EXTRACONTRACTUAL REFERRALS

APPENDICES

King's Fund Institute

EXTRACONTRACTUAL REFERRALS

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APPENDIX 1

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KING'S FUND INSTITUTE/ AUDIT COMMISSION PROJECT Extracontractual Referral study

King's Fund Institute

1. What was the total budget set aside for ECRs at the beginning of 1991/92? £ .....

   What % of your total revenue budget did this represent? .....

2. Was this sum added to during the year? .....

   If so, on what dates? How much on each occasion?

   ..... £ .....

   ..... £ .....

   ..... £ .....

3. Are you planning to add to your ECR allocation in the remainder of 1991/92? .....

   If so, how much? .....

4. What is the most recent date up to which you have information on ECR expenditure (ie invoices received and paid)? We would like to get data from the first three quarters of 1991/92, if possible. .....

5. How much had been spent by this date?

   i) total expenditure £ .....

   ii) emergency expenditure £ .....

   iii) elective expenditure £ .....

Please return to:-
Mary Ann Scheuer, Senior Research Officer, King's Fund Institute, 126 Albert Street, London NW1 7NF
by 21 February 1992.

6. How many cases did this represent?

   i) total .....

   ii) emergency .....

   iii) elective .....

7. How much expenditure was committed in invoices received but not paid by this date?

   i) total expenditure £ .....

   ii) emergency expenditure £ .....

   iii) elective expenditure £ .....

8. How many cases did this represent?

   i) total .....

   ii) emergency .....

   iii) elective .....

9. If possible, could you indicate the distribution of costs per case incurred on ECR invoices received and paid to date.

COST	Total No. of Cases	Total No. of Emergency Cases	Total No. of Elective Cases
< £500			
£500 - £1,000			
£1,001- £2,000			
£2,001- £5,000			
£5,001- £15,000			
> £15,000			

10. What is the total number of elective ECR *applications* received to date? .....

11. What is the total number of elective ECR applications *approved* for payment in 1991/92? .....

12. Of the remainder, how have these been dealt with?
(Please state number of cases)

i) refused for management reasons (eg not a district resident, fundholder's patient) .....

ii) refused as clinically unnecessary .....

iii) placed on waiting list or deferred for treatment expected after 1991/92 .....

iv) re-directed to provider with which district has a contract .....

v) other .....

13. If possible, could you indicate the total number and cost of ECRs by specialty.

SPECIALTY	Total No. of Cases	Total Cost
General surgery		
General medicine		
Urology		
Paediatrics		
Trauma & orthopaedics		
ENT		
Ophthalmology		
Gynaecology		
Geriatric medicine		
Psychiatry		
Mental handicap		
Mental illness		
Obstetrics		
Other (please specify)*		

** only include specialties which account for more than 5% of your ECR spend and/or activity*

APPENDIX 2

APPENDIX 2: CASE STUDY INTERVIEWS

Interviews were carried out with six district health authorities over the period 25 February to 6 March. These were designed to clarify the information provided in answer to the questionnaires and also to provide more detailed information on the management of ECRs. A list of the district officers interviewed is provided at the end of this appendix.

The information collected via these interviews is presented in a common format under the following headings:

1. General Strategy
2. Budget Setting
3. Contract Thresholds
4. ECR Management Teams
5. Decision Making Process
6. Billing Arrangements
7. Price Variations
8. Relations/Communications with GPs
9. The Consumers Perspective
10. Emergency ECRs
11. Other Comments

BARNET DHA

1) General Strategy

The district's general policy is to approve ECRs as long as they are considered appropriate. A summary of their contracts and policies has been circulated to GPs. This states that the main criteria for approving an ECR will be that services are not available under contract and/or there is a good reason why the contracted services are not appropriate for any individual patient. In pursuing this strategy, the avoidance of adverse publicity has been a major consideration.

2) Budget Setting

Data on patient flows for 1989/90 were used as a basis for budget setting. The budget was set at £1.8 million. At the moment, projected expenditure is £1.4 million. The underspend will be used to supplement the health authority's general cash allocation and to meet the costs of excess activity by two local providers.

Next year, the ECR allocation will be increased as some of this year's contract activity will be diverted to ECRs.

3) Contract Thresholds

This year, contracts have been set at any unit dealing with more than 50 cases. For the priority services, an expenditure threshold has been used in addition to case load because a small number of expensive, long-stay cases can imply a major expenditure commitment. For next year, the threshold will be increased to 100 cases for contract setting purposes.

It is also intended to address the problem of under-performance against contracts on the part of some providers by moving a proportion of their activity from contracts on to an ECR basis. In particular, they are planning to move 40 per cent of the activity from four providers from a prospective contractual basis to an ECR basis. An increase in the ECR budget is planned to facilitate this transfer, but it is anticipated that savings will result which can be used for development purposes.

4) The ECR Management Team

The management of the ECR system is the responsibility of the purchasing directorate with advice from a consultant in public health. An information officer has been heavily involved in setting up a database to manage the relevant information. Estimates of time inputs on the part of the relevant staff were as follows:

i) Purchasing director - minimal input now, although there were considerable set-up costs,

ii) Two purchasing managers - 5 per cent each of their time respectively,

iii) Purchasing administrative assistant - half-time,

iv) Information manager - 7 per cent of time,

v) Financial clerk - one-third of time,

vi) Consultant in public health - 14 per cent of whole time equivalent, although part-time (retired) consultant dedicated to ECRs.

5) The Decision Making Process

Elective applications are usually received by fax, usually on the provider's own forms. The purchasing assistant logs the information in manually and on computer records. A computer programme checks that postcodes match those of Barnet Health Authority, that the GP number/name/location is provided, and that the provider is not covered by a contractual arrangement. The computer system is thought to be highly efficient. In addition, there is a manual check of prices against published tariffs.

For the first six months of operating the system, it proved necessary to contact providers frequently for information. However, the system is now working much better and there is less need for this cross-checking.

The purchasing manager decides if the application is likely to obtain a routine approval, eg follow-up appointment, or continuing care. If so, the request is forwarded to the purchasing director for authorisation. If further information is required from providers, contact will be made by the purchasing managers or their assistant. If further information is required from the GP, the purchasing managers pass the application to the public health consultant responsible for ECRs. They ask the public health consultant to look at about 25-35 per cent of the cases. In about 30 per cent of the cases which the public health consultant deals with, the GP is not aware of the referral because it is a tertiary referral, self-referral, referral by another GP (eg a relative's GP) or referral by a non-doctor, eg voluntary agency. The main aim is to find out why the referral was made to that particular provider. Finance staff rarely play a part at this stage unless the request is a very expensive one, eg in excess of £15,000. In such cases, the request will be referred to the three directors (Director of Purchasing, Director of Finance and Director of Public Health) who deal with each case on its individual merits.

The provider will be notified by fax about an authorisation.

The district aims to make a decision within two days from when full information is received. But, it often takes some time to obtain full information. Nonetheless, the majority of decisions are made within three days of application. A number of applications have taken up to one week, whereas a very small number have taken from three to four weeks (eg as when GPs were required to provide more information but were on holiday). The purchasing director wished to audit ECR response times. It was felt that provisional approval could be provided for some cases to go ahead, but payment would not be guaranteed until full minimum data set information had been received.

The district had not used deferrals or re-referrals. No management changes were planned to the above arrangements for next year.

6) Billing Arrangements

Billing arrangements are subject to considerable delays. The district is now receiving 95 per cent of invoices within four to six weeks. However, there are still problems in receiving minimum data sets along with invoices.

The process adopted is as follows. When a bill is received, it is recorded as an expenditure commitment while the information is verified. It is often necessary to chase up minimum data set information separately. Once the validation is completed, the invoice is forwarded to the payments section. The finance data is checked against the published tariffs, and if this is in order, payment is authorised.

7) Price Variations

Price variations are a factor that is taken into account when authorising ECRs. These are sometimes discussed with GPs in exploring possibilities for re-referral to contracted providers. GPs have generally been very interested to learn of price variations because they are not aware of prices.

8) Relations with GPs

The district believes that GPs have been very positive about the way that the ECR system has been managed. There have been no major disputes and only one incident of mis-communication.

If questions arise about a particular referral which require information from a GP, the public health consultant usually gets in contact by telephone. This has happened on a number of occasions in connection with routine procedures when it is not clear why the GP has not referred to a contracted provider. If the GP's reason is to obtain a shorter waiting time, the district will always approve.

There is at present no appeals policy as all rejections have already been thoroughly discussed with GPs.

At the moment, there is no clear pattern of clustering among GPs in relation to the number of ECRs. But information is incomplete on this topic. There are no GP fundholders within the district.

9) The Consumer's Perspective

Patients are not involved in the ECR process as a matter of policy. A few have contacted the district directly. The director of purchasing feels that patients should be aware that they have choices between providers but feels that few patients understand the process.

10) Emergency ECRs

Problems are occurring with emergency ECRs, especially in relation to expensive geriatric and psychiatric cases. There is a suspicion that some cases are inappropriately designated emergencies. For example, there was a case of respite care - which it was thought must be planned by its very nature - having been described as an emergency ECR. There is a feeling that the district should be consulted on some of these cases and that financial incentives are distorting provider's behaviour. The example of an nearby priority unit was cited. In the first three months of the year, the district received a flood of invoices for emergency ECRs from the provider - so they decided to take out a contract. As a result, in mid-year, a block contract was set. Activity is now below the block contract level and much below what was indicated by the ECRs in the first three months.

11) Other Comments

The director of purchasing sees one important by-product of ECRs as being a means of establishing a dialogue with GPs and a lever on contracted providers. She would like to re-open the debate with the GPs about why there are ECRs - what is their purpose and how could the district improve contracted services in specialties with a large number of ECRs.

An example of using ECRs as a lever on a contracted provider is demonstrated by the case of a 16-year old girl who was seven weeks pregnant. The girl was in a state of terror. The first hospital that was contacted by her GP said that there was a three week wait. The second hospital said that they could not treat her because she was outside their catchment area, although the

health authority did not know that the hospital was running a catchment area system and was unhappy about it. In the light of these two responses, the GP contacted a private unit which submitted an ECR application. When the application had been received, the district went back to the first hospital and discussed the implications of ECRs going to the private unit on a longer term basis. This discussion formed a part of a more general district discussion with the hospital about the future of contracted services. Faced with this threat, the hospital responded with an appointment within a few days.

PARKSIDE DHA

1. General Strategy

The Health Authority published a commitment to GPs which stated that they would not refuse an ECR in the first year without the support and willingness of the GP. The DPH said that the Authority wants to accommodate, as far as possible, the preferences of GPs in making referrals, but that she often had to work on the principle that the GP doesn't realise what is available locally and/or does not recognise the opportunity cost of ECRs. In practice, the Authority takes a more interventionist approach than many other health authorities.

Policies are set by a purchasing steering group comprising the DGM, Director of Purchasing, Director of Finance, Director of Public Health, GP representative, Health Authority non-executives. This steering group meets every few months. Proposals to be considered by the group are submitted by the DF, DPH, D Purch and deputy directors of purchasing who meet regularly.

One difficulty facing Parkside is that it assumed responsibility for a portion of Bloomsbury DHA in November 1990 (ie North East Westminster). It was very difficult to establish the patient flows for these residents and this made it difficult to take out contracts for them. As a result the incidence of ECRs has been higher than normal. The problems of managing the referrals associated with this population were compounded because the District did not receive information on the cash allocation for them until January 1992. When this information was received, the ECR budget was increased.

Setting budgets has also been complicated by the treatment of neonatal intensive care units (NICU) in North West Thames RHA. In many regions NICU services are dealt with through contracts. In NWTRHA, however, they have been dealt with under ECR policy. The Region developed a formula based upon historic usage and low-birthweight rates in order to allocate NICU money to districts. Parkside has £500,000 earmarked for NICU services within the ECR budget, but the Region is now clawing back the money that was not used for redistribution to other districts.

2. Budget Setting

Parkside set their budgets using the usual patient flow data and specialty costs. The Deputy Director of Purchasing believes that expenditure will be contained within their budget, taking into account the additions that have been made recently. However, the Finance Department calculations suggest that there will be a slight overspend.

Next year's ECR budget will be smaller than this year's because the District will contract for some flows of North East Westminster patients (eg to Barts). They are also going to issue a number of providers, to whom there are significant ECR flows, with 'letters of intent'. These will authorise the provider to treat patients up to an overall cost ceiling and to bill the District on a per item of service basis. If the provider exceeds the agreed amount, it must apply for individual ECR authorisation. This arrangement is designed to eliminate excessive bureaucracy for regular providers. There will be a separate budget allocation for letters of intent within the overall ECR budget.

The District has not yet arrived at a firm decision for next year's budget because they have not yet received prices from many providers.

The District is planning to change the contractual arrangements governing oral surgery and dental services. This is seen as an area for which demand has increased markedly - and could grow substantially in the future - because

dentists are more reluctant to provide NHS services. This year the District has received numerous ECR cases at A&E walk-in dental clinics. In response to this demand, they decided to require all referrals to be redirected to the community dental services for assessment and treatment or referral to one of their contracted units. For next year, they are planning to consolidate their contracts for oral surgery and dental services onto four providers. This will enable them to develop clear admission protocols and criteria with these providers.

Complex psychotherapy services have also shown up as an expensive ECR item. The DPH said that they are considering developing local provision of these services so that they could reduce their dependency on long, expensive specialist referrals. The Public Health Department is currently discussing the situation with local clinicians and the purchasing team to see if the resources that they are presently spending on out-of-district ECRs could be better spent developing local services.

3. Contract Thresholds

A minimum contract threshold of 150 episodes for a provider has been set this year. Next year the threshold will remain at 150 episodes although letters of intent will cover providers with 50 - 150 inpatient or day case episodes.

4. The ECR Management Team

The purchasing directorate takes the lead in managing ECRs with a significant input from the Department of Public Health. Purchasing managers make authorisation decisions while administrative assistants handle the day-to-day running of the system.

The respective time inputs are as follows:

Purchasing managers [4 or 5 on rota]	- equivalent to 5-10 per cent of WTE
Purchasing administrative assistants	- 40 per cent of grade 6 - 70 per cent of grade 4
Director of Public Health	- 7 per cent
Management Accounts Clerk	- 70 per cent of grade 5
Management Accounts Senior	- 30 per cent of grade 6
District Management Accountant	- 5 per cent of Senior Manager's time

5. The Decision Making Process

Ninety five per cent of ECR applications arrive by fax on providers' forms. Parkside does not have its own application form. The administrative assistants said that a national standardised form would definitely help as many providers' forms were unclear in certain respects.

The following information is scrutinised in relation to ECR requests: address (district resident?), dates of treatment (has it occurred already, or will it take place next year?), specialty and provider (available within contracts?), referring GP (fundholder?), price (tariff?). The level of information provided is generally considered to be adequate. Most queries relate to addresses and sometimes information about the referring GP is missing. Many providers do not indicate dates of admission. Overall, it proves necessary to contact providers in the case of 25-30 per cent of applications in order to obtain complete information.

In the majority of cases a hospital ID number is used as a patient reference, but if further information is required from the GP, the District will usually ask for the patient's name.

The administrative assistants check basic information and may sometimes ask providers why the patient is going to an out-of-London hospital. They do not tend to query London referrals as much, mainly because they assume London referrals are standard flows for the NE Westminster population. Once basic information has been established, the requests are passed on to the Purchasing Manager. If there are no problems, a request will be authorised within 24 hours. If a problem arises (eg referral to a private clinic with which the District is unfamiliar or referral out of district for a standard mental health service which is available locally), the request will be referred to the DPH who will usually contact the referring GP. About 5 per cent of cases have been referred to the DPH. It is the DPH or a consultant in public health who will contact the GP. Members of the purchasing team do not usually contact GPs directly.

When considering an ECR request, the DPH looks first at clinical criteria to establish whether or not the referral seems appropriate. Thereafter she will consider whether there is a local service within contract which could be substituted for the referral. If there is not a suitable contracted local service, the DPH tends to be far more supportive of the referral. Judging appropriateness has been especially difficult in the case of a few, very expensive priority service patients (eg mental health, drug rehabilitation). Local psychiatric clinicians have been asked to carry out independent assessments of patients and to give advice about whether local services would adequately meet their needs. So far this has been done on an ad hoc basis and seems to have worked reasonably well. Local community dental services have also been called upon to act as independent assessors for dental referrals. However, although this system seems to be working well, the DPH feels that the District has not yet had to deal with really tough decisions. So far these have usually by-passed the elective ECR process as they have been designated emergencies.

Financial implications of a referral are considered if it will involve a long term commitment (eg rehabilitation services).

The whole ECR approval process takes, on average 48 hours, although many cases have been dealt with within 24 hours. Some very complicated requests often take up to 14 days. In these cases the Health Authority make sure that the GP is kept in touch so that he/she knows what is happening. Some very long cases have taken up to a month, especially if the Public Health Department is involved.

Decisions are communicated to providers by faxing an authorisation form. If a GP has been contacted for information a letter communicating the decision will also be sent. Authorisation forms are forwarded to the Finance Department so that they can be entered as an expenditure commitment.

6. Billing Arrangements

ECR authorisations are entered into the Finance Department's system as commitments. Thereafter, when a bill is received it is sent to the Purchasing Department for checking and to certify that payment is approved. The Finance Department itself has not experienced any particular problems although it has received a number of queries from providers in relation to bills that have not yet been paid. Delays tend to occur because the Purchasing Department has a large number of queries to clarify before they will certify an invoice.

The Finance Department and Purchasing Departments have separate computer systems. The Finance Department has had theirs running since the beginning of the year, mainly tracking financial information, but also recording information on specialties, providers and treatment. They can analyse information in terms of the providers region/district, payment or authorisation status, specialty, emergency/elective split, date of treatment, and time of payment. They produce regular monthly reports showing actual expenditure plus commitments against the budget (a disk with this information is available). The Purchasing Department is in the process of implementing their system at the moment.

7. Price Variations

No special comments were made in connection with price variations.

8. Relations/Communications with GPs

The district reports good overall relations with GPs. A GP representative sits on the purchasing steering group.

The district is unable to say whether ECRs are concentrated with particular GPs. However, an examination of obstetrics admissions by referring GPs did indicate that ECRs were mainly for homeless people in temporary accommodation (B&Bs). They tended to be admitted to hospitals in the borough of their normal residence.

9. The Consumer's Perspective

There appears to be limited interest on the part of consumers about the ECR system. There was one instance of a patient who had contacted the waiting list hotline run by the College of Health and had lobbied the District to be placed on a shorter waiting list. But this was an isolated case.

The District officers did not see confidentiality as a problem because they felt that people working for the purchasing team are professionals and are bound by the same policies on confidentiality as managers in provider units.

There is no formal appeals procedure. The CHC has suggested that there should be one. There have not been any major disputes to date. However, the Deputy Director of Purchasing felt that with the publication of the Patients' Charter they may well find that they receive more complaints in the future.

10. Emergency ECRs

Emergency ECRs are checked for addresses, contracts and minimum datasets by the administrative assistants. They will query prices against publish tariffs. They will also check source of admission and destination of discharge. Some problems have occurred in connection with oral surgery and in the case of some priority services. It has not always been known whether the cases were genuine emergencies. The London Purchasing Forum has identified the problem of priority services as an area to be looked into next year.

11. Other Comments

Both the DPH and the Deputy Director of Purchasing said that there was a conflict between individual and collective choice. The DPH said that this conflict has always been inherent in the NHS and that ECRs, and the reforms as a whole, have made some of the choices more explicit. Ultimately, someone has to make a judgment. The Deputy Director of Purchasing said that he saw two difficulties arising from the conflict. First, there were difficulties in dealing with one-to-one situations ie talking with GPs and patients. There was a need to make sure that whoever is doing this is trained in counselling

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methods. Second, the conflict needed to be addressed in terms of general policy. The Health Authority is in a position to look after the collective good as opposed to, for example GP fundholders, who only make decisions for their individual patients and don't worry about the impact of their decisions on providers. But there were no easy answers to this problem.

The Director of Public Health said 'Because we know so little, ECRs have taught us quite a lot about how the system works, and about what is lacking in our contracts'.

SOUTH BEDFORDSHIRE DHA

1. General Strategy

South Beds has adopted a proactive strategy towards ECRs. Their general approach has been to concentrate on working with GPs to find suitable referrals under contract, rather than seeking to identify referrals that are clinically inappropriate. However, this has involved scrutinising individual ECRs very thoroughly.

The ECR budget is confined to those procedures not covered by contracts. If an ECR is made for clinical and/or social reasons, then a request will be considered favourably. On the other hand, if the service is one which is covered by contractual arrangements then the burden of proof switches to the GP and the patient. The Director of Public Health supported the view that the District should encourage GPs to redirect referrals to providers with whom the District has contracts. This requires that GPs are kept actively informed about the location and type of contracts that the District has taken out.

Local guidance for managing ECRs was issued by the Director of Public Health in June 1991 (see attached).

2. Budget Setting

As in other districts the budget was set on the basis of patient flow data, average costs and cases not covered by prospective contracts. In addition the initial ECR budget was supplemented to cover some activity that was expected to be covered by contracts but, in the event, was not so covered.

The District expects their ECR commitment to exceed the budget allocation this year, but they expect the actual cash flow to be less than budget because some commitments will not take place until next year.

Next year's ECR budget will be increased, using 1991/92 commitments as a guide, and taking into account the time lag in treatment which occurs. The exact amount of the planned increase is not yet known.

