for services where a combination of small and variable patient numbers, scarcer clinical expertise and sometimes high costs militates against a local approach.

So what has gone wrong? Primarily, the lack of reliable information about aggregate spends and a mistaken desire to map the budget against historical expenditure at PCT level has got NHS England into a sorry pickle.

The holy grail for specialised services is a funding arrangement based on weighted capitation reflecting a genuine sharing of risk across the population. Weighted capitation reflects the overall health need of a population rather than its particular use of services.

Poor use of weighted capitation

Sir David Carter's report on specialised commissioning in 2006 strongly advocated such an approach yet, when the Specialised Healthcare Alliance came to assess progress in February 2010, it found the percentage of expenditure calculated by weighted capitation ranged from as little as 1.23 per cent in the East Midlands to a

high of 25 per cent in London. The vast majority of expenditure was budgeted on the basis of actual costs per PCT or in some cases three year rolling averages.

The reluctance of PCTs to use weighted capitation should have been consigned to history with the arrival of NHS England. The absence of reliable aggregate data for specialised expenditure, however, caused NHS England to rely on the best approximations available from erstwhile PCT sources.

This seems to have sucked NHS England into the fallacy that clinical commissioning groups contribute towards specialised services in proportion to what they get out, threatening to undermine the principle of sharing risk across England at birth.

Inadequate funds

Furthermore, either NHS England and its local area teams have been singularly inept at managing costs or the funds retained for the purpose of specialised commissioning were inadequate from the outset. The latter seems to be borne out by the sheer size of the reported overspends in the patches managed by Wessex and Surrey and Sussex, which, at approaching 10 per cent, would otherwise beggar belief.

The scope of services prescribed as specialised under the 2012 act is significantly greater than before, including expensive additions such as all radiotherapy and chemotherapy drugs, as well as HIV outpatient care. Getting the global sum right first off was therefore always going to be a challenge.

An upshot of this mismatch between the funds retained by NHS England and the funds required for specialised commissioning has been mid-year topslicing of CCGs. This has created a sense of injustice of the kind that the new arrangements should have allayed.

It has also been done in a way that is genuinely inequitable for those area teams commissioning services for significant numbers of patients from the rest of the country. Most conspicuously, it would seem wrong for London CCGs to be topsliced per capita given the catchment area for the capital's specialised services.

Teething problems

These are major teething problems, but teething problems for all that. The priority should be to get a better understanding of the rationale for the new arrangements for funding specialised services right across the NHS.

In year two, we will have an actual level of spend across England of the kind that was previously lacking. The need for mid-year adjustments should therefore be considerably reduced if not eliminated. Crucially, however, any disaggregation of funding should be on the basis of weighted capitation.

The new arrangements for specialised commissioning have tremendous potential to deliver benefits in terms of more efficient services delivering better outcomes for patients with rare and complex conditions. First, however, we need to get the money right.