3. Contract Thresholds

A nominal threshold of 50 cases was used for contracting purposes.

4. ECR Management Team

The responsibility for managing ECRs has changed three times during the first year.

To begin with, responsibility was shared between two contract managers and an assistant contract manager. The Director of Commissioning was ultimately responsible for ECRs. The Assistant Contracts Manager - who has stayed involved with ECRs throughout the whole year - said that it was a difficult period because there were no real protocols for handling ECRs and the Director of Commissioning was new to the District. The Contracts Managers and Assistant Contracts Manager were all making authorisation decisions.

In October 1991, a new Contracts Manager was employed and was given responsibility for ECRs. Under the new arrangements, the Assistant Contracts Manager reported to the new manager who made authorisation decisions. However, this arrangement did not prove satisfactory to the Assistant Contracts Manager. She felt that she was relied upon for advice by the new manager but that, paradoxically, her role was being downgraded to a more clerical one.

In February 1992, the Deputy Director of Finance took over managerial responsibility for ECRs with the Assistant Contracts Manager (now called ECR Manager) reporting to him. Under this arrangement, the ECR Manager makes authorisation decisions, consulting with the Deputy Director of Finance, public health consultants or contract managers if she has any queries. The decision to involve the Finance Department more directly in the management of ECRs was undertaken partly for personnel reasons, but also because it was felt that the Finance Department had the necessary quantitative skills for monitoring and payment.

The Deputy Director of Finance said that the District had learned a number of lessons from the staffing difficulties it had experienced over the last year. In particular, he felt that it was much better to have the process concentrated with a few people who see it as an important part of their job rather than dispersed among a number of officers. Among other things, this meant that the District was able to achieve greater consistency both in terms of information and in terms of its responses to providers. He also felt that the District had under-invested in ECR management for most of the year. This was complicated by the fact that it was laborious to use their information systems as these were based upon paper records and used several different databases. It was hoped to simplify this system next year.

At present the time commitments on ECR management are as follows:

- the ECR Manager works full time on this task,
- the Deputy Director of Finance allocates about 7 per cent of his time,
- clerical support represents about 40 per cent of a wte,
- secretarial support represents about 6 per cent of a secretary's time,
- public health involvement involves about 10 per cent of the time of a senior registrar or public health consultant.

5. Decision Making Process

Most ECR applications are received by letter either from GPs before referral or from providers. Between 30 and 40 per cent of applications are received by fax. Sometimes applications are received by telephone. In fact, GPs are now calling quite frequently to ask about a case before they make a referral. These enquiries are not logged into the information system. All other applications, however, are logged which means that the District can tell how many inappropriate ECRs they have to deal with.

The applications go directly to the ECR Manager who checks the following information: postcode (resident?), GP details (fundholder?), procedure/diagnostic code, provider and specialty, treatment date (already occurred?).

Earlier in the year, it was necessary to make a number of calls to providers to make it clear that authorisation for treatment would not be provided unless the District received full information. Subsequently applications have improved a good deal in this respect.

The District supports a North West Thames RHA proposal for a standard ECR application form.

The ECR Manager appears to be quite active in querying ECR applications by, for example, asking providers and/or GPs for the reasons for referral. She will generally accept ECR cases for reasons of social support needs, long case histories with a provider, long waiting times, continuing ECR care, and

special clinical reasons for referral. On the other hand, she will look very carefully at a request if the procedure is fairly routine and would be available under an existing contract. In such cases the ECR Manager will generally call the referring GP, cite the cost of the service and explain that the service is available under contract with another provider. So far she has received a good response from GPs. She is now finding that GPs are redirecting referrals themselves, either after asking about referrals or just on the basis of their knowledge of contracts elsewhere. She believed that she had arranged for over 40 ECR cases to be redirected this year, and would like to do more of this next year.

The Contracts Manager tends to rank ECRs in terms of urgency so that the more urgent cases will be dealt with first.

The financial implications of ECRs are considered, especially in the case of a small number of very high cost procedures. The Director of Public Health said that GPs often did not realise the cost of a referral and were open to discussing options.

Plans for managing ECRs next year anticipate a number of improvements. These include: streamlining administrative procedures by developing a computer database; drawing on the informal case-law that has been established in dealing with ECRs to date; challenging providers on prices; investigating more referrals and trying to transfer ECRs to contracted providers (requiring GPs to contact the Health Authority before they make a referral out of contract is under consideration); challenging providers when they are not given prior notification of an elective ECR, or if the notification is so short that the authority is not able to make a considered decision.

6. Billing Arrangements

The District requires the standard invoice information along with minimum datasets. Lack of information on invoices is a much bigger problem than it is in the case of applications. Often invoices do not have the correct authorisation number or were not notified to the District beforehand. The District believes that certain providers are consciously failing to notify them beforehand and is therefore denying payment to all ECRs which took place - without authorisation - after 31 September 1991.

Overall, the staffing changes and diffusion of responsibility for ECR management over the year has meant that the billing system has been rather poorly handled. A large backlog has built up. The District under estimated the amount of work that it would require to follow up details for invoices and to enter them on to its computer system.

7. Price Variations

The Deputy Director of Finance said that it was often difficult to establish the relative costs of ECRs because of the absence of a standard basis for tariffs which were developed by different providers. For example, some include a number of outpatient visits with inpatient episode costs, others have separate outpatient costs as well as day case and overnight costs. Nonetheless, he would like to use price variations to manage ECRs in the future. He feels that it is appropriate to develop a standard basis for ECR tariffs because purchasers have no opportunity to negotiate ECR prices in the way that they do with other contracts.

8. Relations/Communications with GPs

Despite operating a highly interventionist policy in relation to GPs, the District reports that GPs are generally satisfied with the way the system is operating.

The District has set up a general purchasing forum where contracts managers and public health consultants meet with four GP representatives every month. As part of this forum, an ECR appeals mechanism has been set up. So far, however, there have not been any real disputes or appeals. The forum has proved to be very useful in giving GPs the opportunity to raise issues and also as a means of informing them about the Health Authority's approach. The ECR Manager feels that providers sometimes manipulate patients and GPs, and that the GP forum has been a useful way of addressing this problem.

9. The Consumer's Perspective

The health authority has received a small number of calls from patients about ECRs. But these are unusual.

The ECR manager felt that confidentiality was an important issue and supported the omission of names from forms unless absolutely necessary.

10. Emergency ECRs

The biggest problem encountered in connection emergency ECRs is that the tariff often does not seem to correspond particularly well with the work that has actually been undertaken. For example, a person was admitted to A&E for observation overnight and a full finished consultant episode was charged. The ECR Manager feels that the District could save thousands of pounds every month if they were able to get more precise tariffs in connection with emergency ECRs.

HEREFORDSHIRE DHA

1. General Strategy

The District does not have a policy which has been endorsed by the Health Authority, but their general approach is to exert minimal interference and to accept GP referral decisions. The District had been building up expertise on managing ECRs and learning by doing.

The Director of Public Health identified what he perceived as conflicting messages in relation to overall ECR policy emanating from the Department of Health. One message said that GPs should be free to refer and to take advantage of shorter waiting lists. The other message is that district health authorities must work within a fixed budget and determine priorities. Hereford is at the moment tending towards emphasis on GPs referral freedom because of the political situation.

2. Budget Setting

As elsewhere, budgets were based upon 1989/90 patient flow data and average costs. The ECR budget was determined after prospective contracts had been agreed. In the West Midlands, ECRs excluded regional specialties.

In the event, the original expenditure estimates did not provide sufficient funds to cover the District's ECR commitments. In part, this arose because of a change in definition of regional specialties which meant that the District had to cover more cases than expected. It was also felt that the patient flow data obtained from the Mersey tapes did not identify cross-regional flows particularly well. These were important in the case of Hereford. Finally, some specialties were not well identified, eg rehabilitation for head injuries.

Herefordshire is now facing an ECR overspend, exactly how much is unclear. The finance department is presently calculating total estimated expenditure and commitments. This process involves a good deal of imprecision because of limited information.

Next year the District's ECR budget will increase to about £750,000 or 1.34 per cent of the total revenue budget. This represents an increase of about £70,000 on this year's final budget, but an increase of £200,000 in this year's original budget. They have decided that some prospective contracts with Birmingham and Shropshire providers will be reduced in size or withdrawn because they feel that managing activity through ECRs gives the District more control.

3. Contract Thresholds

The District did not use a precise threshold for setting contracts, although contracts were generally taken out if expenditure was expected to exceed £20,000.

4. ECR Management Team

The Contracts Support Manager plays the major part in managing ECRs. He devotes about 80 per cent of his time to the task. This involves dealing with requests and making all approval decisions. The Director of Contracting devotes about 20 per cent of his time to the ECR process, mainly through the approval (and dispute) of invoices. A secretary devotes about 25 per cent of her time to supporting the ECR team. Public health has a minimal involvement.

5. Decision Making Process

Most ECR requests are received from providers by post, although an increasing number (about 15 per cent at present) are being received by fax.

Each request is checked manually on the basis of administrative criteria. It has been found that postcodes and dates of birth are the items of information which are most often missing. In about 10 per cent of cases, it proves necessary to check information on patient addresses with the FHSA. In about 5 per cent of the cases, it is necessary to contact the provider for more information.

A standardised ECR form has been piloted by West Midlands RHA to see if requests can be handled without use of the patient's name. Herefordshire feel that it is difficult to manage without names. They point out that it is impossible to link a hospital admission number to an FHSA registration list (to check residency) and that they cannot communicate with GPs unless there is a named patient involved.

Until November, most ECRs were approved fairly automatically. Now, however, the District is seeking to defer non-urgent elective work until after April 1992. They are not approaching GPs to question referral decisions but are deferring treatment.

When a decision to defer treatment has been made, the Health Authority sends a letter to the provider involved. A letter is also sent to the referring GP explaining the Health Authority's financial position, requesting deferral, and asking if there are any clinical reasons why a deferral is inappropriate. To date, only three or four GPs have requested that treatment is brought forward. These decisions are generally handled by the Contracts Manager on the basis of advice received from the Director of Contracting. The Public Health Department is not consulted.

When a deferral has been agreed the provider is sent authorisation for treatment after 1 April 1992 and the District enters a commitment against its 1992/93 budget.

Financial implications enter decisions on referral for all cases. The District is not just deferring expensive cases. However, they do look at high cost referrals more carefully to check the facts and their appropriateness.

The District reported that 90 per cent of ECR cases are dealt with within 24 hours. Decisions are always in the post within 2 days.

The District does not have a policy for excluding any types of treatment on clinical grounds, but the Director of Purchasing believes that this will become an issue in the future. At the moment, they are deferring some difficult decisions until after April 1992. In doing this, the Contracts Manager does rank ECRs in terms of his perception of their urgency.

6. Billing Arrangements

When an invoice is received, it is checked to make sure that minimum dataset information is attached. In the case of elective procedures, a check is made to make sure that authorisation was given. Queries are referred to the provider. If everything is in order, the invoice is sent to the Finance Department who check the price against published prices. If no problems arise, payments are made.

The District has experienced considerable delays in receiving invoices. At the time of the interview (February 1992) bills for activity which took place in May, July and September 1991 were in that day's post. The district is

presently disputing a large number of invoices, representing about £100,000 of expenditure.

7. Price Variations

The contracts manager said that while he noticed price variations, very often he only knew the specialty and not the procedure. It was dangerous to make decisions on price, he felt, because he did not really know what was happening with the patient.

8. Relations/Communications with GPs

The Director of Public Health explained that the District is seeking to support GP referral decisions wherever possible. There was, however, a budgetary constraint. He took the view that if you allow GPs to act responsibly with an awareness of the resource implications of ECRs, they will be careful about the decisions they make. Information had been provided to GPs about the District's financial difficulties and also direct discussions had been held with GPs representatives.

No appeals procedure has been established to deal with deferred cases, however the District indicated that it is prepared to consider GPs views informally if they oppose a deferral decision. Some GPs have expressed their concern, but most of them seem to realise that ECR policy is basically establishing a waiting list in the way that waiting lists have been established in the past. There has been no contact with the local medical committee.

The District set aside a £20,000 reserve to cover GP fundholding cases which exceeded £5,000, but no call has been made on this budget to date.

9. The Consumer's Perspective

The contracts manager felt that patients were gradually becoming more aware of the system, mainly as a result of being told about the system by their GPs.

10. Emergency ECRs

If the Contracts Manager receives notification of an emergency ECR (as a courtesy), then he gives verbal authorisation. The normal procedure is for the Director of Contracts to receive an invoice, for the Contracts Manager to check postcodes, whether the invoice refers to a regional specialty, etc and then to approve the invoice. Problems sometimes occur with out of date addresses being used.

There is no evidence that elective referrals are being inappropriately designated as emergencies, but some suspicion of this possibility was expressed.

11. Other Comments

Limited choice of local access to well developed acute services means that there are strong geographical flows out of the District and sometimes out of the Region. The Mersey tapes did not accurately identify flows to, for example, Oxford, Cardiff and the rest of Wales, and therefore the District feels that it did not receive adequate funding for these flows. There is also concern that the treatment of regional specialties has penalised the District. These factors are seen as major contributors towards the District's overspend.

SOLIHULL DHA

1. General Strategy

The general policy is to accept GP referral decisions - and not question whether an ECR should take place - but to manage the flow by deferring approval for a treatment when necessary. Having said this, there have been a few cases where the district has worked with GPs to re-direct referrals to less expensive and/or more or equally appropriate providers.

Within the year the District decided to consider modification of this approach. Questionnaires were sent to GPs asking how they would like ECRs to be dealt with in the future in the light of budget constraints. In particular, they were asked whether they preferred to continue to use waiting time as the sole rationing mechanism or whether they would prefer availability of services under district contracts and clinical appropriateness to be added as relevant criteria. Only 22 per cent of GPs responded, providing no clear picture. As a result the District decided to continue to ration on the basis of waiting times.

2. Budget Setting

The total ECR budget was set as a residual after patient flows on contracts had been determined. In addition, £180,000 was added to cover planned cases at a rehabilitation unit and at a family services unit.

In August 1991, the District realised that they were exceeding their ECR budget allocation and started to delay elective cases which were available under district contracts. In November 1991, an additional sum was added to the ECR budget from district reserves.

The District expects to finish the year with total ECR expenditure within £50,000 of their budget.

The District plan to allocate £900,000 or 1.4 per cent of their total budget to ECRs next year. This represents only a £5,000 increase on this year's final budget but a £250,000 increase on this year's initial budget allocation.

Next year's budget will be affected by an increase in the number of patients registered with GP fundholders. This year the District has three fundholding practices and this will grow to seven practices next year, covering 34 per cent of their population. This may mean that the District will only need to contract for a small amount of activity in some units and so existing contract arrangements may be converted to ECRs. The district is also considering removing contracts from two units which have over-performed. At the moment they are experiencing difficulty in agreeing contract terms with these units.

3. Contract Thresholds.

A minimum threshold of £50,000 was set for prospective contracts. An exception occurred in the case of the rehabilitation unit referred to above which had a small number of high cost cases - which exceeded a total of £50,000 - but did not want a block contract because of the possibility of receiving more than the expected number of cases. The family services unit which provided a mix of community, geriatric and paediatric services at a level above the threshold was also dealt with outside the contract system.

4. ECR Management Team

ECR management is led by the purchasing directorate with minimal involvement from the Department of Public Health.

The Director of Purchasing estimates that he spends about 5 per cent of his time on ECR management and the Deputy Director of Purchasing estimates that she spends about 20 per cent of her time. In addition secretarial support is provided and this represents about 15 per cent of the secretary's time. The Public Health Director estimates that about three hours per month is spent on ECRs in their department.

5. Decision Making Process

The majority of ECR requests are received by fax although some come by post. They are passed immediately to the Deputy Director of Purchasing for scrutiny and approval. Some local providers, or providers who submit a large number of ECR requests, use the Health Authority's own ECR request form. But most providers use their own form.

The following information is checked manually when an ECR request is received: address and postcode; referring GP - making sure that a fundholder is not involved; provider and specialty - making sure that the case is not covered by a contract or regional specialty; price in relation to tariff; date of treatment; type of treatment eg outpatient, inpatient.

It proves necessary to contact providers for additional information fairly often. Usually this arises because incomplete information has been provided on, for example, the specialty involved or the referring agent.

If an ECR is appropriate on administrative grounds, the District will try to accommodate the referral. However, there have been occasions when GPs have been contacted to let them know that a similar service exists under contract elsewhere.

The majority of ECRs are authorised within two days. The whole process generally takes a maximum of five days. However, there have been a few cases where redirection to other providers has been involved and this has taken up to three weeks where complex cases have been involved.

The deferral of ECR treatment was used as a response to over-spending until the budget was supplemented. There were no cases of outright refusal because of budgetary restrictions.

The District was uneasy about making judgements on individual ECR requests on the basis of clinical criteria. Their basic response was: if you go down this route, how far do you go? What information will you require to make a decision? They had considered the general question of rationing and felt that they were more likely to adopt a strategy in which categories of treatment were considered appropriate/inappropriate rather than make judgements on the basis of individual cases.

The District adopts a strategy of scrutinising expensive cases, ie £3,000 and above, more closely than less expensive ones. There is a tendency to look for alternatives for referral in these cases. However, when it comes to the prospect of delaying treatment, this is judged on clinical grounds and not financial ones.

6. Billing Arrangements

The Deputy Director of Purchasing receives invoices from providers. If these cover emergency cases, she enters on them on the computer database, checks the facts and if everything is in order approves the invoice for payment. For elective cases, invoices are checked to ensure that an application was received and approved, and that the invoiced amount is for the amount approved. Again, if the information is satisfactory, approval for payment is given.

The District finds it necessary to query between 10 and 20 per cent of invoices, mainly on the grounds of insufficient information being provided.

The District is still receiving a large number of invoices for cases that were undertaken prior to notification. At the moment, they are not withholding payment on these cases.

7. Price Variations

Price variations between providers have been enormous. Sometimes these arose because of misclassification on the part of providers, eg inpatient prices being quoted for day cases. The Deputy Director of Purchasing believed that cost-per-day prices would be important in distinguishing between the costs of long stays and short ones. She was also rather doubtful about the incentives that providers faced for reducing the price of ECRs.

8. Relations/Communications with GPs

The Deputy Director of Purchasing has been quite willing to contact GPs by telephone to make sure that they are aware of alternative possibilities in the case of ECRs. This would include offering information on services available under contracts elsewhere, the availability of cheaper ECRs elsewhere and also whether other services would be more appropriate for the patient. In the last case, the Director of Public Health has had occasion to contact GPs to enquire about clinical reasons for referral. There have been three cases where the District has worked with GPs and as a result a patient has been redirected to another provider, also as an ECR.

The District has been monitoring GP referrals and has sent a report to GPs about their ECR activity. The only evidence of concentration of spending to date is in the case of individual, high-cost patients (eg a rehabilitation case).

The District has set aside £24,000 to cover GP fundholder referrals which exceed the £5,000 limit. To date, this money has not been called upon.

9. The Consumer's Perspective

The District has received telephone calls from three or four patients in connection with ECRs. There is a feeling that hospitals may be using patients to exert pressure on the Health Authority. But, overall, patients are not aware of the ECR process. The Community Health Council has not been involved, except in the case of one patient who was affected by a deferral.

The question of confidentiality arose in connection with the use of patients' names during the ECR process. At present it seems that quite a heavy reliance is placed upon identifying named patients for checking purposes. For example, if the authority needs to correspond with the GP, it will go back to the provider and ask for the patient's name. Similarly, it was claimed that checking an invoice was easier in the case of a named patient. Also, repeat appointments are filed together (to ease the approval process for continued care) and that this must be done by name. At the same time, however, it was recognised that using names was not necessarily good practice. The District supports the West Midlands pilot project which was being developed to avoid the use of named patients.

10. Emergency ECRs

Emergency ECRs are handled in the standard way, checking the invoice to establish that the patient is a district resident, that the providers does not have a contract with the district, and that a regional specialty is not

involved. No outstanding problems involving emergency ECRs were mentioned.

11. Other Comments

Although the district takes the general stance of not questioning or interfering with GPs' referral decisions, and the purchasing team does not involve the department of public health very much, a public health consultant emphasised the active role their department played in developing this approach. A consultant (Mike Graveny, who is now at South Warwickshire DHA) developed a decision tree to help the purchasing team last April.

It is not clear how active a role the Deputy Director of Purchasing is taking in managing elective ECRs - they say that they do not question referrals, and yet there are examples where they have worked with GPs to find other possible referrals if an ECR is unreasonably expensive.

NORTH DERBYSHIRE DHA

1) General Strategy

N Derbyshire have adopted a generally permissive policy on ECRs. They see their role as accommodating GP referral patterns and claim to have approved almost 100 per cent of requests. They point to the large number of contracts they have taken out with different providers (ie 30) as a factor that has made ECRs unnecessary in most cases. They have also benefited from growth monies which have meant that adequate funds are available for ECRs.

2) Budget Setting

1991/92 budgets were set on the basis of 1989/90 patient flow data. This provided information on out-flows in terms of activity and finance. After contracts had been made, the balance was available for ECRs.

The district expects to break even this year although it is noticeable that they have received £300,000 in two tranches from region. They also claim to have (and this was confirmed by them on questioning) 250 elective ECRs that have been approved for treatment during the remainder of 1991/92. This compares with 271 which have been undertaken during the first ten months of the year.

In 1992/93, the same arrangements for budget setting will apply with one or two exceptions. For example, there are plans to take out a contract for cardiology and cardiac surgery which is presently offered on an ECR basis at a cost of around £10,000 per case by the Seacroft and Killingbeck Hospital at Leeds.

They are also planning to add £400,000 to this year's ECR budget and to set aside a contingency fund of £200,000. This increased allocation was explained as a commitment to funding ECRs.

3) Contract Thresholds

Prospective contracts are taken out if there are at least 50 cases or the total cost is expected to amount to £50,000 or more. This threshold was determined in the light of a desire to avoid excessive bureaucracy on small case flows.

4) The ECR Management Team

There is a high level of devolution of management responsibility. The Senior Assistant, Director of Finance assumes responsibility for the day-to-day management of the system. Involvement by the Director of Public Health and the Director of Finance is minimal (minutes per week).

No-one besides the Senior Assistant, Director of Finance is involved unless a figure of £2,000 per case is reached. At this figure and above, the Director of Public Health is informed, but will not necessarily become involved. This will only occur when there are particularly problematic cases. An example was cited which had arisen because GPs were referring patients to a private hospital in a neighbouring district for the treatment of alcohol dependency. The hospital had marketed its services well and GPs were responding. The cost amounted to about £8,000 per case. There is no comparable in-district specialty. However, fears about inappropriate referrals and costs have led to GPs being consulted on the issue. This had involved the Director of Public Health.

The Senior Assistant, Director of Finance devotes about one half day per week to ECRs. He has an assistant that devotes one day per week to them. In

addition, there is an admin and clerical (grade 3) staff member who works nearly full-time on ECRs and an admin and clerical (grade 5) staff member who works three quarter time on them.

5) The Decision Making Process

Requests for approval of elective ECRs are received by telephone, letter and fax from providers. These are received by the Senior Assistant, Director of Finance who scrutinises the applications and takes responsibility for authorisation.

A protocol describing district policy on ECRs was issued at the beginning of the year and circulated to the main providers (attached). In addition, the district has produced a form for each provider to complete for submission to the district for approval (attached). When the form is received, patient details are checked, especially the postcode. There is also a check to establish that the patient is not registered with a GP fundholder. Cost details are also checked against the tariff obtained from each hospital.

In fact, the majority of providers use their own forms, although this is not a major problem because the forms usually contain the same information as the district form. The ME is piloting a standard form in the West Midlands region. North Derby strongly support this move.

If an ECR is not approved, a telephone call is made to the provider to inform them.

It is occasionally necessary to contact GPs for more information when patient details do not tie up, eg students living away from home.

North Derbyshire has not needed to defer any ECRs until next year, nor re-direct them to in-district providers or others with whom they have contracts.

The average length of time taken from receipt of an ECR application to communication of the decision is two days. The minimum time was 24 hours, whereas the maximum time taken for a difficult case was two weeks.

No procedures have been excluded on clinical grounds though the issue of IVF was raised. This may be something that will need to be dealt with in the future. At present, the view that is taken is that IVF was not provided by the district prior to the reforms and nothing has changed in this connection. Hence, a request for an IVF ECR would not be approved.

6) Billing Arrangements

The ME has specified that all providers must invoice within a month of the end of the month in which the patient has been treated. North Derbyshire do not monitor this timetable very closely. They do not believe that failure to achieve this target poses many problems for them. When an invoice is received, it is compared with the original authorisation to verify all details including the price. If everything is in order, it will be approved for payment.

Sometimes, there is insufficient information received along with the invoice. This usually occurs when minimum data set information is not attached to an invoice. This probably occurs in about 10 per cent of cases, although providers have improved in this respect over the year.

The district reported that delays in receiving invoices do not pose any particular problems because they take the view that once authorisation has been given, treatment will take place and therefore they anticipate the cost.

There are, however, some cases of patients that should have been treated but they have not received an invoice yet. In fact, their response to our questionnaire suggests that there are 250 such cases remaining this year. The view was expressed that the district does not wish to contact providers to investigate the reasons for the absence of an invoice in case it stimulates activity.

7) Price Variations

It was reported that there has been a comparative study of units within the Trent region and that this has established that there are significant price variations for comparable procedures between providers. However, North Derbyshire do not use price as a criterion for approval of ECRs. Moreover, there are no plans to introduce it as a criterion. In the case of providers outside Trent, it was explained that they might react to price variations, but it was pointed out that this would introduce another delay into the approval process. It will be necessary to refer back the case to the Director of Public Health to obtain his advice. All in all, the district did not interpret its role as one of shopping around on the grounds of price. It did not want to get involved in detailed scrutiny: this was seen as interference with their open access policy.

8) Relations/Communications with GPs

North Derbyshire see their function as one of accommodating GP referrals. The Director of Public Health sent a letter to all GPs at the beginning of the year in which he sought to alert them to the implication of high cost ECRs (attached). Although all ECRs above £2,000 are scrutinised, the Senior Assistant DF did not see it as his role to necessarily question GP decisions. He is prepared to back the GP's judgement.

There has been little reason to communicate with GPs directly since the system has been underway. Exceptions have arisen when GPs have contacted the district to ask about the possibility of an ECR. But only three or four cases of this nature have occurred.

Information on referring GPs is not presently added to the district database. Hence it is impossible to establish whether some GPs use ECRs more than others. However, the district do not think that there is much clustering.

To date, there have been no examples of ECRs in excess of £5,000 incurred by GP fundholders that have been notified to the district.

9) The Consumer's Perspective

It was felt that the vast majority of patients do not know about the ECR system. However, some know because of initiatives such as the National Helpline and try to get treatment earlier. The district has no particular objection to this strategy. It was felt that public awareness of the ECR system was fairly low because North Derbyshire had taken out a large number of contracts which had overwhelmingly met the choices that GPs would want to make.

Problems of confidentiality were described as the biggest headache. The district is able to organise its own system to avoid problems, but it is unable totally to control providers. Often, invoices will be sent by providers with the patient's name on them. This was unnecessary. An identifier code is all that is required. It should also be made clear that all correspondence from providers should be stamped private and confidential and addressed to a named officer at the district. Because it is known that fax machines are a threat to confidentiality, the district had a fax installed in its own ECR office.

The district has not seen the need for an appeals procedure. It was felt that in the future, the grounds for rejection would be thoroughly considered and so they did not anticipate that it would become an issue. It is not seen as an area in need of priority treatment in the immediate future. However, it was pointed out that there is an appeals procedure if the district refuses to pay a bill. This occurs mainly in the case of emergency admissions when ME policy dictates that the case should be referred to region.

10) Emergency ECRs

In general, there have not been many problems with the management of emergency ECRs. An example of one case was provided in which an elderly patient was admitted as an overnight emergency in an acute elderly unit with high in-patient costs. The next day, the patient was transferred to another unit. The district was charged for two episodes of care, which amounted to more than would have been the case in one two-night stay. Nonetheless, this was seen as an exception rather than the rule.

There was, however, some concern that a few referrals may have been inappropriately designated as emergencies. This is not based upon hard evidence but there is nonetheless a suspicion that some providers may be designating cases as emergencies when they are unable to get approval for elective ECRs. A case of an emergency admission in relation to a toe-nail procedure was cited as an example.

11) Other Comments

It was felt that there was potential for conflict between individual and collective choice within the ECR system, but that it was unlikely to happen in North Derbyshire given the present people and personalities. The district goes as far as possible to reflect GP preferences. These are practically all taken into account. If in the future, however, they decided to divert activity from one supplier to another for financial reasons, this would provide the potential for disagreement with GPs. They are aware of the potential for disagreement in this connection and are eager to take GPs along with them on any policy changes.

DISTRICT OFFICERS INTERVIEWED

Barnet DHA

Sean Morgan, Assistant Contracts Manager
Arthur Gunawardena, Deputy Director, Information
Bill Howes, Director of Finance
Betty Arrol, Director of Corporate Development and Contracts*
Phil Slayen, Consultant in Public Health Medicine

Parkside DHA

David Parker, Deputy Director of Purchasing*
Dr Leila Lessof, Director of Public Health
Kathy Neville, Assistant Director of Finance
Claire Davis, Administrative Assistant, Contracting

South Bedfordshire DHA

Sharon Butler, ECR Manager*
Bob Kosian, Deputy Director of Finance
Dr Woolaway, Director of Public Health
Sara Thompson, Contracts Manager

Herefordshire DHA

Richard Banyard, Director of District Support Services*
Neil Manson, Contracts Support Manager
Jill Sinclair, Financial Analyst
Dr Martin Brooks, Director of Public Health

Solihull DHA

Dr Stephen Green, Director of Development and Service Purchasing*
Caroline Hyde-Price, Deputy Director of Purchasing
Dr Rosemary Gellar, Consultant in Public Health Medicine

North Derbyshire DHA

Richard Hodges, Senior Assistant Director of Finance (Purchasing)*
Eric Morton, Director of Finance
Nick Salfield, Director of Public Health

* Lead contact officer for ECR project

APPENDIX 3

NORTH DERBYSHIRE HEALTH AUTHORITY

ACCEPTANCE OF NON-EMERGENCY ELECTIVE REFERRALS

CONFIDENTIAL INFORMATION

PROVIDER DETAILS

NAME: .....

ADDRESS: .....

.....

TEL.NO.: ..... FAX NO.: .....

CONTRACT I.D. ..... UNIT CODE: .....

CONTACT NAME: ..... CONTACT NO.: .....

CONSULTANT: ..... SPECIALTY: .....

PATIENT DETAILS

NAME: ..... SEX: M / F

ADDRESS: .....

.....

POST CODE: .....DATE OF BIRTH .....

REFERRING G.P. / CLINICIAN .....

PATIENTS G.P. .....

PURPOSE OF REFERRAL/PROCEDURE REQUIRED: .....

.....

EXPECTED DATE OF TREATMENT: .....

EST.COST OF TREATMENT: £.....

APPROVAL TO PROCEED

North Derbyshire Health Authority gives approval for the above treatment to proceed, and to pay the costs upon completion of the treatment.

SIGNED: .....

SENIOR ASSISTANT DIRECTOR OF FINANCE

OUR REF: CO1 / .....

DATE: .....

FOR OFFICE USE ONLY

INVOICE NUMBER	
INVOICE DATE	
INVOICE AMOUNT £	
DATE PASSED FOR PAYMENT	
DATE PASSED TO DIR.OF PUBLIC HEALTH	

COMMENTS :

APPENDIX 4

NORTH DERBYSHIRE HEALTH AUTHORITY

PROTOCOL ON EXTRA-CONTRACTUAL REFERRALS

1. North Derbyshire Health Authority has considered the NHSME's advice with regard to meeting the costs of treatment provided to its residents on an extra-contractual basis. The emphasis on having a simple, non-bureaucratic procedure for the authorisation of treatment has been noted.

2. We consider that it is neither practical nor consistent with securing the delivery of effective care to our residents for providers to seek prior approval, per se, for each and every elective treatment. However, given that the costs of ECRs will be met from a finite contingency reserve, the Authority will require prospective notification of each elective referral in order to provide for an effective commitment accounting system in the financial management of ECRs.

3. This protocol does not apply to referrals to units with which the Authority will have a service agreement in 1991/92.

Emergency Treatment

4. North Derbyshire Health Authority will meet the cost of any emergency treatment provided extra-contractually to its residents, except (a) A&E and GU Medicine treatment, which is the responsibility of the host DHA; (b) treatment by Supra Regional Services and London Postgraduate SHAs; and (c) Regional Specialty treatment in Trent Region.

5. Each invoice for an emergency ECR treatment will be submitted within one month of the completion of the episode of care and must be accompanied by the full contract minimum dataset (MDS). Payment will not be made unless the MDS is supplied.

Elective Treatment

6. A Unit receiving an elective extra-contractual referral of a North Derbyshire resident should notify the Authority prior to the commencement of inpatient treatment (ie when the case is booked), advising it of

- the patient's name and address;
- the name and address of the referring clinician;
- the name, address (and DHA if a DMU) of the Unit;
- the proposed treatment;
- the Unit's tariff for the treatment.

7. Notification should be made - by letter or fax - to

Mr R Hodges
Senior Assistant Director of Finance (Purchasing)
North Derbyshire Health Authority
Scarsdale Hospital
Newbold Road
Chesterfield S41 7PF

Tel: (0246) 231255
Fax: (0246) 206672

8. The Unit may then proceed to treat the patient (subject to 9 and 10 below) and will receive an order number to quote in the invoice it subsequently issues.

9. The Authority will require prior approval to be sought for elective treatment where prospective treatment costs exceed £2000 for a patient. Such cases will be identified when advance notification of treatment costs is made, and in respect of such cases (but only these) the Unit will not proceed with treatment until authorisation has been given. The District will respond as quickly as possible, subject to the possible need to consult the referring clinician.

10. The Authority will not pay for elective treatment within Supra Regional Specialty or London Postgraduate SHA services or Regional Specialty services in Trent Region, these being subject to separate contractual arrangements.

11. Each invoice for an elective ECR treatment will be submitted within one month of the completion of the episode of care and must be accompanied by the full contract MDS. Payment will not be made unless (a) there has been advance notification of the treatment in accordance with 5 and 6 above, and (b) the MDS is supplied.

Payment

12. Payment of invoices for ECR treatment will normally be made within one month of receipt. Delay may occur, however, should it prove necessary to seek clarification of, or otherwise query, the invoice.

13. Should an invoice for an elective ECR be significantly at variance from the costs notified prior to treatment, the Authority will wish to investigate the reasons for this. Full payment may not be made if invoiced costs significantly in excess of those notified cannot be justified to the Authority's satisfaction.

Monitoring

14. The Authority will monitor patterns of elective ECRs during the year, and may wish to discuss these with referring clinicians. It will be particularly concerned to identify the existence of elective ECRs for which an established contractual alternative exists.

15. Should the cumulative costs of elective ECRs threaten to exceed the resources set aside by the Authority to deal with these, it may be necessary to review this protocol with a view to introducing a procedure whereby each elective ECR will need to be approved prior to treatment.

Review

16. This protocol follows the policy guidance issued by Trent Regional Health Authority on the management of ECRs. It will be kept under review in light of any changes to the Regional guidance, or in central requirements.

APPENDIX 5

NORTH DERBYSHIRE HEALTH AUTHORITY
District Headquarters, Scarsdale Hospital,
Newbold Road, Chesterfield S41 7PF.
Telephone 0246 231255 Fax 0246 206672

Your Ref:
Our Ref: NJS/JRE
Please ask for: Dr. N.J. Salfield
Extension: 4306

PERSONAL AND IN CONFIDENCE

Dear Dr. ,

HIGH COST EXTRA-CONTRACTUAL REFERRALS

We have recently authorised the treatment of ,
for at the , a centre with which the Authority does not have a service agreement. The estimated cost of treatment is £ , which will be met by the Authority from the limited reserve it holds for dealing with extra-contractual referrals.

It is currently our policy to meet the costs of all such referrals, but at the same time we feel it important to draw to the attention of GPs the high costs associated with certain treatments and services. For 1991/92 the Authority has a total reserve of £1,062,000 to meet the costs of a projected total of more than 800 ECRs. If the Authority's capacity to meet the ECR commitment is not to be exceeded, it is clearly important that high-cost referrals should particularly be kept under review.

You may wish to consider for the future in light of the cost, whether the treatment represents value for money in terms of the clinical outcome, and, in particular, if it should prove necessary, whether re-referral of the same patient would be of any further benefit.

There may be alternative sources of treatment, including hospitals offering a comparable service with which the Authority has a service agreement, to which in the future you may wish to consider referring patients. The GP Catalogue issued by the Authority in March, 1991 and updated in August, 1991 identifies the specialties covered by the Authority's contracts with different hospitals. We currently have contracts with 25 acute units in North Derbyshire and all the surrounding Districts. These have been let to reflect as far as possible the preferences of GPs as a whole.

I trust this clarifies the position but please do not hesitate to contact me should you wish to discuss this further.

Yours sincerely,

Dr. N.J. Salfield,
Director of Public Health.

APPENDIX 6

Barnet Health Authority

Request for Elective Extra Contractual Referral

In Confidence

PROVIDER

1. Provider Code _____
2. Name of Provider _____
3. Hospital/Unit Name _____
   (to which referral is made)
4. Date of Request _____
5. Contact Name _____
6. Phone No. _____
7. Fax No. _____
8. Address _____

Postcode _____

PATIENT

9. Patient Surname _____
   Other Names _____
10. Address of Patient _____
11. Date of Birth _____
12. Sex (M/F) _____
13. NHS No. _____

Postcode _____

REFERER

14. Name of GP _____
15. GP Code _____
16. GP Practice Code _____
17. Tel. No _____
18. GP Address _____
19. Source of Referral (Patients's GP / Consultant / Other-Specify) (Delete as appropriate)

If other than patient's GP please give:

20. Referer's Name & Position _____
21. Address _____
22. Tel No. _____
23. If Consultant name of specialty _____
24. Date of Referral

TREATMENT

25. Specialty to which patient referred _____ Korner Code _____
26. Condition referred for _____
27. Purpose of Referral/Procedure _____

28 Is Referral for

- Outpatient Consultation/Investigation ☐
- Inpatient Admission ☐
- Daycase ☐
- Outpatient Treatment ☐
- Outpatient Follow up to Inpatient Treatment ☐

29. Is Out-Patient Referral New Patient/Re-Attendance ?
30. Expected Date of Admission/Appointment _____
31. Expected Length of Stay _____
32. Tariff/Cost £. _____

Completed form should be sent to Mrs. B. Arrol, Director of Corporate Development and Contracts. Fax no.081 200 3739 Tel no. 081 200 1555 ext.3413 District Offices,Colindale Hospital,Colindale Avenue,London. NW9 5HG

i) A decision normally will be made within two working days of receipt of full information. Non response should not be taken as agreement to meet the cost of treatment.

ii) The provider should ensure that the treatment is of high quality and of a standard conforming to policies agreed with the host purchaser Health Authority.

iii) The provider should accept legal liability and indemnify Barnet H.A. from any claim arising from the provision of treatment in the provider hospital/unit.

iv) The referral should be for NHS treatment only.

To be used by Barnet Health Authority

Barnet Health Authority hereby authorises/does not authorise commencement of above Consultant Episode. If any of the information given above changes Barnet H.A. should be informed.

Approval no. [ ] must be quoted on the invoice, which should be accompanied by full Minimum Data Set as specified by :

NHS ME DSC 11/90 (Inpatient)
NHS ME DSC 13/90 (Outpatient)

Explanation for refusal of authorisation :

_____

_____

_____

_____

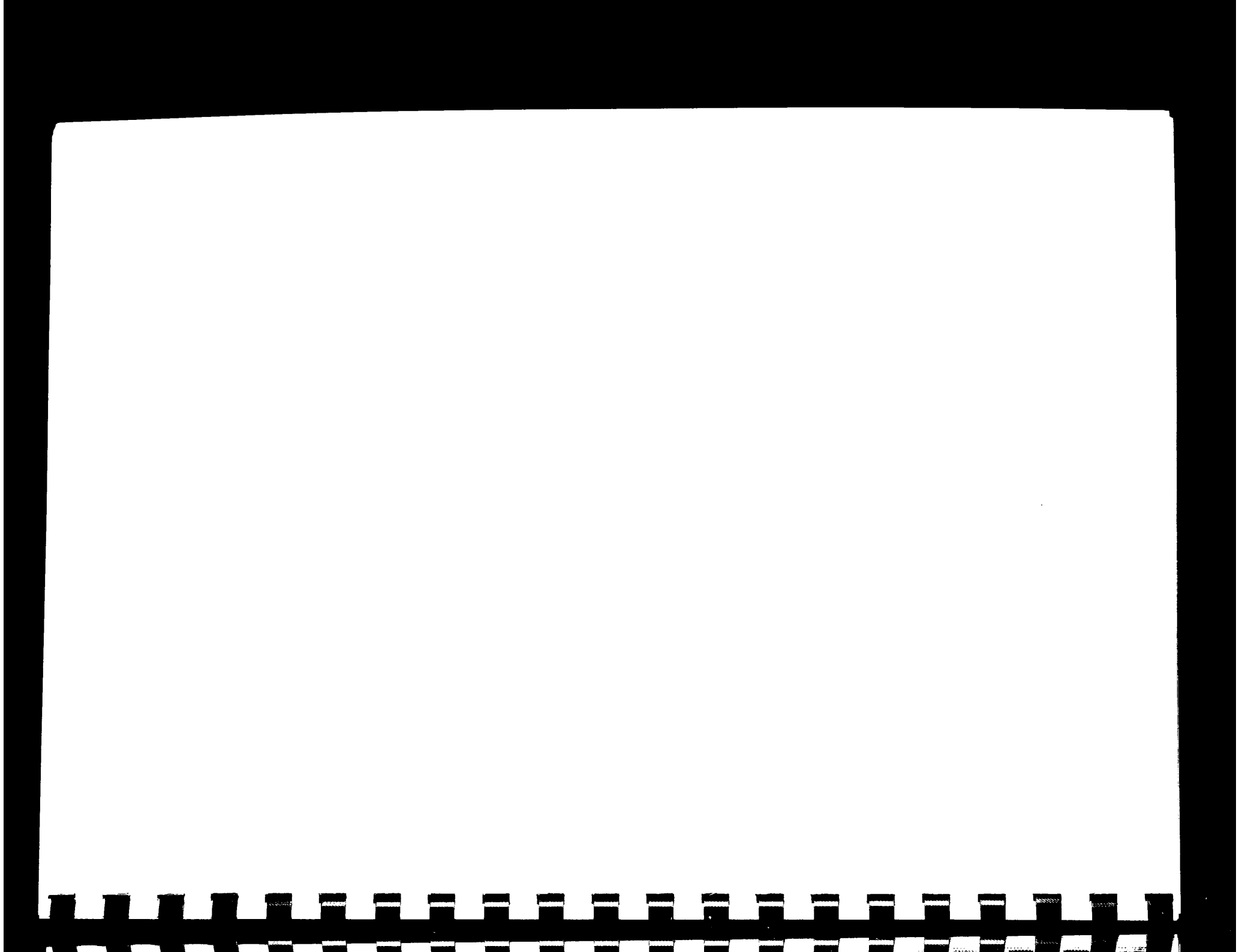
_____

_____

Signed by _____ Position Held _____ Date _____

[redacted]

APPENDIX 7



SUMMARY OF BARNET HEALTH AUTHORITY CONTRACTS 1991/92

ACUTE SERVICES

Contracts have been agreed with each of the following hospitals. Patients treated there will not incur additional cost to the DHA.

Barnet General/Edgware General
Royal Free
Whittington/Royal Northern
Chase Farm
Middlesex/UCH (inc. Royal London Homeopathic, Hospital for Tropical Diseases, Royal Ear Hospital, Elizabeth Garrett Anderson, St Philip's, St Paul's, St Peter's, Shaftesbury, St Pancras)
St Mary's (inc. Western Ophthalmic, Samaritan)
Mount Vernon
St Bartholomew's (inc. Homerton, Hackney, St Mark's)
Northwick Park
Royal National Orthopaedic
North Middlesex
Harefield
Charing Cross/Westminster (inc. West London, Westminster Childrens)
Central Middlesex
St Thomas's (inc. St John's)
Royal National Throat, Nose & Ear
Guy's/Lewisham
Watford General
Royal London
St Charles

COMMUNITY & PRIORITY SERVICES

A contract has been agreed with Barnet Community Health Services Unit. This covers not only the community based services, but also the hospital services based at:

Napsbury Hospital
Finchley Memorial
St Stephens
Potters Bar
Colindale
Barnet Psychiatric Unit

The Authority also has contracts with the following hospitals

Harperbury
Leavesden
Cell Barnes
Shenley

A few Barnet residents are already accommodated in other long-stay hospitals. They too are covered by contract.

SPECIALIST SERVICES

Arrangements have been made through Region to ensure access to specialist services. Some of these are covered through contracts, others will be handled on an extra-contractual basis. As a general rule, GPs should assume that they will have the freedom to refer patients to regional/supra regional services as previously.

SPECIAL HEALTH AUTHORITIES

The Postgraduate Teaching Hospitals (Special Health Authorities) have contracts with the Department of Health. Access is therefore available to the following hospitals without additional cost to the DHA:

Hammersmith, Queen Charlotte's
Royal Marsden
Great Ormond Street, Queen Elizabeth (Hackney)
Royal Brompton, London Chest
National Hospitals for Neurology and Neuro-surgery (Queen Square, Maida Vale)
Moorfields
Eastman Dental
Bethlem Royal, Maudsley

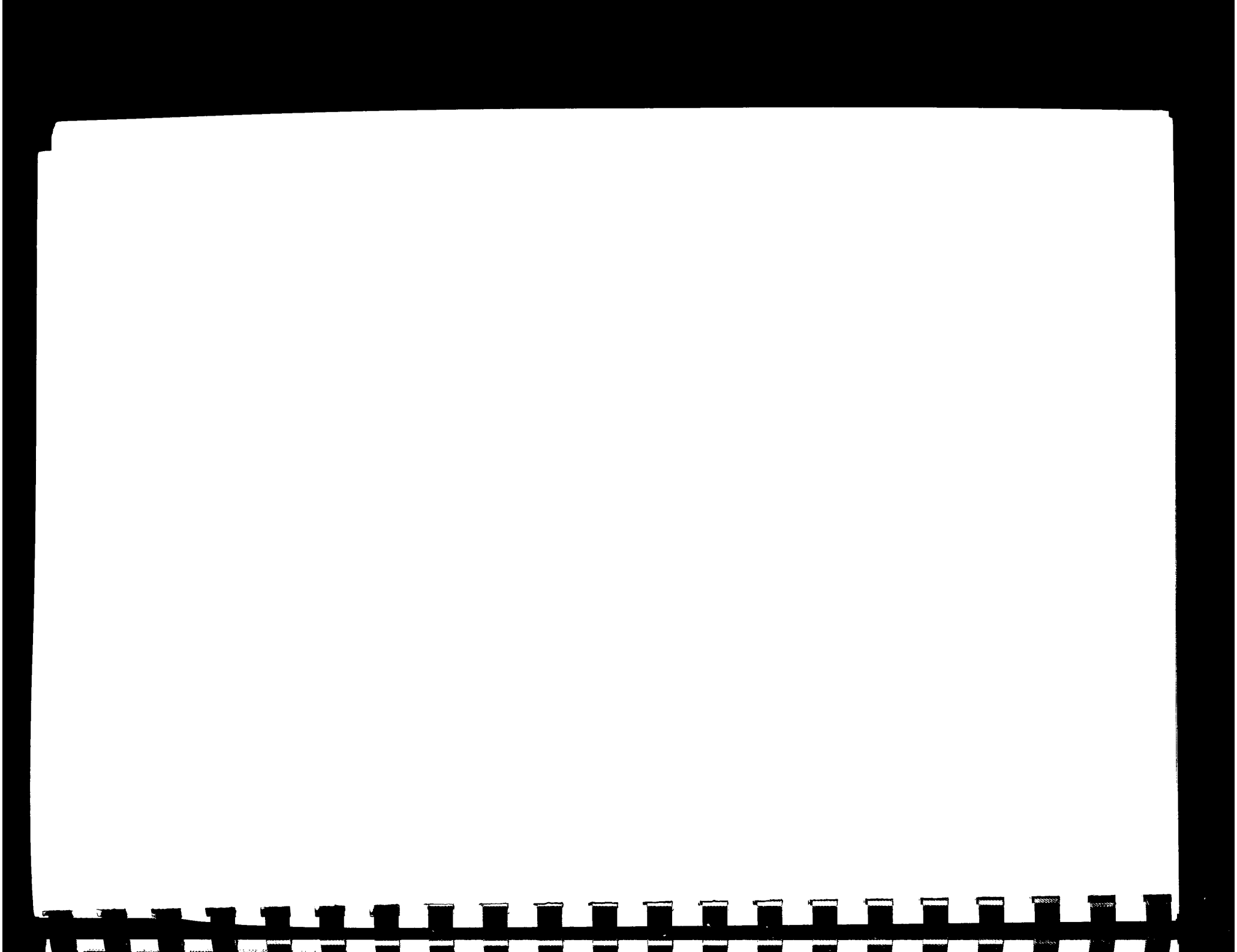
EXTRA CONTRACTUAL REFERRALS (ECRs)

Contracts are based on past referral patterns and it is intended that these will meet most of the needs of GPs. However, it is recognised that GPs will occasionally wish to refer patients to hospitals outside of the contractual arrangements. Barnet Health Authority has a limited fund available to meet such requests.

For elective cases the GP should make the referral in the usual way. The hospital will then contact Barnet Health Authority to ensure that it is prepared to meet the cost. The main criteria are that similar services are not available 'on contract' and/or there is good reason why the contracted services are not appropriate for any individual patient.

Sometimes a Public Health physician will contact the referring GP to discuss the reasons for the referral. Alternatively, GPs may wish to check with HA officers the likelihood of the referral being accepted before contacting the hospital.

Patients requiring emergency treatment who are admitted off contract will be treated without question. The hospital will bill the patient's Health Authority, which must pay.



Staff dealing with ECRs are subject to strict rules regarding confidentiality.

The extra contractual process will provide the Health Authority with useful information which will inform future contracting intentions.

QUALITY STANDARDS

Barnet Health Authority has specified a number of quality standards in its contracts, and has highlighted the following for special focus this year.

1 All patients should normally be seen at least once by the consultant (or his or her senior registrar) under whose care they are admitted, or attend for an episode of outpatient care.

2 Waiting times at outpatients – 80% of patients to see doctor within 30 minutes of appointment time; 100% of outpatients to see doctor within one hour of appointment time.

3 First urgent out-patient consultation within two weeks of receipt of GP referral letter.

4 First routine outpatient consultation within 12 weeks (varies for specialties) of receipt of GP referral letter.

5 Standards required for maximum time lapse between decision of consultant to admit and the actual inpatient admission are:

EMERGENCIES – immediate admission

URGENT – within one month

ROUTINE – by 31.3.92 no patient to have waited more than two years

– by 31.3.93 no patient to have waited more than one year.

6 Information to be provided to the DHA on the regular accepted indicators of care e.g. infection rates, wound infections, pressure sores, readmission rates.

7 Letter to GP by first class post (or other rapid means) setting out treatment, drugs prescribed, and any other crucial information within five working days of patient discharge.

8 To ensure that all premises are kept clean.

9 Palatable meals and beverages, observing personal and ethnic choice, to be provided for patients, well presented at the appropriate temperature.

10 The provider should ensure that the views of patients are regularly sought.

Feedback from GPs will be welcomed regarding compliance with these standards.

CONTACTS

Barnet Health Authority has established a Purchaser Group of Senior Officers to manage the commissioning of Health Services for Barnet residents, and to co-ordinate all aspects of purchasing. The Purchaser Group comprises the five Executive Directors of the Health Authority, the FHSA General Manager and more recently Dr Judy Gilley, as Chair of the LMC has joined the group.

The opportunity this presents for working with general practitioners is warmly welcomed.

Any general practitioner wishing to find out more about contracting/purchasing should contact:

Name and Designation	*Phone No.*
Dr Judy Gilley **Chair,** **Local Medical Committee**	**081-346 1976**
Dr Fiona Sim **Director of** **Public Health**	**081-200 1555** **X 3416**
Mrs Betty Arrol **Director of Corporate** **Development & Contracts**	**081-200 1555** **X 3407**

Barnet Health District Offices
Colindale Hospital
Colindale Avenue
London NW9 5HG

August 1991

APPENDIX 8

ECR 1

PARKSIDE HEALTH AUTHORITY

AUTHORISATION DOCUMENT

EXTRA - CONTRACTUAL REFERRALS No

PLANNING AND INFORMATION DEPARTMENT

Receiving Account Title (ie. Name of DHA/Trust) : .....

PGO Account Number : .....

Payee Reference (optional) : .....

	£		
Emergency ECRs		Month and Year	.....
Elective ECRs	_____	Payment due by	.....
Total	_____		

	SIGNATURE	DATE
Certified for payment :	.....	.....

FINANCE DEPARTMENT - MANAGEMENT ACCOUNTS

CHECKER

Keyed as "PAID" on ECR database (Man A/Cs) [ ]

SIGNATURE ..... DATE .....

PAYMENT CODE

		AMOUNT
	TOTAL	

SIGNATORY

		DATE
Certified for Payment	.....	.....
Name (capitals)	.....	

REVISED: 11TH NOVEMBER 1991

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APPENDIX 9

Parkside

EXTRA - CONTRACTUAL REFERRALS - PAYMENT PROCEDURE 1991/92

ELECTIVE ECRs

1. Planning and Information Department receive request from provider unit to authorise an extra-contractual referral for elective treatment. Staff check that patient is in fact a Parkside resident, and check the cost of the ECR against the ECR database system. This data base which was compiled by Information staff holds a list of all provider units ECR tariffs registered with the Regional Health Authorities. If these two items are validated, then the request is approved and the Planning and Information Department complete an authorisation form.

2. Planning and Information Department fax copy of authorisation form to provider unit to notify ECR has been approved.

3. Planning and Information Department send second copy of authorisation form to the Finance Department Management Acoounts Section, and file original form for reference.

4. Management Accounts Section enter details of authorisation form on data base compiled in section as a record of ECR future expenditure commitments.

ELECTIVE + EMERGENCY ECRs

5. Planning and Information Department receive invoice requesting payment for extra-contractual referral(s) from a provider unit.

6. In theory, no ECR payment can be made unless the invoice is accompanied with the Minimum Minimum Data Set (MMDS) or "statement data" regarding the patient and treatment details. In practice any invoice which contains information on the patient's district of residence, treatment and tariff price will be passed for payment.

7. All emergency ECRs validated by the Northern Flat File must be paid. Elective ECRs should only be paid if the provider unit first secured proof of agreement to pay from Parkside.

8. Information staff check the patient is a Parkside resident, and that the cost of the ECR treatment agrees with the price held on the ECR database system. If, the address is incorrect, the invoice is sent back to the provider unit to be redirected to the correct district of residence. If the ECR tariff is incorrect, the price is queried with the provider unit.

9. If the information on the invoice is valid, Information staff approve it for payment, and write on the invoice which speciality the ECR procedure should be assigned to.

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EXTRA -CONTRACTUAL REFERRALS - PAYMENT PROCEDURE 1991/92 (CONT).

10. Information Staff enter details of approved ECR invoice on ECR monitoring system (separate system from ECR tariff database).

11. Information Staff pass invoice to the appropriate Purchasing Manager for certification.

12. Purchasing Manager completes first half of the Extra-Contractual Referral authorisation form. The amount payable for emergency ECRs and elective ECRs must be calculated and separately on the ECR1 form. The form is certified for payment by an authorised signatory - Jac Kelly, David Panter, Ian Gregory, Caroline Lowdell or Mike Silvera.

13. Purchasing Manager sends ECR1 form plus invoice attached to the form to Finance Department Management Account section.

14. The checker in Management Accounts checks the extra - contractual referral tariff or price on the invoice with the list of ECR tariffs by provider unit issued by the RHA. (A copy of the ECR tariff database will be supplied to the Management Accounts section by Information Staff). If the amount does not tally, the checker queries it by telephone with the Planning and Information signatory.

15. Checker in Management Accounts checks amount authorised on ECR1 form agrees with amount on invoice; and checks that the name of health authority on ECR1 form tallies with the invoice. If any item is incorrect, the checker queries it by telephone with the Planning and Information signatory.

16. If all the data is correct, the checker completes the second half of the ECR1 form and enters the correct payment code in the box.

17. The checker enters the invoice details on the ECR database maintained by Management Accounts, and marks the invoice as "PAID". If the invoice is for an emergency ECR, a new record will need to be set up; if the invoice is for an elective ECR, the record should already have been set up using the ECR authorisation form. If there is no record on the database for an elective ECR, the checker queries it by telephone with the Purchasing Manager, since all elective ECRs <u>must</u> have been authorised prior to the arrival of the invoice.

18. If Information Staff have indicated the specialty to which the invoice should be assigned (see point 9), enter this information on the ECR database. If not, leave record blank, and enter proceedure only

19. The checker signs the second half of the form.

20. From now on procedure is identical with points 9-22 in Block Contract payments procedure document.

REVISED 11TH JULY 1991

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BLOCK CONTRACTS - PAYMENT PROCEDURE 1991/92

1. Planning and Information Department complete first half of the Block Contract authorisation form for Provider X for month Y for £Z, at least three days before the due date of payment. No payment should be made unless an invoice is received from the provider for the appropriate month. The invoice should be attached to the authorisation form and certified for payment by an authorised signatory (Jac Kelly, David Panter ~~or~~ Ian Gregory or Carolyn Lowdell).

2. Planning and Information Department send BC1 form plus invoice to Finance Department Management Accounts Section.

3. Checker in Management Accounts Section checks the forms to see whether:

i) A block contract exists with the unit.

ii) The amount is correct.

iii) The account reference numbers are correct.

iv) The form has been signed by an authorised signatory.

4. The checker in Management Accounts cross-checks the information with data on the EPIC system, and ticks the appropriate box on the BC1 form if the data matches.. At present, enter N/A for not available in box on form.

5. If any item is incorrect/does not tally with EPIC or Management Accounts Records, the checker queries it by telephone with Planning and Information Department. If any item has been altered, the alteration must be certified by the Planning and Information Department signatory.

6. If all the data is correct, the checker enters "PAID" against the contract information held on EPIC. (This field is not yet available therefore enter N/A in box on form).

7. The checker enters the correct payment code in the box on the BC1 form.

8. The checker completes the second half of the Block Contract authorisation form and signs it.

9. The checker takes the form to an authorised signatory in the Finance Department (Keith Ford, Kevin Gaffney, Kathy Neville, Malcolm Causon or Matthew Bryant).

10. The signatory checks the BC1 form, certifies it for payment, and returns it to the checker in Management Accounts.

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BLOCK CONTRACT - PAYMENT PROCEDURE 1991/92 (cont).

11. The checker makes a copy of the BC1 form and attached invoice and files them in a special file held in Management Accounts.

12. The checker passes the form to the Financial Accounts Section at least one day before the due date of payment time. Please note that this is the minimum time allowed - if invoices and BC1 forms arrive well before the payment date they should be processed as soon as possible to avoid a backlog in the system.

13. Financial Accounts staff complete the banking form RFT1 from information on BC1 forms (Receiving Account Title, PGO Account Number, Payee Reference, Amount).

14. Financial Accounts staff pass RFT1 form plus supporting documents for certification to authorised signatories in the Finance Department (N. B. The BC1 forms and the RFT1 form must not be certified by the same person as in Paragraph 9). The signatory returns the form to the Financial Accounts.

15. Financial Accounts staff carry out electronic transfer of funds as per details on RFT1 form on the day payment is due.

16. Financial Accounts Staff complete a "Receivable Order" Slip if attached to invoice and return to provider unit.

17. Remittance advice slip copies filed in Financial Accounts section together with the banking form RFT1 and the original invoices and BC1 forms.

18. Financial Accounts Staff pass a copy of RFT 1 form plus coded slip of top copy (white) and yellow copy of the DFO/8 form (Remittance Advice voucher) to the Payments Section.

19. Payments staff key in the invoice data on the Accounts Payable system from the RFT1 form and DFO/8 form.

20 Payments staff mark the transactions as "prepaid" so that no cheques are produced by the Accounts Payable System.

21. Payments staff file RFT1 form and DFO/8 vouchers as "paid" invoices.

22. Payments staff notify Management Accounts that the invoice details have been entered on the AP system.

REVISED 24TH APRIL 1991

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APPENDIX 10

Written by public health consultant

SOUTH BEDFORDSHIRE

Extra-contractual Referrals:
A Discussion Document for the TOG → Transitional Operational Group

1. Introduction

1.1 An ECR is a request to commence a patient episode in a provider unit with whom the health authority (HA) has no contract. It is not an invoice.

1.2 Referring doctors should inform the HA of all non-emergency ECRs referred by them.

1.3 All provider units receiving non-urgent ECRs should seek authorization before commencing treatment. In emergencies, care is started and the purchasing HA informed as soon as possible.

1.4 There are limited funds to support ECRs that are approved by the HA over the financial year.

1.5 Inadmissible ECRs are where a patient is not resident in the district, referral is to a special health authority or a patient is in a fund-holding practice (if the ECR cost is less than £5,000 and the treatment is not exempt from their funding).

1.6 The Director of Public Health issued some local guidance for managing ECRs in June 1991 (see attached document).

2. Present Process

2.1 Normally the ECR manager receives a telephone call, fax or letter requesting authorization of an ECR.

2.2 Many requests come directly from the referring doctor. About two thirds come from the provider unit to which the patient has been referred. Some of these are patients placed on a waiting list prior to 1st April 1991. Many, however, are patients referred without the referring doctor informing the HA.

2.3 Urgent and emergency ECRs are automatically approved often without even dispute as to cost.

2.4 Of around 1,500 ECRs received so far, about 400 were inadmissible for reasons covered in 1.4. Only two ECRs have been rejected outright. About 20 ECRs were accommodated in units where the HA has a contract. The charges for about 20 ECRs approved were renegotiated with provider units.

out of district

→ * to 31 Dec 91

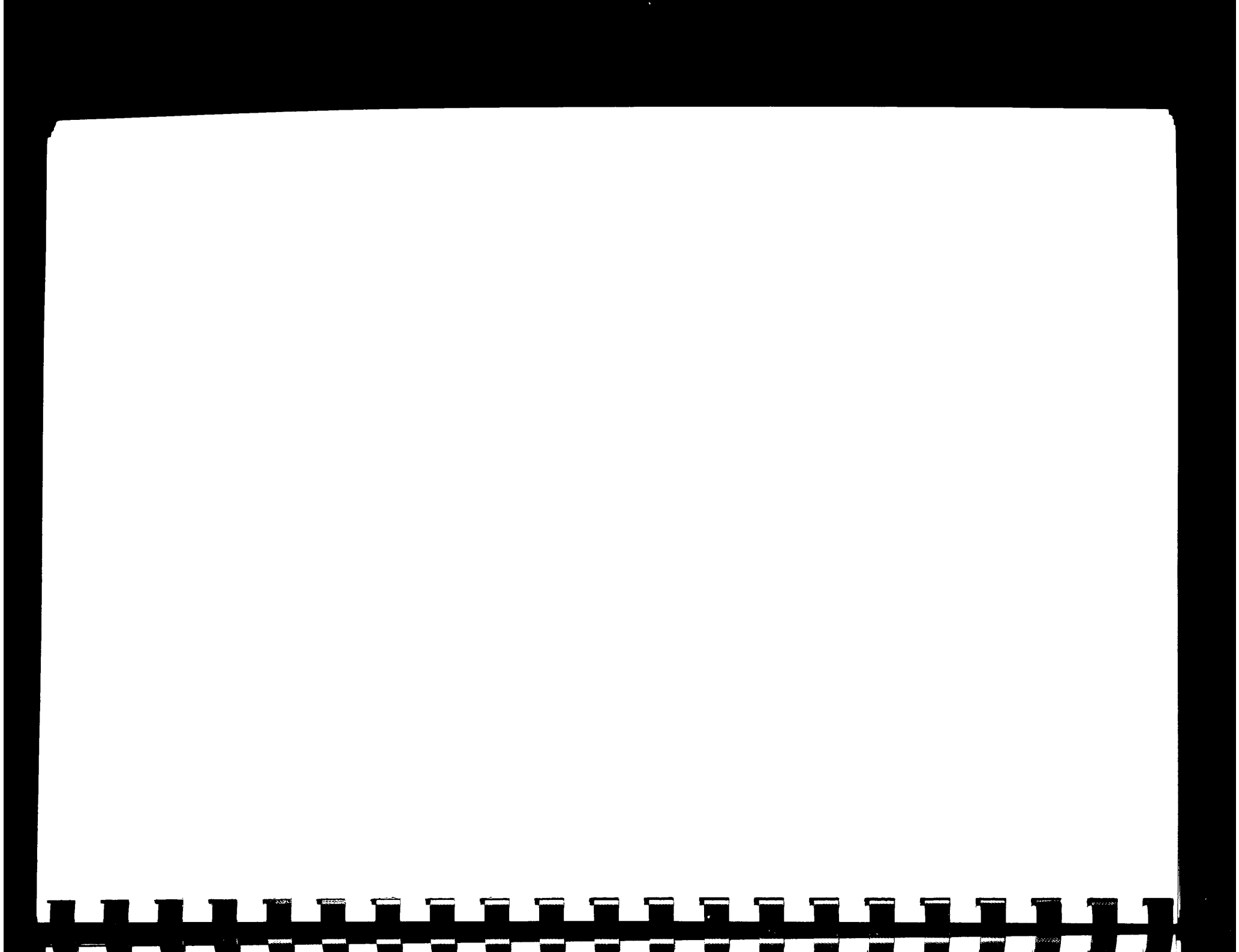
2.5 Where the ECR has been identified as contentious, the referring doctor is always contacted by the ECR manager.

3. Problems with the ECR process

3.1 The ECR budget is overcommitted raising problems with funding the ECRs in the remainder of the financial year.

3.2 In addition to supporting ECRs, the ECR fund has been used to support contracts which have overrun.

*



3.3 The poor availability of comparative cost per case prices for treatments makes it difficult to identify ECRs that are contentious on grounds of excessive cost.

3.4 While prioritisation of ECRs for procedures of lesser or doubtful health gain may be desirable the lack of an explicit process to support this is a problem.

3.5 The failure both of referring doctors and provider units inform the HA about ECRs in good time prior to patient treatment has limited the scope of the HA to make rational and fair decisions about supporting such ECRs.

3.6 There is a problem of patient confidentiality as each ECR bears the patient's name address and clinical diagnosis.

4. Recommendations

4.1 The HA should modify the process for ECRs so that referring doctors must seek authorization for the ECR prior to patient referral.

4.2 While this should be developed collaboratively with doctors wherever possible, the HA needs a mechanism to deal with persistent refusal to co-operate with the authorization process. This should be made explicit to all referring doctors.

4.3 Referring doctors need to be fully informed about where the HA has placed contracts and what services are available within these contracts. Unnecessary ECRs occur because of ignorance of this.

4.4 Much better knowledge about comparative costs for treatments is needed and an ECR cost per case database should be developed by the HA.

4.5 There is only limited scope to challenge an ECR on the basis of health gain or urgency for the patient. The DHA is poorly placed to question clinical judgement except in cases where there is clearly doubtful health gain. The identification of some of the treatments which fall into this category should be undertaken and guidelines for their prioritisation developed.

4.6 A monitoring process for ECRs should be developed as they may indicate deficiencies of quality or availability of services within existing contracts. This information may then be used in modifying future contracts.

4.7 Because emergency ECRs (about a third of the total) do not require prior authorization by the HA, they are often treated like invoices. While these ECRs should be supported this should not preclude scrutiny of them to ensure that the patient status of "emergency" is not abused nor the charge excessive.

4.8 Mechanisms to ensure patient confidentiality should be established by the HA and strictly adhered to.

John Henderson
Senior Registrar in Public Health
South Beds Health Authority
January, 1992

APPENDIX 11

SOUTH BEDFORDSHIRE

Introductory Points

1. What is an ECR?

2. What is the budget for ECRs?

   As ECR costs exceed the ECR fund, there is a need to make judgements about which ECRs can be afforded.

3. Some guidelines for prioritising ECRs is therefore necessary.

4. The following principles will be used in assessing whether an ECR will be funded.

Principles for Funding

1. The vast majority of ECRs where is there no clear disparity in cost or appropriateness will be funded automatically.

2. Where the cost of a procedure are high comparatively or there is a clear doubt about the effectiveness or health gain in the referral, the ECR will be reviewed.

3. Where an existing contract has been placed which will cover the ECR at the same level of quality.

Methodology to be used

1. Every ECR will be checked by a Contracts Manager and the majority funded automatically.

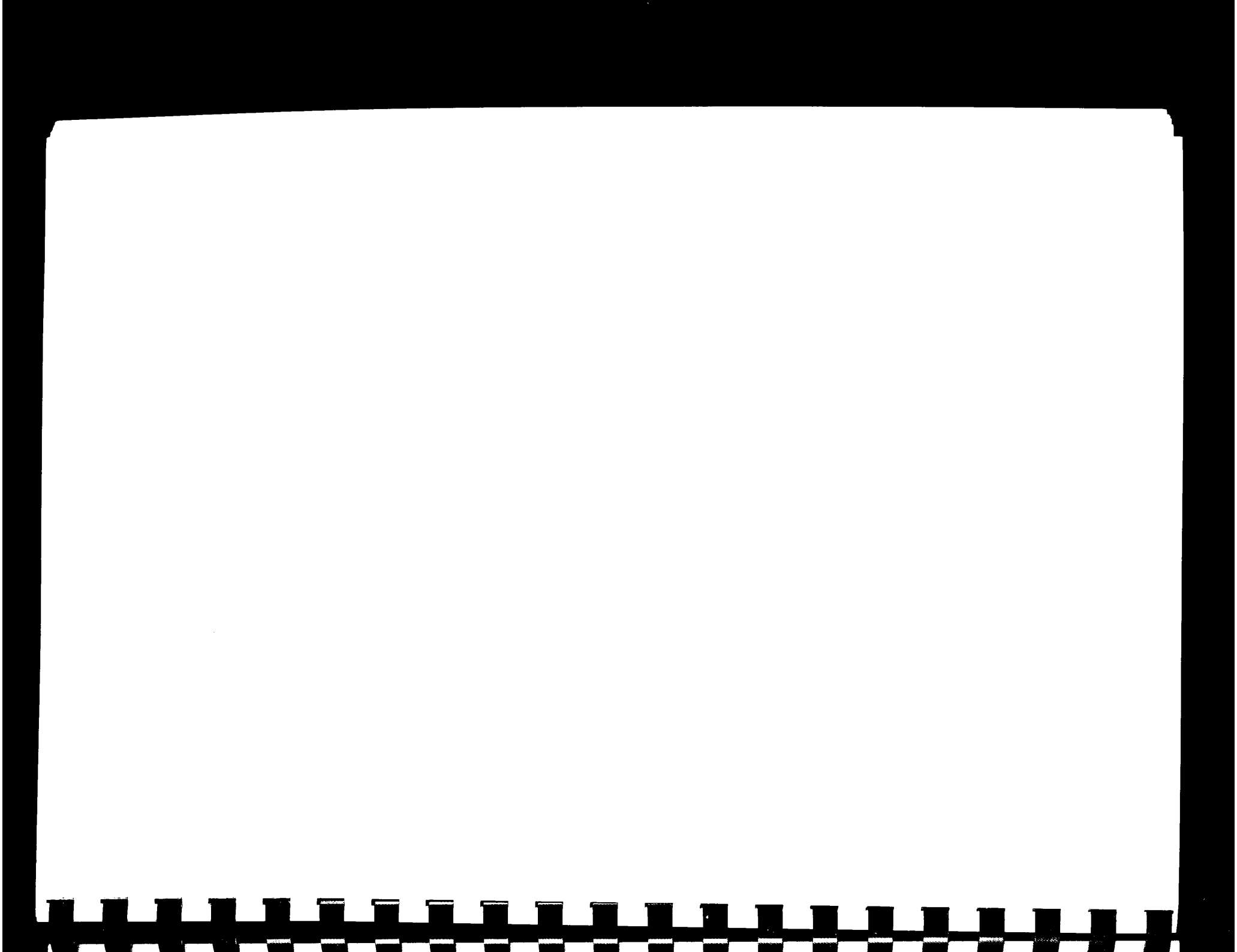
2. Where an ECR is costly or at first inspection inapropriate, this will be discussed formally with the Director of Public Health or a nominated deputy.

3. The referring doctor will always be contacted and the matter discussed. If the doubt is a clinical one (ie the health gain or cost effectiveness of the treatment is in doubt) the matter will be discussed with the referring clinician by the DPH.

   If the query is an operational or cost one only, (ie a large cost differential) the query may be pursued by the Contracts Manager.

4. A short term mechanism whereby GPs can contest ECRs which are refused should be established. This might work through the LMC. The DHA Commissioning Team meets with the LMC GP representatives regularly. Those ECRs which are refused and are contested by GPs could be discussed in that meeting and a process of arbitration carried out. This mechanism might give the GPs more confidence that there was a democratic process going on.

MW/PF/contracts/commt/proto
18th June 1991



APPENDIX 12

SOLIHULL HEALTH
Solihull Health Authority, 21 Poplar Road, Solihull, West Midlands, B91 3AH
Tel: 021-704 5191 Fax: 021-705 9541

SG/DSB

5th March 1992

Ms Mary Ann Scheuer,
Senior Research Officer,
King's Fund College,
126 Albert Street,
LONDON NW1 7NF

Dear Mary Ann,

RE: EXTRA CONTRACTUAL REFERRALS

Further to our meeting on 3rd March I enclose a copies of the following:

1. Our policy for handling extra contractual referrals.
2. Interim guidance for general practitioners which refer to our approach to handling referrals outside contracts.

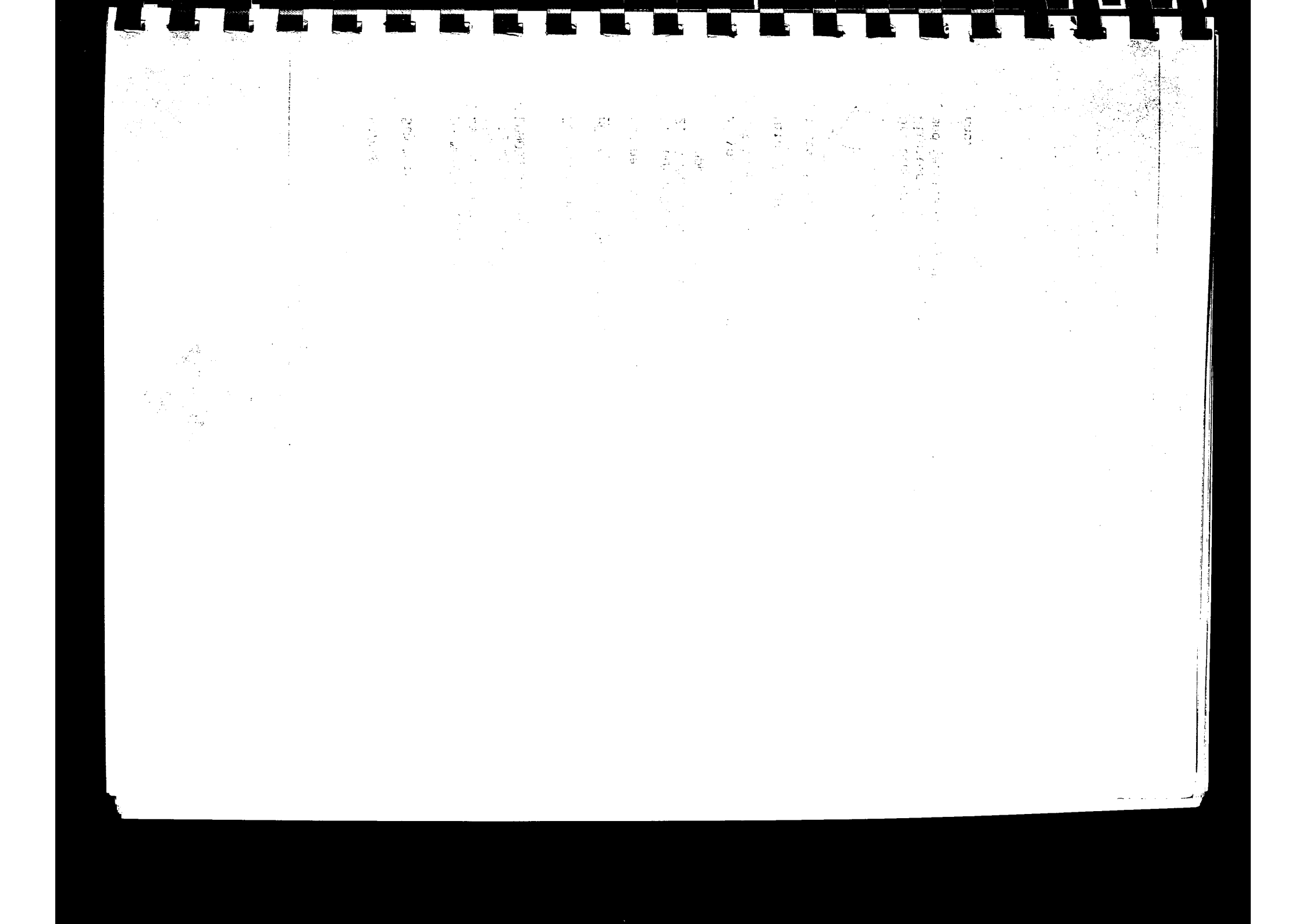
If you have any queries about this information please do not hesitate to get back in touch.

With kind regards.

Yours sincerely,

Dr. Stephen Green
Director of Development
and Service Purchasing

Enc.



SOLIHULL HEALTH AUTHORITY

WORKING FOR PATIENTS: INTERIM GUIDANCE

FOR GENERAL PRACTITIONERS - APRIL 1991

INTRODUCTION

This paper has been prepared and issued to GPs in Solihull as Interim Guidance on the implementation of Working for Patients. The Guidance is interim because the final allocations to all Health Authorities within the West Midlands Regional Health Authority are still being finalised. The Contracts which have been negotiated cannot be signed finally until the allocations are known. If the allocation is insufficient we will need to make adjustments to some of the contracts to bring them into line with the funding available.

We will be issuing a Guidance Manual to each General Practice for use during the year. It will be in loose-leaf form so that revised guidance can be issued from time to time, as well as monitoring information and new material.

The process of implementing the White Paper has been subject to discussion in regular meetings between representatives of the LMC; the FHSA; and the Health Authority

STEADY STATE FOR 1991/92

All District Health Authorities have been negotiating Contracts with Provider Units for the provision of services in 1991/92. One of the principles behind this process is that there should be a steady state with the only changes being planned changes. The Contracts that Solihull Health Authority has been negotiating should therefore enable GPs to continue to refer patients for investigation, diagnosis, treatment and care as they have done in the past.

NATURE OF CONTRACTS

The vast majority of the Contracts for Solihull residents are Block Contracts. This means that Solihull patients will have access to the services they have received in the past. They will be treated according to their clinical priority among patients resident in other Health Authorities and patients referred by GP Fundholders. The Contracts negotiated include the following elements:

- The nature and level of service to be provided.
- The price to be paid for the services.
- Quality measures
- Agreed arrangements for monitoring contracts.
- Commitments to compliance with legal and other statutory requirements.

The incorporation of quality standards into health care contracts is a new area for Provider Units and Purchasers. For the first year we have looked partly to Provider Units to state the quality

standards they currently use; and partly to some generic quality standards developed by Purchasers across Brimingham, Solihull and Sandwell, together with proposals for development during the year. To insist suddenly on significantly different standards would not be consistent with the requirements of maintianing a steady state in the first year of contracting.

SERVICES COVERED BY CONTRACTS

The Contracts arranged cover both hospital and community services. Most of the community services will continue to be provided by the Solihull Community and Mental Health Services Unit. Where Solihull residents have, by reason of convenience, received care from the Community Services of neighbouring Health Authorities, this care will continue to be provided. Similarly some residents of neighbouring Health Authorities will continue to receive care from Solihull's Community Services.

For Acute Services we have negotiated contracts with most of the main hospitals in the surrounding Health Authorities, as well as at Solihull and Marston Green Hospitals.

Regional Specialties are being contracted for by the West Midlands Regional Health Authority. Again the aim of the contracts being placed is to maintain a steady state. Existing referral patterns should not be affected by other than planned changes.

Supra-Regional Specialties i.e. those which are available in one or two centres in the country are funded by the Department of Health and will be contracted by the Department.

REFERRALS OUTSIDE CONTRACTS OR EXTRA-CONTRACTUAL REFERRALS

There are some flows of patients in small numbers to hospitals which are not being contracted for. This is because the flows are too small to be consistent. A contingency reserve will be held to pay for care outside contracts.

For genuine emergency admissions to hospitals with which Solihull does not have a contract, payment by Solihull Health Authority will be made automatically.

For non-emergency work, Provider Units will be required to check with Solihull Health Authority to see when we can pay for treatment from our contingency. In some cases this may be some way ahead, depending on the demands placed upon the reserve. This means a Waiting List will be created. When delay could be of harm to individual patients, we have asked Provider Units to let you know so that you may consider re-referring to a hospital with which we have a contract. The clinical priority of such patients could then be considered alongside other referrals to that hospital.

REFERRAL LETTERS AND MINIMUM DATASET

When hospitals receive referrals from GPs they will want to identify whether patients are covered by a Contract or not. To do that the hospital needs to have a certain minimum set of data. A national Minimum Dataset has been published and the national GP referral letter is being amended. Further details are provided in the Contracting Newsletter which accompanies this guidance. The FHSA will make the initial distribution of the new referral letter to each General Practice.

It will be important that GPs complete the whole of the Minimum Dataset on the new referral letter. This will help speed up the referral process.

WHERE ARE SOLIHULL HEALTH AUTHORITY'S CONTRACTS?

Solihull Health Authority has negotiated contracts with –Provider Units. To help you see where these contracts are, Appendices 1 and 2 list the hospitals and services covered:

- Appendix 1 lists each Provider Unit and the Specialties/Services within it.
- Appendix 2 list Specialties and Services (in Alphabetical order) and where they are available.

Specialty Designation

In the case of acute hospital services the specialties identified relate to the designation of individual consultants providing care.

Open Acess Services

For Open Access Pathology and Radiology services each Health Authority has a contract with its own Provider Units for them to provide Open Access to GPs who have used the service in the past, irrespective of where their patients live. This means that GPs in Solihull will be able to continue to use Open Access services wherever they have been used to using them.

Accident and Emergency Services

For Accident and Emergency/Casualty services each Health Authority has a contract with its own Provider Units, as appropriate, for them to continue to provide a service to people who attend, wherever they live. This is to ensure that immediate treatment is not delayed and that responsibility for that immediate treatment is clear.

Total Cost of Contracts

The total cost of the Contracts placed is £56 millions. The total contingency fund reserved for Extra-Contractual Referrals should be in the order of £600,000 depending on the final Regional allocation.

GENERAL PRACTITIONERS WITH RESIDENTS OF OTHER HEALTH AUTHORITIES

A significant number of GPs in Solihull have patients registered with them who are resident in adjacent Health Authorities e.g. Birmingham and Warwickshire. These people will be eligible for services which have been contracted for by the Health Authorities in which they live. Those Health Authorities will also be responsible for agreeing to pay for any Extra-Contractual referrals for those residents. The reverse will be true for GPs who practice outside Solihull and have a small proportion of people registered with them who live in Solihull. In these circumstances accurate recording of Post Codes is very important.

FURTHER ENQUIRIES

Contracting for services is new for the NHS. Despite the simple Block Contracts which have been arranged, it is likely that some operational difficulties may be encountered. If you have problems please contact one of the following, they are all on the same telephone number.

WHERE ARE SOLUTIONS

Solihull Health Authority has
these contracts are Appendix

- Appendix
- Appendix
  ...s are available.

Specialty Dentistry

In the case of
Undersea consultations

Open Access

Pan Open Access
Surgery Provider
the part
contained in

Accident and

For Accident
own Providing
special
Appendix

Total Cost of

The
Extra-Contractual
assessment.

GENERAL PRACTITIONER

HEALTH AUTHORITIES

A significant number of
different Health
for
Health Authorities will
referrals for
have a small proportion
demonstrably

PARTNER ENQUIRIES

Commissioning for services is now
...ly that
practices please contact one of the following

☎ Tel. No. 021-704-5191

- Dr Stephen Green - Director of Development & Service Purchasing
- Dr Rob Cooper - Director of Public Health
- Dr Rosie Geller - Consultant in Public Health
- Mrs Clare Ashton - Chief Nursing Officer
- Mr Colin Jackson - Chief Executive
- Mrs Caroline Hyde-Price - Service Purchasing

We will try to solve any problems you may have, although the problems which are raised will probably be new to us as well.

HOTLINE FOR INFORMATION & OPERATIONAL ISSUES

There has been some interest in the Health Authority establishing a permanent Hotline for Information on contracts and operational issues e.g. comparative waiting times. These is being given further thought and details will be included in the final Guidance Manual.

FEEDBACK ON SERVICES

In addition to short term problems, the joint LMC/FHSA/Health Authority group is also interested to receive any feedback on the services which have been contracted. This is so that we can look forward to 1992/93 and the opportunities for improving services which the next round of contract negotiations presents.

Dr Stephen Green Director of Development & Service Purchasing

Issue Date: 26.3.91.

SOLIHULL HEALTH AUTHORITY APPENDIX 1.

SERVICES CONTRACTED FOR SOLIHULL RESIDENTS - BY UNIT & SPECIALTY/SERVICE

This list excludes contracts for Regional Specialties which are being dealt with by the Regional Health Authority.
Indicative workloads have been agreed with each Unit. They have not been shown at this stage because some adjustments need to be made for GP Fund Holders.

Dr S. Green - Director of Development & Service Purchasing.
22/03/91

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
Broms/Redd	MA		
Acute Unit	MA1		
Alexandra	M0101		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Ophthalmology	130
		General Medicine	300
		Dermatology	330
		Paediatrics	420
		Geriatric Medicine	430
		O&G - Obstetrics	501
		O&G - Gynaecology	502
		Mental Illness - Other	710
Bromsgrove General	M0102		
		Ophthalmology	130
		General Medicine	300
Highfield	M0108		
		Trauma & Orthopaedics	110
		Rheumatology	410
C Birm	MM		
QE Hospital Unit	MM1		
Queen Elizabeth	M1202		
		General Surgery	100
		Urology	101
		ENT Surgery	120
		Dental Surgery	140
		Plastic Surgery	160
		Cardiothoracic Surgery	170
		General Medicine	300
		Cardiology	320
		Rheumatology	410
		Geriatric Medicine	430
		Haematology	823
Gen & Dental Hosps Unit	MM2		
Birmingham General	M1201		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		Ophthalmology	130
		Dental Surgery	140
		Plastic Surgery	160

PERMANENT HEALTH ACTIVITY

SERVICES CONTRACTED OUT

This item excludes contra
dealt with by the Region
Indicate type of activ
above at this centre
GP Fund Holders

Dr S Green - Diab
£27000/yr

REGION ACTIVITY (N)

Bromo/Pendo

Acute Unit

Alcyandra

Bromsgrove

Highfield

C Ward

Consultant

St Josephs Unit

Green Oliandra

Psych & Dental Hosp Unit

Psychiatry General

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
		Cardiothoracic Surgery	170
		General Medicine	300
		Cardiology	320
		Dermatology	330
		Genito-Urinary Medicine	360
		Neurology	400
		Rheumatology	410
		Geriatric Medicine	430
		Mental Illness - Other	710
		Haematology	823
Dental	M1207		
		Dental Surgery	140
		Restorative Dentistry	141
		Orthodontics	143
Childrens' Hosp Unit	MM3		
Birmingham Childrens	M1203		
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Ophthalmology	130
		Dental Surgery	140
		Paediatric Surgery	171
		Dermatology	330
		Paediatrics	420
		Child & Adolescent Psychiatr	711
		Haematology	823
		Spina Bifida	SBI
O&G Unit	MM4		
Maternity	M1211		
		Paediatrics	420
		O&G - Obstetrics	501
		O&G - Gynaecology	502
Womens'	M1204		
		O&G - Gynaecology	502
Mental Health Unit	MM5		
Charles Burns Clinic	M1210		
		Child & Adolescent Psychiatr	711
Midland Nerve	M1205		
		Mental Illness - Other	710
Queen Elizabeth	M1202		
		Mental Illness - Other	710
Uffculme	M1209		
		Mental Illness - Other	710
		Psychotherapy	713
Elderly & Phys Disabled Unit	MM7		
Moseley Hall	M1208		
		Rehabilitation	314
		Geriatric Medicine	430
Coventry	MS		
Acute - Walsgrave Unit	MS1		
Walsgrave General	M1701		
		General Surgery	100
		Urology	101
		ENT Surgery	120
		Paediatric Surgery	171

Dental

Medicare

Veterans

Other

Workers Comp

Other

Coverage

Acute - Catastrophic

Maintenance Dental

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
		General Medicine	300
		Cardiology	320
		Dermatology	330
		Thoracic Medicine	340
		Rheumatology	410
		Paediatrics	420
		Geriatric Medicine	430
		O&G - Obstetrics	501
		O&G - Gynaecology	502
		GP Maternity	610
		Radiology	810
Acute - City Unit	MS2		
Coventry & Warwick	M1702		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Dental Surgery	140
		Orthodontics	143
		Plastic Surgery	160
		General Medicine	300
		Cardiology	320
		Dermatology	330
		Rheumatology	410
		Paediatrics	420
		Haematology	823
Paybody	M1706		
		Ophthalmology	130
		Genito-Urinary Medicine	360
E Birm	MN		
EBH - General Unit	MN1		
Birmingham Chest Clinic	M1330		
		Thoracic Medicine	340
East Birmingham Hospital	M1301		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Ophthalmology	130
		Dental Surgery	140
		Orthodontics	143
		Plastic Surgery	160
		Paediatric Surgery	171
		Accident & Emergency	180
		Anaesthetics	190
		General Medicine	300
		Cardiology	320
		Dermatology	330
		Thoracic Medicine	340
		Infectious Diseases	350
		Genito-Urinary Medicine	360
		Neurology	400
		Paediatrics	420
		O&G - Gynaecology	502
		Radiotherapy	800
		Radiology	810
		Haematology	823

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
		AIDS/HIV Services	A01
EBH - Yardley Gn Unit	MN2		
Arden Lodge	M1302		
		Geriatric Medicine	430
		GP Other	620
		Hearing Service	HEAR
East Birmingham Hospital	M1301		
		Geriatric Medicine	430
Kidder	MC		
MH Unit	MC2		
Lea Castle	M0307		
		Mental Handicap	700
Lea Hospital	M0306		
		Mental Handicap	700
N Birm	MP		
Acute & Midwifery Unit	MP1		
Good Hope	M1401		
		General Surgery	100
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Dental Surgery	140
		Plastic Surgery	160
		Accident & Emergency	180
		Anaesthetics	190
		General Medicine	300
		Medical Oncology	370
		Paediatrics	420
		O&G - Obstetrics	501
		O&G - Gynaecology	502
Mental Health & Elderly Servi	MP2		
Highcroft	M1407		
		Mental Illness - Other	710
N Warks	MK		
Coleshill St Gerrards	M1099		
Coleshill St Gerrards	M1099		
		Trauma & Orthopaedics	110
Community Health Unit	MK2		
Chelmsley	M1004		
		Mental Handicap	700
		Janet Shaw Unit	JSU
RHA	MZ		
Blood Transfusion Service	MZ1		
Blood Transfusion Service	M2399		
		Ante Natal Screening	ANS
S Birm	MQ		

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
Acute Unit	MQ1		
Birmingham Accident	M1502		
		Trauma & Orthopaedics	110
		Plastic Surgery	160
		Anaesthetics	190
Royal Ortho Woodlands	M1503		
		Trauma & Orthopaedics	110
Selly Oak	M1501		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Ophthalmology	130
		Dental Surgery	140
		Orthodontics	143
		Plastic Surgery	160
		Accident & Emergency	180
		General Medicine	300
		Haematology (Clinical)	303
		Cardiology	320
		Dermatology	330
		Medical Oncology	370
		Neurology	400
		Rheumatology	410
Mental Health Unit	MQ2		
Monyhull	M1509		
		Mental Handicap	700
Reaside	M1514		
		Regional Secure Unit	RSU
S Warks	ML		
Acute Unit	ML1		
South Warwickshire	M1102		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Dental Surgery	140
		Orthodontics	143
		Cardiothoracic Surgery	170
		Accident & Emergency	180
		Anaesthetics	190
		General Medicine	300
		Cardiology	320
		Dermatology	330
		Thoracic Medicine	340
		Paediatrics	420
		Geriatric Medicine	430
Stratford Hospital	M1103		
		General Surgery	100
		Trauma & Orthopaedics	110
		Ophthalmology	130
		Dental Surgery	140
		Geriatric Medicine	430

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
		GP Other	620
Warneford General	M1101		
		Urology	101
		Ophthalmology	130
		Dental Surgery	140
		Plastic Surgery	160
		Dermatology	330
		Medical Oncology	370
		Paediatrics	420
		O&G - Obstetrics	501
		O&G - Gynaecology	502
Mental Health Unit	ML2		
Central	M1110		
		Mental Illness - Other	710
Comm, Handicap & Local Hosp U	ML3		
Royal Midland Counties	M1106		
		Rehabilitation	314
Weston Hospital	M1112		
		Mental Handicap	700
Sandwell	MU		
Acute Unit	MU1		
Sandwell DGH	M1901		
		Plastic Surgery	160
Solihull	MV		
Acute Unit	MV1		
Marston Green	M2002		
		General Surgery	100
		Anaesthetics	190
		General Medicine	300
		Paediatrics	420
		O&G - Obstetrics	501
		O&G - Gynaecology	502
		GP Maternity	610
		GP Open Access	
Solihull Hospital	M2001		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Orthodontics	143
		Paediatric Surgery	171
		Accident & Emergency	180
		General Medicine	300
		Cardiology	320
		Thoracic Medicine	340
		Neurology	400
		Paediatrics	420
		Geriatric Medicine	430
		O&G - Obstetrics	501
		O&G - Gynaecology	502
		GP Maternity	610
		Radiotherapy	800

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
		Accident & Emergency Departm	A&E
		Community Midwifery	CM
		GP Open Access	GPOA
Comm & Mental Health Servs Un	MV2		
Community Health Services	M2080		
		Community Health Services	COM
		Primary Care/Health Promotio	PC
Hollymoor	M2004		
		Mental Illness - Other	710
		Child & Adolescent Psychiatr	711
John Alexander Black Unit	M2033		
		Mental Illness - Other	710
Lyndon Clinic	M2031		
		Mental Illness - Other	710
		Child & Adolescent Psychiatr	711
MH Community Nursing Services	M2097		
		Mental Handicap	700
MH Community Residential Unit	M2098		
		Mental Handicap	700
Middlefield	M2005		
		Mental Handicap	700
District HQ	MV3		
Health Education Dept	M20HE		
		Health Education	HE
W Birm	MR		
Acute & Mat'y Services Unit	MR1		
DRH Maternity	M1611		
		O&G - Obstetrics	501
Dudley Road	M1601		
		General Surgery	100
		Urology	101
		Trauma & Orthopaedics	110
		ENT Surgery	120
		Dental Surgery	140
		Orthodontics	143
		Paediatric Surgery	171
		Accident & Emergency	180
		Anaesthetics	190
		General Medicine	300
		Gastroenterology	301
		Endocrinology	302
		Haematology (Clinical)	303
		Cardiology	320
		Neurology	400
		Rheumatology	410
		Paediatrics	420
		O&G - Gynaecology	502
Mental Health SU	MR3		
All Saints	M1608		
		Mental Illness - Other	710
Single Specialties Unit	MR4		
Centre for Impaired Hearing	M1630		
		Hearing Service	HEAR
Eye Hospital	M1603		

HEALTH AUTHORITY/UNIT	CODE	SPECIALTY/SERVICE	KORNER CODE
Skin Hospital	M1605	Ophthalmology	130
		Dermatology	330
WM Ambulance Service	ME		
Emergency Ambulance Service	MEMAM		
Emergency Ambulance Service	MEMAMB	Emergency Ambulance Service	EMAMB

SOLIHULL HEALTH AUTHORITY APPENDIX 2.

SERVICES CONTRACTED FOR SOLIHULL RESIDENTS - BY SPECIALTY/SERVICE & UNIT

This list excludes contracts for Regional Specialties which are being dealt with by the Regional Health Authority.
Indicative workloads have been agreed with each Unit. They have not been shown at this stage because some adjustments need to be made for GP Fund Holders.

Dr S. Green - Director of Development & Service Purchasing.
22/03/91

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
Accident & Emergency (180)			
S Warks	(ML)	South Warwickshire	(M1102)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Solihull	(MV)	Solihull Hospital	(M2001)
Accident & Emergency Departm(A&E)			
Solihull	(MV)	Solihull Hospital	(M2001)
AIDS/HIV Services (A01)			
E Birm	(MN)	East Birmingham Hospital	(M1301)
Anaesthetics (190)			
S Warks	(ML)	South Warwickshire	(M1102)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Birmingham Accident	(M1502)
W Birm	(MR)	Dudley Road	(M1601)
Solihull	(MV)	Marston Green	(M2002)
Ante Natal Screening (ANS)			
RHA	(MZ)	Blood Transfusion Service	(M2399)
Cardiology (320)			
S Warks	(ML)	South Warwickshire	(M1102)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
E Birm	(MN)	East Birmingham Hospital	(M1301)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)
Cardiothoracic Surgery (170)			
S Warks	(ML)	South Warwickshire	(M1102)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
Child & Adolescent Psychiatr(711)			
C Birm	(MM)	Birmingham Childrens	(M1203)
C Birm	(MM)	Charles Burns Clinic	(M1210)
Solihull	(MV)	Hollymoor	(M2004)
Solihull	(MV)	Lyndon Clinic	(M2031)
Community Health Services (COM)			
Solihull	(MV)	Community Health Services	(M2080)
Community Midwifery (CM)			
Solihull	(MV)	Solihull Hospital	(M2001)
Dental Surgery (140)			
S Warks	(ML)	Warneford General	(M1101)
S Warks	(ML)	South Warwickshire	(M1102)
S Warks	(ML)	Stratford Hospital	(M1103)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
C Birm	(MM)	Birmingham Childrens	(M1203)
C Birm	(MM)	Dental	(M1207)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Coventry & Warwick	(M1702)
Dermatology (330)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	Warneford General	(M1101)
S Warks	(ML)	South Warwickshire	(M1102)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Birmingham Childrens	(M1203)
E Birm	(MN)	East Birmingham Hospital	(M1301)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Skin Hospital	(M1605)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Emergency Ambulance Service (EMAMB)			
WM Ambulance Servic	(ME)	Emergency Ambulance Service	(MEMAM)
Endocrinology (302)			
W Birm	(MR)	Dudley Road	(M1601)
ENT Surgery (120)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	South Warwickshire	(M1102)

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
C Birm	(MM)	Queen Elizabeth	(M1202)
C Birm	(MM)	Birmingham Childrens	(M1203)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)
Gastroenterology (301)			
W Birm	(MR)	Dudley Road	(M1601)
General Medicine (300)			
Broms/Redd	(MA)	Alexandra	(M0101)
Broms/Redd	(MA)	Bromsgrove General	(M0102)
S Warks	(ML)	South Warwickshire	(M1102)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)
Solihull	(MV)	Marston Green	(M2002)
General Surgery (100)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	South Warwickshire	(M1102)
S Warks	(ML)	Stratford Hospital	(M1103)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)
Solihull	(MV)	Marston Green	(M2002)
Genito-Urinary Medicine (360)			
C Birm	(MM)	Birmingham General	(M1201)
E Birm	(MN)	East Birmingham Hospital	(M1301)
Coventry	(MS)	Paybody	(M1706)
Geriatric Medicine (430)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	South Warwickshire	(M1102)
S Warks	(ML)	Stratford Hospital	(M1103)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
C Birm	(MM)	Moseley Hall	(M1208)

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
E Birm	(MN)	East Birmingham Hospital	(M1301)
E Birm	(MN)	Arden Lodge	(M1302)
Coventry	(MS)	Walsgrave General	(M1701)
Solihull	(MV)	Solihull Hospital	(M2001)
GP Maternity (610)			
Coventry	(MS)	Walsgrave General	(M1701)
Solihull	(MV)	Solihull Hospital	(M2001)
Solihull	(MV)	Marston Green	(M2002)
GP Open Access (GPOA)			
Solihull	(MV)	Solihull Hospital	(M2001)
Solihull	(MV)	Marston Green	(M2002)
GP Other (620)			
S Warks	(ML)	Stratford Hospital	(M1103)
E Birm	(MN)	Arden Lodge	(M1302)
Haematology (823)			
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
C Birm	(MM)	Birmingham Childrens	(M1203)
E Birm	(MN)	East Birmingham Hospital	(M1301)
Coventry	(MS)	Coventry & Warwick	(M1702)
Haematology (Clinical) (303)			
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Health Education (HE)			
Solihull	(MV)	Health Education Dept	(M20HE)
Hearing Service (HEAR)			
E Birm	(MN)	Arden Lodge	(M1302)
W Birm	(MR)	Centre for Impaired Hearing	(M1630)
Infectious Diseases (350)			
E Birm	(MN)	East Birmingham Hospital	(M1301)
Janet Shaw Unit (JSU)			
N Warks	(MK)	Chelmsley	(M1004)
Medical Oncology (370)			
S Warks	(ML)	Warneford General	(M1101)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)
Mental Handicap (700)			
Kidder	(MC)	Lea Hospital	(M0306)

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
Kidder	(MC)	Lea Castle	(M0307)
S Warks	(ML)	Weston Hospital	(M1112)
S Birm	(MQ)	Monyhull	(M1509)
Solihull	(MV)	Middlefield	(M2005)
Solihull	(MV)	MH Community Nursing Services	(M2097)
Solihull	(MV)	MH Community Residential Unit	(M2098)
Mental Handicap Assessment (700)			
N Warks	(MK)	Chelmsley	(M1004)
Mental Handicap Long Stay (700)			
N Warks	(MK)	Chelmsley	(M1004)
Mental Handicap Rehabilitati(700)			
N Warks	(MK)	Chelmsley	(M1004)
Mental Illness - Other (710)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	Central	(M1110)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
C Birm	(MM)	Midland Nerve	(M1205)
C Birm	(MM)	Uffculme	(M1209)
N Birm	(MP)	Highcroft	(M1407)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	All Saints	(M1608)
Solihull	(MV)	Hollymoor	(M2004)
Solihull	(MV)	Lyndon Clinic	(M2031)
Solihull	(MV)	John Alexander Black Unit	(M2033)
Neurology (400)			
C Birm	(MM)	Birmingham General	(M1201)
E Birm	(MN)	East Birmingham Hospital	(M1301)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Solihull	(MV)	Solihull Hospital	(M2001)
O&G - Gynaecology (502)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	Warneford General	(M1101)
C Birm	(MM)	Womens'	(M1204)
C Birm	(MM)	Maternity	(M1211)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Solihull	(MV)	Solihull Hospital	(M2001)
Solihull	(MV)	Marston Green	(M2002)
O&G - Obstetrics (501)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	Warneford General	(M1101)
C Birm	(MM)	Maternity	(M1211)

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
N Birm	(MP)	Good Hope	(M1401)
W Birm	(MR)	DRH Maternity	(M1611)
Coventry	(MS)	Walsgrave General	(M1701)
Solihull	(MV)	Solihull Hospital	(M2001)
Solihull	(MV)	Marston Green	(M2002)
Ophthalmology (130)			
Broms/Redd	(MA)	Alexandra	(M0101)
Broms/Redd	(MA)	Bromsgrove General	(M0102)
S Warks	(ML)	Warneford General	(M1101)
S Warks	(ML)	Stratford Hospital	(M1103)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Birmingham Childrens	(M1203)
E Birm	(MN)	East Birmingham Hospital	(M1301)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Eye Hospital	(M1603)
Coventry	(MS)	Paybody	(M1706)
Orthodontics (143)			
S Warks	(ML)	South Warwickshire	(M1102)
C Birm	(MM)	Dental	(M1207)
E Birm	(MN)	East Birmingham Hospital	(M1301)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)
Paediatric Surgery (171)			
C Birm	(MM)	Birmingham Childrens	(M1203)
E Birm	(MN)	East Birmingham Hospital	(M1301)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Solihull	(MV)	Solihull Hospital	(M2001)
Paediatrics (420)			
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	Warneford General	(M1101)
S Warks	(ML)	South Warwickshire	(M1102)
C Birm	(MM)	Birmingham Childrens	(M1203)
C Birm	(MM)	Maternity	(M1211)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)
Solihull	(MV)	Marston Green	(M2002)
Plastic Surgery (160)			
S Warks	(ML)	Warneford General	(M1101)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
S Birm	(MQ)	Birmingham Accident	(M1502)
Coventry	(MS)	Coventry & Warwick	(M1702)
Sandwell	(MU)	Sandwell DGH	(M1901)
Primary Care/Health Promotio(PC)			
Solihull	(MV)	Community Health Services	(M2080)
Psychotherapy (713)			
C Birm	(MM)	Uffculme	(M1209)
Radiology (810)			
E Birm	(MN)	East Birmingham Hospital	(M1301)
Coventry	(MS)	Walsgrave General	(M1701)
Radiotherapy (800)			
E Birm	(MN)	East Birmingham Hospital	(M1301)
Solihull	(MV)	Solihull Hospital	(M2001)
Regional Secure Unit (RSU)			
S Birm	(MQ)	Reaside	(M1514)
Rehabilitation (314)			
S Warks	(ML)	Royal Midland Counties	(M1106)
C Birm	(MM)	Moseley Hall	(M1208)
Restorative Dentistry (141)			
C Birm	(MM)	Dental	(M1207)
Rheumatology (410)			
Broms/Redd	(MA)	Highfield	(M0108)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Spina Bifida (SBI)			
C Birm	(MM)	Birmingham Childrens	(M1203)
Thoracic Medicine (340)			
S Warks	(ML)	South Warwickshire	(M1102)
E Birm	(MN)	East Birmingham Hospital	(M1301)
E Birm	(MN)	Birmingham Chest Clinic	(M1330)
Coventry	(MS)	Walsgrave General	(M1701)
Solihull	(MV)	Solihull Hospital	(M2001)
Trauma & Orthopaedics (110)			
Broms/Redd	(MA)	Alexandra	(M0101)

SPECIALTY/SERVICE (KORNER CODE)	HEALTH AUTHORITY (CODE)	HOSPITAL	CODE
Broms/Redd	(MA)	Highfield	(M0108)
N Warks	(M1)	Coleshill St Gerrards	(M1099)
S Warks	(ML)	South Warwickshire	(M1102)
S Warks	(ML)	Stratford Hospital	(M1103)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Birmingham Childrens	(M1203)
E Birm	(MN)	East Birmingham Hospital	(M1301)
N Birm	(MP)	Good Hope	(M1401)
S Birm	(MQ)	Selly Oak	(M1501)
S Birm	(MQ)	Birmingham Accident	(M1502)
S Birm	(MQ)	Royal Ortho Woodlands	(M1503)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)
Urology	**(101)**		
Broms/Redd	(MA)	Alexandra	(M0101)
S Warks	(ML)	Warneford General	(M1101)
S Warks	(ML)	South Warwickshire	(M1102)
C Birm	(MM)	Birmingham General	(M1201)
C Birm	(MM)	Queen Elizabeth	(M1202)
E Birm	(MN)	East Birmingham Hospital	(M1301)
S Birm	(MQ)	Selly Oak	(M1501)
W Birm	(MR)	Dudley Road	(M1601)
Coventry	(MS)	Walsgrave General	(M1701)
Coventry	(MS)	Coventry & Warwick	(M1702)
Solihull	(MV)	Solihull Hospital	(M2001)

SOLIHULL HEALTH AUTHORITY

EXTRA-CONTRACTUAL REFERRALS:

PROCEDURE FOR SOLIHULL RESIDENTS

1. CONTACT PERSON AT SOLIHULL HEALTH AUTHORITY

All communication in relation to Solihull residents should be directed to:

Dr S. Green,
Director of Development and Service Purchasing,
Solihull Health Authority,
21, Poplar Road,
Solihull,
West Midlands B91 3AH
Tel. No. 021-704-5191. Fax. No. 021-705-9541

2. PATIENTS AND THE ECR PROCESS

The patient should not be involved directly in any negotiations between the Provider and this Health Authority over diagnosis, treatment, care, or cost.

3. REGIONAL SPECIALTY DIAGNOSIS AND TREATMENT

In the West Midlands RHA, Regional Specialty services are being contracted for by the Regional Specialties Agency (RSA). All ECRs for Solihill residents in a Regional Specialty should therefore be referred to the RSA at West Midlands RHA Headquarters.

4. EMERGENCY CARE

Solihull Health Authority will reimburse the cost of any bona fide emergency admission of Solihull residents without prior authorisation (exclusive of Accident and Emergency Department treatment and costs; and Genito-Urinary Medicine/Aids). An Emergency is defined as:

> "any patient treated at, and/or transported to, a Provider Unit as a result of a 999 telephone call, or designated as such by his/her General Practitioner or the hospital doctor responsible for his/her care."

Payment will be made on receipt of an invoice accompanied by the Contract Minimum Dataset relating to the patient and information on who referred the patient (i.e. G.P. or consultant); subject to checking that the individual is a Solihull resident.

Invoices should be submitted within 28 days after the end of the month in which the episode of treatment is completed, or at monthly intervals for long stay patients. For the purposes of this

procedure "long stay" is defined as "patient stays of more than 28 days". Invoices should be submitted to the address at the start of this Procedure.

5. NON-EMERGENCY/ELECTIVE REFERRALS

Payment for such cases will not be automatic. Before accepting any referral the Provider must seek written authorisation from Solihull Health Authority. Authorisation will be required at two stages:

1. when the person is referred for diagnosis; and
2. after the diagnostic process has been completed and the proposed treatment regime has been identified.

5.1. FOR OUTPATIENT CONSULTATION AND DIAGNOSIS

The Provider is asked to complete the attached form and send it to the contact person at the start of this procedure. The form sets out the information required by Solihull HA in order to give agreement to pay for the treatment.

The Provider will be notified of Solihull HA's decision within 10 working days of receipt of the information. The Purchaser will at that time notify the Provider of the Contract Identifier/Approval Code. This Contract Identifier should be used on the subsequent invoice and on any related correspondance.

Once the diagnostic process is complete, an Invoice together with the appropriate Contract Minimum Dataset should be sent to the Contact Person at the start of this Procedure. This should be sent within 28 days after the end of the month during which the patient was discharged from outpatient care.

5.2. FURTHER TREATMENT AND/OR INPATIENT ADMISSION

If further treatment is required a further copy of the attached Form should be sent to Solihull Health Authority.

The Provider will be notified of Solihull Health Authority's decision within 10 working days of receipt of this information.

Invoices, together with the appropriate Contract Minimum Dataset should be submitted within 28 days after the end of the month in which the episode of treatment is completed, or at monthly intervals for long stay patients. For the purposes of this procedure "long stay" means "patient stays of more than 28 days". Invoices should be submitted to the address at the start of this Procedure.

6. TIMING OF DIAGNOSIS AND/OR TREATMENT

In some instances the date on which funding can be released by Solihul Health Authority may be further into the future than is desirable for the patient's need for diagnosis/treatment. If such cases arise, Solihull Health Authority expects the Provider to refer the patient back to the GP, suggesting to him/her that they may like to refer the patient to one of Solihull Health Authority's Block Contracts.

7. COST OF TREATMENT

It is expected that Providers will comply with FDL(90)34, dated 31st December 1990 (and any subsequent national guidance), in the charges made for diagnosis, treatment and care.

8. CONTRACT MINIMUM DATASETS - FORMATS

The preferred form for receipt of Contract Minimum Datasets is as computer data files. Solihull will be operating the West Midlands Bridging DISS solution for Contract Managament and Invoice Processing. Preferred formats for computer data files are:

- IRC Patient Administration System Users:

  Outpatients - OPX14

  Finished Consultant Episodes - XTRACTCE until Version 400 is installed, XTRACTMDS after Version 400 is installed.

- CMS/91 Users:

  Output files from the system.

9. PAYMENT OF INVOICES

Payment will be made within one month of the invoice date, providing the invoice is sent on the same day, and accompanied by the Contract Minimum Dataset. If there is any delay on the part of the Provider in dispatching the invoice and Contract Minimum Dataset, or due to postal disputes etc., it will be paid within one month of receipt or earlier if possible. The invoice should clearly state the necessary payment details, including the Contract Identifier/Approval Code, and the Contact Person in case of query.

10. QUALITY

Solihull Health Authority will expect the quality standards applied to Solihull residents to meet those agreed between the major Purchaser of the Unit's services and the Unit concerned. Solihull Health Authority reserves the right to audit this from time to time.

Dr S. Green

Director of Development and Service Purchasing.

Issue Date 20.3.91.

SOLIHULL HEALTH AUTHORITY

IN CONFIDENCE

REQUEST FOR AUTHORISATION FOR AN ECR

PROVIDER UNIT DETAILS

Contact Name : .....

Contact Title : .....

DHA : ..... Code : .....

Unit : ..... Code : .....

Address : .....

..... Post Code : .....

Telephone Number : ..... Fax Number : .....

Hospital : ..... Code : .....

Speciality : ..... Korner Code : .....

PATIENT / REFERRAL DETAILS

Surname : ..... First Names : .....

Sex (delete one) : Male / Female Date of Birth : ..... / ..... / .....

Address : .....

..... Post Code : .....

Condition Referred for : .....

.....

Why was referral made to your unit? (e.g special features of the service Unit provides) : .....

.....

Referring Doctors Name : ..... G.P. Code : .....

Patient's G.P. Name : ..... G.P. Code : .....

DIAGNOSIS / TREATMENT PROPOSED

Is request for (delete one) : Diagnostic Stage / Treatment Stage

Diagnostic / Treatment stage proposed : .....

.....

Cost of Diagnostic Stage - £..... Cost of Treatment Stage - £.....

Proposed date of diagnostic / treatment stage : ..... / ..... / .....

DETAILS OF CONTACT PERSON AT SOLIHULL HEALTH AUTHORITY

Mr S. Green, Director of Development and Service Purchasing.

Solihull Health Authority, 21 Poplar Road, Solihull, B91 3AH Tel No. : 021 704 5191 Fax No. : 021 705 9541

AUTHORISATION

You may proceed with the Diagnostic / Treatment Stage (delete as necessary) identified above on or after ..... / ..... / .....

Signed : ..... Date : ..... / ..... / ..... Contract Identifier : ..... / ..... / .....

APPENDIX 13

Herefordshire Health Authority

Victoria House
Eign Street
Hereford HR4 0AN
Telephone: Hereford 272012 (STD code 0432)

Our Ref: RB/jea/M2f

Your Ref:

used to dispute invoices

Dear

CONTRACTING INVOICE

I am returning to you the attached invoice(s) for the following reasons:

[ ] No Herefordshire E.C.R. authorisation number quoted.

[ ] Not a Herefordshire resident.

[ ] Is a designated Regional Specialty (please re-direct to: Regional Specialties Agency, West Midlands Regional Health Authority, 146 Hagley Rd.,Birmingham B16 9PA).

[ ] Invoice not raised within national time limits.

[ ] No patient postcode quoted.

[ ] No G.P. details quoted (necessary to exclude possibility of being the responsibility of a G.P.fundholder).

[ ] Other reason:

Yours sincerely,

R. F. Banyard
DIRECTOR OF DISTRICT SUPPORT SERVICES

APPENDIX 14

EXTRA CONTRACTUAL REFERRALS: A REVIEW OF POLICY AND PROCEDURES IN NORTH WEST THAMES

SUMMARY

The aim of this paper is to review the problems and achievements of the first eight months of the new extra-contractual referral (ECR) arrangements, and where possible make recommendations for future practice. It draws on information supplied by DHAs but makes some reference to the experience of provider units. It does not deal with the arrangements used by GPFHs. It also draws attention to the anticipated national guidance on handling ECRs and reports progress on these proposals.

More detailed conclusions are set out in the main body of the report but in summary, significant improvements could be expected if the following were implemented;

1) GPs should be encouraged to discuss any referrals outside contracts with a named contact in the DHA before referral

2) a national standard ECR form together with national guidance on confidentiality

3) agreements on the difference between urgent and emergency cases

4) a maximum time limit within which authorization will be given with an agreed fast track procedure for urgent cases

5) greater clarification on residential status issues

6) review of access to independent clinical advice

7) guidelines on how refusals to authorize are handled

8) opportunities were initiated for structured learning about handling difficult and expensive to place patients

9) improved provider and purchaser access to computerised GP and postcode files

10) a computerised ECR administration system linked to PAS

11) improved mechanisms for agreeing ECR price tariffs

12) providers further reviewed the training needs of all levels of staff who have contact with patients, within the context of contracting.

INTRODUCTION

At the end of November purchasers in the Region had received approximately 4750 requests for authorization of ECRs. The forecast for the year end is approximately 7125 requests. This figure includes requests for inpatient, new and follow-up outpatient appointments and day case treatment and accounts for less than 0.2% of all work undertaken within this Region. Not all these

authorization requests are for treatment within the Region. The average number of ECR requests made by a GP are thought to be in the order of 3-4 per annum. In volume terms many of the referrals are for acute episodes, in terms of cost and time spent processing, however, referrals for psychiatric services and treatment of conditions associated with disability often present a more significant burden.

Clearly ECRs form only a small part of clinical workload - typically around 1.3% of District budget commitments and around 1.5% of provider income. Nevertheless, effective management of such referrals is an integral and important part of the contracting system. Purchasers responsibilities in authorizing ECRs are (i) sustaining patient/GP freedom of choice, (ii) providing access to specialist referral centres where no prior contractual arrangements exist and (iii) remaining within budget. They also have a further responsibility in using the referral information to set appropriate contracts and budget reserves for the following year.

The information to support this paper was gathered during visits to all purchasers within North West Thames Region. Section 1 provides a description of purchasers' ECR authorization procedures. Sections 2-9 discuss the issues that have emerged and make more detailed recommendations for future practice.

AUTHORIS.PRO/JANUARY 1992
SARAH TAYLOR

1 AUTHORIZATION PROCEDURES

1.1 Purchasers' policies on ECRs were developed to ensure access to services. All purchasers sought to consult widely on their authorization criteria with GPs and GP representatives such as the LMC. The final policies were presented to and approved by each DHA. All purchasers have undertaken extensive work to communicate their contractual and ECR arrangements to GPs. This work has included presentations, letters, update sheets, information packs and individual practice visits.

1.2 Most Districts (9 out of 13) actively manage the ECR approval process in order to remain within budget and authorization is only given for those ECRs where there is a clear reason why the patient cannot be treated at a unit under contract. In general Districts have adopted similar criteria with authorization based on the referral falling within one of the following categories:

* the patient is already on a waiting list for treatment
* the patient has had previous treatment at that unit and continuity of care is important.
* there are persuasive social or personal reasons
* the referral is for an appropriate service not provided within the existing contract portfolio.

1.3 In addition, very sympathetic consideration is given to a referral for the following reasons:

* where the patient, for cultural or personal reasons, prefers to be treated by a practitioner of their own sex
* where the patient is an employee of the provider and needs speedy or confidential treatment elsewhere
* where the appropriate contracted provider unit has unpleasant psychological associations for the patient.

1.4 A number of districts have decided that shorter waiting times are not sufficient reason for approval of ECRs unless there is a clinical need specified by the referring consultant or GP. This decision is broadly consistent with the 'steady state' principles and also ensures that money remains available for ECRs of higher clinical priority. In these circumstances Districts usually endeavour to find a unit under contract that can offer a similar waiting time for treatment.

1.5 Referrals made for appropriate reasons will be considered favourably, but approval is not guaranteed. Unconditional approval can be given only while funds remain. As budgets become limited in the fourth quarter some District may have to negotiate with providers to place the patient on a waiting list or to defer payment

for treatment until the next financial year. Obviously, this must be done with due regard for clinical priorities.

1.6 Where there is no clear reason for the ECR the District will contact the GP to discuss the referral. This process is either carried out by or underwritten by a medical intermediary. In most cases this is the Director of Public Health, in one case a representative of the LMC sub-committee and in another the FHSA medical advisor.

1.7 In nearly all cases GPs have been willing to re-refer the patient to a unit under contract or to discuss the reasons for making the original referral. There have been very few adverse reactions, from either GPs or patients. In a number of cases the GP has not known that the service is available at a unit under contract. There is no evidence of a distortion of good clinical practice. Re-referral to an existing contract has occurred in less than 5% of ECR requests.

1.8 Two Districts (North and South Beds) have gone a step further and persuaded GPs to notify them before an ECR is made. GPs were advised that this process would save time for the patient and reduce administration for both the provider and the purchaser. Additional paperwork at this stage has to be weighed against the small number of ECR's made by a GP in a year.

1.9 Some GPs on the boundary of the Region may experience a slightly higher level of ECR activity than average and purchasers are considering ways of reducing workload and inconvenience eg letters of intent. Some of the workload could be reduced if repeat authorizations did not require full details each time. The purchaser systems should be able to derive the patient details from previous authorization codes.

1.10 The issue of FDL(91)115 which dealt with providers seeking payment for ECRs where prior approval had not been secured caused concern. The advice of RHA has been that this guidance was intended to prevent 'gamesmanship' in the first 6 months ie purchasers should pay for work which they would have approved if asked. They should not feel compelled to pay for work which legitimately fell outside their own authorization criteria or in circumstances similar to those where they had already refused approval.

1.11 There is a continuing trend towards increasing consumer power within the NHS. This is supported by more and more work assessing the outcome and quality of various treatments. In the future ECR authorisation criteria can be expected to reflect the increasing interest in this area.

1.12 A flow chart describing Good Practice is set out in ANNEXE A.

2 ADMINISTRATION

2.1 There have been a number of claims and counter claims between purchasers and providers over the administration of the system, and at times these exchanges have become quite heated. It is clear that at the beginning of the year some providers did not fully understand purchasers' need for information and the resulting delay in approval.

Information

2.2 Purchasers require certain basic information on authorization forms to check that the ECR request is valid. Not all Districts record invalid requests but those that do report levels of 3-15%. These requests occur for the following reasons:

* patient on GPFH list
* private referral
* contract already exists with the Unit
* GP has no knowledge of referral
* patient not a district resident
* self-referral treatment.

2.3 The majority of these requests are resolved by communication between the unit and the District purchasing team and do not involve the GP or the patient. Most Districts feel that the level of inappropriate requests is falling as units overcome teething problems in the new systems but there should be pressure exerted on the Post Office to ensure the quality and timeliness of the national postcode directory.

2.4 There are still problems with incomplete information on request forms. Purchasers report a wide variation in the proportion of request forms that have to be queried with providers, (from 20% to 80%). It is clear that some units were much better prepared than others for the start of the ECR process. In some cases these experiences may influence purchaser decisions on whether or not to contract with a particular unit. In all units, however, queries about clinical details cause problems because the staff processing ECR's do not possess the necessary medical knowledge and treatment records or these are not immediately to hand.

2.5 Where the referring GP is not part of the practice where the patient is registered, it is very important that this information is known to the provider when they are identifying the purchaser. Many of the refusals to pay invoices in the first few months of contracting came from mistakes in identifying the purchaser based upon inaccurate information about actual addresses and registered GPs. Some FHSAs have been experiencing problems trying to cope with telephone calls from purchasers and providers trying to determine the correct GP. GPs must be reminded to give full details of the practice where the patient is registered and their home address. Purchasers and providers need access to the national GP file at local level.

2.6 Purchasers have also reported problems with the invoices supplied by providers. Invoices are still arriving more than a month after the month in which the episode took place and without supporting minimum data sets and purchasers authorization codes. This makes the purchasers task of remaining within budget, considerably more difficult. In response, some purchasers will pay invoices with just the authorization code attached, others will only pay on production of the MDS.

2.7 Clearly, providers have had a difficult task in setting up systems to identify ECRs, and purchasers report that the information supplied is improving. However, some providers do not charge for outpatient appointments and a small number of these have not developed a system for identifying ECRs at outpatient level, because of the considerable associated cost.

2.8 Providers have also pointed out that the task is made more difficult by each provider producing their own authorization request form. One provider has identified over 120 ECR forms. Providers have produced their own authorization request forms, but these do not always supply sufficient information. (See ANNEXE B).

2.9 By way of an extreme example, the Oxford DHA form runs to 5 pages; when one unit was asked to complete the form for an outpatient X-ray it took 25 minutes to complete for a £17 procedure!

Delays

2.10 All Districts report that they can turn round urgent ECR requests within a day, by telephone if necessary, and routine requests within 3-5 days if correct and complete information is supplied by the provider. All but two Districts can process complete invoices within one month. The two exceptions reported a backlog which is now being addressed.

2.11 For their part, providers claim they have to deal with unwarranted delays in seeking approval and that this can add to the length of time a patient waits - particularly in the case of an outpatient appointment. Both parties report difficulties in contacting the relevant member of staff to discuss individual ECRs. In some provider units this has been exacerbated by a high turnover of staff in such posts.

2.12 **The NHSME have recently made clear that a requirement to seek a lengthy notice period (eg. 28 days) when seeking authorisation for elective ECRs is not acceptable.**

2.13 Additional problems have been caused in determining the purchaser with referrals such as students, school boarders, services personnel, etc. Improved clarification in these types of cases would be welcome.

2.14 These problems should not have caused delays in the treatment of patients. The approval system is designed for requests for ECR treatment weeks or months ahead. The principle has always been that if the provider has made proper effort to seek approval from the purchaser and has met no response then treatment should not be delayed and funding can be resolved retrospectively. It is crucial that providers do make proper effort to use the system. Payment for ECR treatment that has "slipped through the net" without prior authorization is no longer acceptable to purchasers.

Administrative Workload

2.15 The quality of information is gradually improving, however, this problem has caused a great deal of extra work for both purchaser and provider in seeking and supplying clarification. The total time spent on handling ECRs varies across purchasers from 4 - 60 hours per week. All Districts feel that the process takes up too much senior management time including regular input from Directors of Purchasing, Public Health, Information and Finance. Most are looking to devolve the running of the system to support staff with senior managers involved on an exceptional basis. This needs careful handling as funds run low towards the end of the year.

Recommendations:

* RHAs to support the introduction of a national ECR authorization request form (this issue is discussed in ANNEXE B)

* routine referrals should be processed within 5 working days, urgent referrals within 48 hours

* contact officers in both providers and purchasers, or their deputy, should always be available by telephone (core hours 10-4 pm)

* the letters of intent system should be extended where practical

* purchasers should keep queries about treatment details to a minimum to reduce provider workload

* all paperwork and inquiries should quote the purchasers authorization/reference code

3 CONFIDENTIALITY

3.1 There have been genuine concerns raised about maintaining patient confidentiality during these communications - this was

addressed in Regional guidance issued in March 1991. All purchasers have taken this issue seriously and a number of steps have been taken:

(i) all staff have been reminded of their conditions of employment regarding patient confidentiality

(ii) all ECR mail marked confidential is opened by designated staff only

(iii) all paperwork is locked away when staff are not in attendance.

3.2 Problems have arisen over the use of faxes and although purchasers have made arrangements to receive confidential information at secure machines some faxes do get misdirected.

Recommendations:

* **where fax machines are used the patient's name and address should be faxed, phoned or posted separately**

* **both parties should ensure that written communications about ECRs are marked confidential and addressee only**

* **the patient's name should be used only when necessary, ie not during enquiries on matters of principle.**

* **national guidance will address this issue (see Annexe B).**

* **consideration should be given to whether prisoners names need to be given in ECR requests since the processing of the request will reveal that the patient is a prisoner.**

4 SCOPE OF AUTHORIZATION

4.1 ECR authorization requests are raised for all forms of inpatient, outpatient and day case treatment. Purchasers have taken different approaches to when and how often providers should seek authorization during a patient's course of treatment and how long the authorization will be valid. The different approaches are outlined below;

(i) authorization is being required for the first appointment, whether charged for or not, and all subsequent appointments and episodes of treatment (this is often a GPFH model)

(ii) authorization is being required for the first appointment and will then cover any subsequent treatment

(iii) authorization can be assumed for outpatient appointments but must be sought for inpatient treatment.

4.2 It is apparent that most purchasers consider it unacceptable to step in after the first appointment and refuse authorization

for subsequent appointments. Nevertheless, there is a necessity to reduce the workload for both purchasers and providers by increasing the uniformity of approach and to control ECR expenditure and remain within budget.

One possible model of care in the future is that patients are referred back to their GP after seeing a consultant, and any decision to treat is taken by GP and patient. However, this is not current practice. To redirect referrals in this way would result in repeat appointments and tests, incurring increased costs for the service and inconvenience for the patient.

Considering these principles the third approach would be clearly unacceptable to most purchasers. The first approach does not increase the purchasers opportunities to redirect referrals since the appropriateness of the referral has been agreed in principle with the first appointment. It does afford greater ease of accounting for purchasers.

Recommendations:

* **authorization should be sought for the first appointment and will then cover any subsequent treatment as long as providers notify purchasers if/when further treatment is to take place**

* **time limits could be set reflecting the waiting time and not an arbitrary time limit**

* **authorization should be valid for an explicit period (regardless of year end). If they fall in a new financial year purchasers should make clear whether their intention is to pay only at current year prices plus inflation.**

5 HANDLING OF RE-DIRECTED REFERRALS

5.1 There has been some confusion amongst providers about purchasers' authorization procedures and in particular what happens when they do not receive authorization to treat a patient. Units are not necessarily aware that purchasers have consulted with the relevant GP to redirect the referral to an alternative provider where a contract exists. From the unit's point of view the patient has been refused treatment. In some cases the unit has contacted the patient before the GP and this causes concern. Where a referral is changed purchasers should make clear, to the GP and the unit, who will notify the patient and how this explanation will be handled. One purchaser in the Region has occasionally contacted the patient direct.

Recommendations:

* **when purchasers refuse authorization at a particular unit they should also inform providers that the patient's GP**

contract already exists

* **informing the patient's GP should take place immediately the decision is made**

* **if the provider communicates with the patient directly information about redirection should be included**

6 REFUSED REFERRALS

6.1 Most 'refused' ECRs are actually inappropriate referrals (see section 2.2) or are redirected into existing contracts (see sections 1.6 - 1.9). To date very few ECR's have actually been refused. By the end of October there had been only 10 genuine refusals across the Region. These have all been for ECR's about which the patient's GP had no knowledge and further more considered the proposed treatment to be inappropriate.

6.2 Few districts have set up any kind of appeal system for GP's or patients. The DHA's approach has been to ensure that any redirection of referrals or refusals of authorisation is done with full consultation and agreement with the patients's GP.

6.3 One district has set up a GP panel to review broad issues surrounding ECR's. However, on the whole, organisations such as the LMC have not seen it as their role to agree ECRs or to review the referrals of individual GP's.

7 DIFFICULT AND EXPENSIVE REFERRALS

7.1 Certain types of referrals (mostly tertiary) pose particular difficulty to DHAs due to the lack of independent advice regarding appropriateness, inadequate information about effectiveness and the strain that some of these referrals place upon the reserves budget. Better information is required to support 'good purchasing'. Peter Jefferys has drawn together some information on tertiary psychiatric referral centres in the Region and has distributed this together with a guide to good purchasing for psychotherapy services. This type of work may need to be extended.

7.2 Although relatively infrequent, single cases can cost £60-80,000 per episode for intensive and lengthy care and this places DHAs under pressure in making the right judgement on behalf of the total resident populations' needs. At least one DHA in another Region has avoided many of these problems by explicitly making provision only for acute ECRs. Contracts have been negotiated with non-acute providers on the basis that no monies have been withheld. In these circumstances the provider unit has the resources to treat locally, to refer within the purchasers existing contracts/SHA or to refer to a specialist centre and meet the bill from its own funds.

7.3 In both approaches there is a possibility that the patient may not receive the optimum care - either because the purchaser has a vested interest in containing costs or because the provider has a similar vested interest. This is an area requiring further consideration.

Specialist Acute Mental Health/Learning Disability Referrals

7.4 Listed below are the approximate numbers of ECRs for North West Thames residents seeking certain specialist services. These figures are based on data collected to the end of October.

	APPROVED	NOT APPROVED
PSYCHOTHERAPY	8	2
ADOLESCENT PSYCHIATRY	15	8
LEARNING DISABILITY ASSESSMENT	2	1
DETOXIFICATION/DRUG DEPENDENCY	21	4
FAMILY THERAPY	9	4
SLEEP THERAPY		1
SECURE ENVIRONMENT	6	
COMPLEX EPILEPSY	8	
MOTHER AND BABY UNIT	1	
TOTAL	67	20

7.5 The "Not Approved" ECRs represent 23% of such referrals, however the data is somewhat misleading. A small number of these ECRs did not proceed because the patient either became acutely ill or did not wish to continue treatment. Nevertheless, these figures projected would indicate approximately 150 patients are involved in such referrals during the year, representing service costs in the Region of around £2.5m. The data is very approximate and because of the small numbers involved rounding up for the year will not be very reliable.

7.6 Some of these ECR's reflect shortcomings in specialist and tertiary services provided by local providers and regional units. Regional Guidance or review of the following services has been, or is in the process of being, provided:

* Psychotherapy - Purchasing Guidelines circulated

* Adolescent Psychiatry - Regional review Commissioned by Sheila Adam, report end April 1992

* Substance Misuse/Detoxification - Regional Guidelines to be issued March 1992

* Services for Mentally Disordered Offenders/Medium Secure Unit - Consultation on Regional Strategy initiated Feb 1992

* Mother and Baby unit - regionally initiated medical audit initiated February 1992, reporting June 1992.

Recommendations:

* where purchasers retain a budget for MH/LD referrals they should review their sources of independent and specialist clinical advice

* consideration should be given to commissioning the assistance of Regional advisory groups in producing information about specialist services and in suggesting independent professional sources of further advice in difficult cases

* more structured learning is needed about the outcome of decisions to refuse, redirect or approve difficult and expensive to place patients

* purchasers should work together with the RHA to establish alternative or more local suppliers of specialist services where appropriate

Infertility Services

7.7 ECRs for this particular service have caused districts some difficulties because funding, in particular for In-Vitro-Fertilisation, was not clearly identified prior to April 1991. These referrals can also incur high costs. A number of districts have not authorized ECRs for residents who began the treatment as private patients.

Recommendations:

* Purchasers should review their sources of independent and specialist clinical advice

* NHS patients already on the programme or on a waiting list should be funded

* purchasers should agree treatment protocols with providers for new patients eg funding for three attempts

* purchasers procedures should take into account the of the stress suffered by individuals undergoing this form of treatment and ensure clinical teams in provider units explain any protocols sympathetically.

Long-Stay Care

7.8 Four Districts have reported ECR requests for residents needing long stay care as a result of chronic illness or disability eg multiple sclerosis and brain injuries. Some long-stay care will be covered under block contracts, but across the Region there could be 20-25 such ECRs during the year at a cost of

approximately £100k each per annum. The high cost and unpredictability of these referrals cause particular budgeting problems for purchasers. One purchaser has had six such ECRs, most have had none.

7.9 The purchasers concerned have reviewed these referrals to ensure that they represent the most appropriate care for the individual, in particular as some placements are in private sector organisations. Again, purchasers must have due regard for the emotional stress experienced by families faced with this situation. A number of purchasers have found that funding a defined assessment or rehabilitation programme has given them better information on which to decide the most appropriate longer term care. One purchaser is giving consideration to the potential for running a placement service for their residents in cooperation with providers.

Recommendations:

* **purchasers should seek independent specialist advice in the absence of in-house expertise**

* **procedures should take into account the particular stress experienced by people faced with this situation and should ensure that any assessment programmes are explained to the patient and their carer**

* **further consideration should be given to the role of purchasers in finding suitable placements for long-stay care**

8 PRICING AND BILLING ARRANGEMENTS

8.1 All purchasers are undertaking both current and commitment accounting in order to maintain control of their ECR budget. As with other forms of ECR monitoring, Districts have developed their own computerised system as the information requirements have become apparent.

8.2 As a direct result of the ECR management procedures detailed above most districts will remain within budget this year. Only 2 districts are forecasting funding problems that cannot be met from reserves.

8.3 Purchasers have reported a number of concerns about ECR prices. Most provider units within the Region do not charge for outpatient episodes and it was expected that this would be generally the case. However, some providers, in NWT and other Regions, are making such charges. Purchasers have raised concerns about the method of calculating separate outpatient charges and the accuracy of the data used.

8.4 The total invoiced amount for episodes of emergency care is another common source of dispute between purchasers and providers. One invoice included charges for four consultant

episodes in two different specialties for a patient who was admitted to the hospital for one day. This sort of problem is often the result of mistakes by provider coding staff and the incidence should decrease as people get used to the system.

8.5 Average specialty cost has been the basis of pricing this year and this has caused some difficulties, in particular in emergency mental health admissions. **A single overnight stay has incurred costs of up to £6000. This problem should now be resolved through the issue of FDL(91)135.**

8.6 Concerns were voiced at the beginning of the year that providers might fast-track ECR admissions because they represent additional income. It has been very difficult for purchasers to establish if this has been the case. Waiting list information is only available for whole specialties and not for particular procedures, and clinical priorities will determine how long a patient may wait for admission. There is a reasonably even split in opinion amongst purchasers on whether or not fast-tracking has occurred.

8.7 There were also concerns that providers would re-classify episodes as emergencies in order to avoid the authorization process. Most purchasers feel that this has not been the case. Emergency invoices have, for the most part, reflected an appropriate geographical distribution and type of treatment. It would, however, be appropriate to reach closer agreement between purchasers and providers of the definition of "urgent" as a classification.

8.8 Few purchasers have as yet attempted to monitor value for money in ECRs since provider pricing structures make direct comparisons difficult. The RHA will be collating tariffs for 1992/93 at the end of March and drawing attention to price variations from the preceding year.

Recommendations:

* **provider price structures for 1992/93 should reflect actual treatment more closely eg pricing for procedure, overnight stay, sub-specialty etc**

* **the basis for prices, including outpatient episodes, should be made clear**

* **purchasers should investigate unusually short waiting times on an exceptional basis to assess the possibility of fast-tracking**

* **purchasers should assess value for money by monitoring the level of actual consultant episodes their residents have received against the level of ECR expenditure.**

* **purchasers should keep GPs informed of the budgetary**

position on ECRs and communicate messages clearly if authorizations have to be deferred.

ANALYSIS OF ECR FLOWS

9.1 An analysis of the flow of ECRs and the reasons for such referrals can be used to inform the contracting process and can reveal health care needs not currently met by local provider units. At the start of the year most purchasers recorded and monitored ECRs on manual systems and developed their own computerised systems as the information requirements became apparent. All purchasers can now analyze ECRs for their residents by elective and emergency treatment and by provider unit and specialty. In some instances this has revealed gaps in specialist provision and dissatisfaction in certain areas of local acute services.

9.2 At the time of this review purchasers were just beginning to analyse the monthly data collected. Early trends must be treated with caution as the volatility of ECRs, particularly for services such as orthopaedics, suggests that data for more than one year would provide a more reliable indicator for investment in services and the placing of contracts. Nevertheless purchasers have included in their plans for 1992/93 patterns of ECR flows that are consistent enough to be converted into contracts.

9.3 Tertiary referrals are another important area of analysis. Such referrals can incur high costs and should be identified in preparation for possible sub-contracting arrangements in the future. Currently 7 out of 13 districts can analyse their data for tertiary referrals. The others can only identify such referrals by manually sorting through all previous ECRs. One district in the Shires has identified that approximately 3% of their ECRs are as a result of tertiary referrals. The proportion may be very different in London Districts.

9.4 Some purchasers have analysed ECR data by referring GP's and this has provided further information on the use of services by residents. In most cases it would appear that high levels of ECR's from GP's can be due to poor access or dissatisfaction with local services. Where this is not the case further consideration may need to be given to peer review opportunities to address exceptional circumstances.

Recommendations:

* purchasers need to develop systems that will provide analysis of ECRs by the following categories:

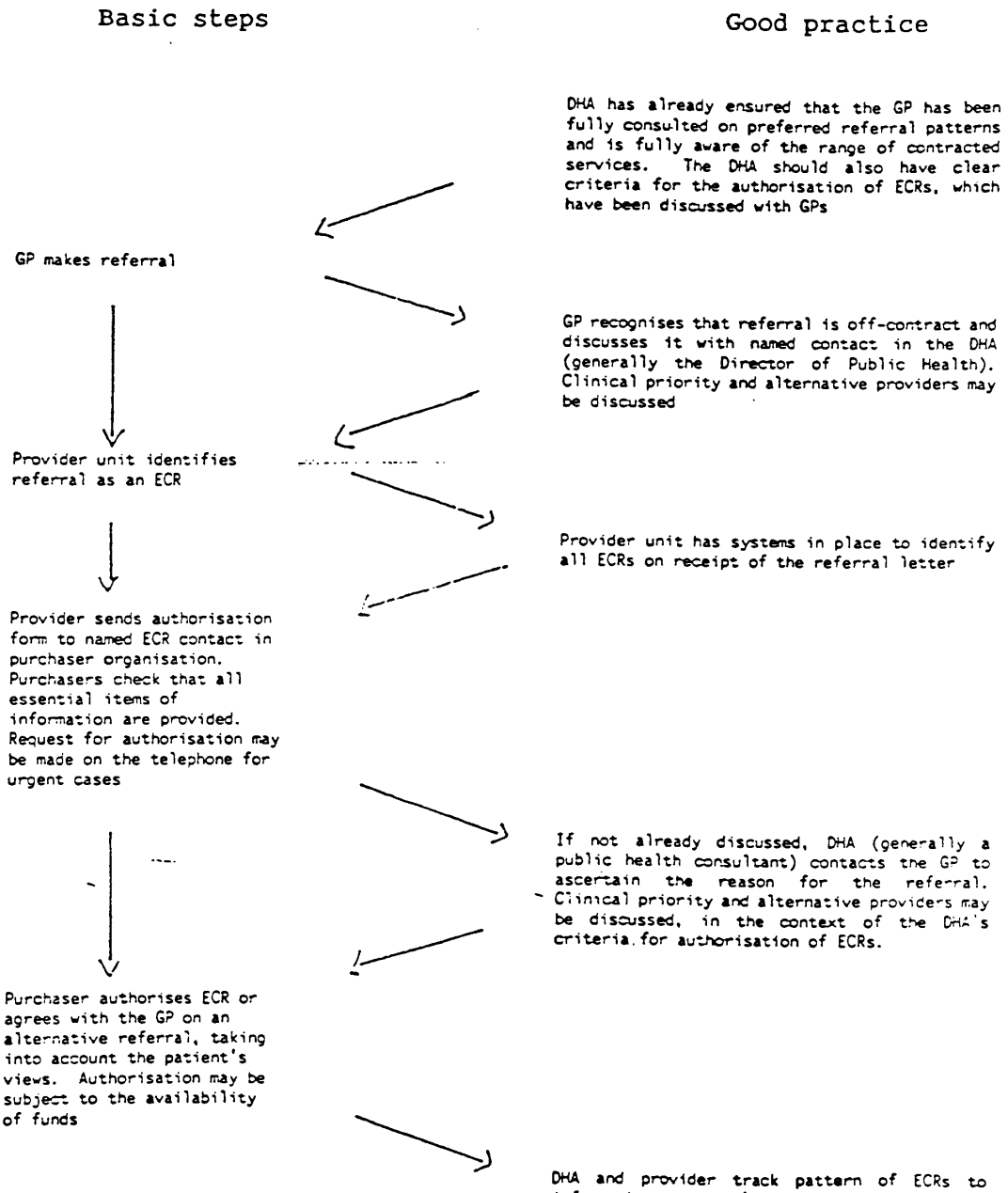
  emergency and elective episodes
  provider unit
  specialty
  by referring GP
  secondary/tertiary referral
  outpatient, day case and inpatient treatment

* ECR data should be used to support discussions with providers on improvements to contracted services

* discussions with GPs on decisions on the placing of contracts should be supported with ECR data where relevant

Annex A

HANDLING NON-URGENT ECRs



ANNEXE B

NATIONAL AUTHORIZATION REQUEST FORM

1. There has been considerable discussion over the amount and type of information required by purchasers for ECR approval and the number of different forms that providers have to stock. Purchasers in this region would support use of a national request form provided that it includes all the information they need to give approval. As a minimum the form should include:-

   * full name (see paragraph 5 below)
   * address of patient (including postcode)
   * date of birth
   * type of treatment inpatient/outpatient/day case
   * proposed date of admission or appointment
   * specialty
   * anticipated cost
   * name and address of GP
   * referring clinician if not GP
   * relevant known details about the reason for the referral eg continue treatment
   * provider name, address and telephone number and contact name for queries.

2. ECR patients have to be uniquely identified for authorization and invoicing purposes. Until NHS numbers are widely used by GPs and provider units, the most practical identification is the patients name and date of birth. The confidentiality issues this raises are discussed in the main report.

3. The patients' full address and GP details are needed to establish that the district is responsible for funding the care of that individual. Postcode alone is not sufficient since these areas across district boundaries. Details of specialty, and if available reason for referral, will allow purchasers to decide on authorizations without further communication with provider or referring clinician. Clearly the reason for a new referral to a particular unit is not always available but its inclusion where possible will result in considerable time saving.

4. Information on the type of treatment, anticipated cost and proposed date of admission or appointment is needed so that districts can ensure funds are available at the time of invoicing.

5. The NHSME are currently sponsoring a number of pilot sites to look at ways of reducing the use of patient name in the contracting environment, and of ensuring the secure handling of named information where there is a 'need to know'.

The pilots have three principal objectives:

- to assess the practicality of doing without name in the information that routinely goes from providers to purchasers in seeking authorisation for ECRs;

- to assess the practicality of doing without name on invoices for cost per case treatment (both for ECRs and cost per case contracts);

- to develop guidance on the establishment of 'safe havens' in providers and purchasers to ensure controlled access to patient information.

The ME's Information Management Group are overseeing these pilots, which are being set up in Northern, Yorkshire and West Midlands regions to run through February. East Anglian and South West Thames regions are also involved in considering the implications of the objectives.

Following their interim findings they will be issuing further draft national guidance for comment.

APPENDIX 15

King's Fund Institute
126 ALBERT STREET
LONDON NW1 7NF
TELEPHONE 071-485 9589
FAX 071-482 3584

14 February 1992

David Pace
Director of Resources
South West Thames RHA
40 Eastbourne Terrace
London
W2 3QR

Dear

The King's Fund Institute is undertaking a study of extracontractual referrals (ECRs) for the Audit Commission. While most of our study is focusing upon the experience of six districts, we would like to gather a more comprehensive picture from each region. Because of our time constraints in reporting back to the Audit Commission, we would appreciate it if you could return this information to us by 5 March.

This study will form part of the Audit Commission's report on the purchasing role of district health authorities. We are not carrying out an audit of ECR arrangements; rather, we want to establish a picture of ECRs and build up information on resourcing levels for the benefit of all health authorities. The report would only mention individual health authorities by name after agreeing full details with you.

First of all, we would appreciate it if you could provide us with the following information *for each of your districts*:

* the amount of money set aside for ECRs (total) at the beginning of 1991/92 and at each quarter;

* the proportion of the districts' revenue budget this ECR budget represents, at each of these points;

* the actual quarterly expenditure (invoices received and paid) for ECRs, please show total spend as well as spend for elective and emergency ECRs; and,

* the predicted over/underspend of ECRs against budget for 1991/92.

If it is possible, we would like to gather information through December 1991. We only need this on a quarterly basis, but if it is just as easy or easier to present this to us on a monthly basis that is fine.

cont/...

Secondly, what advice did your region give to districts about the amount to set aside for ECRs in 1991/92? Have you modified this advice or policy for 1992/93 budgets? In addition, we understand that several districts have increased their 1991/92 ECR budgets during the year from reserves held either at district or regional level. Has your region given any such contingency reserves to districts? Will you hold back similar contingency reserves in 1992/93?

Finally, we would appreciate any monitoring information which you have collected on the ECR activity levels in your districts - such as the number of emergency ECRs and the number of elective ECR applications, approvals and/or refusals. We understand that some regions are not collecting this sort of data, and would appreciate any monitoring information that you could share with us.

Thank you very much for your time and co-operation. If you have any questions, please do not hesitate to call me.

Sincerely,

Mary Ann Scheuer
Senior Research Officer

APPENDIX 16

Parkside

M E M O R A N D U M

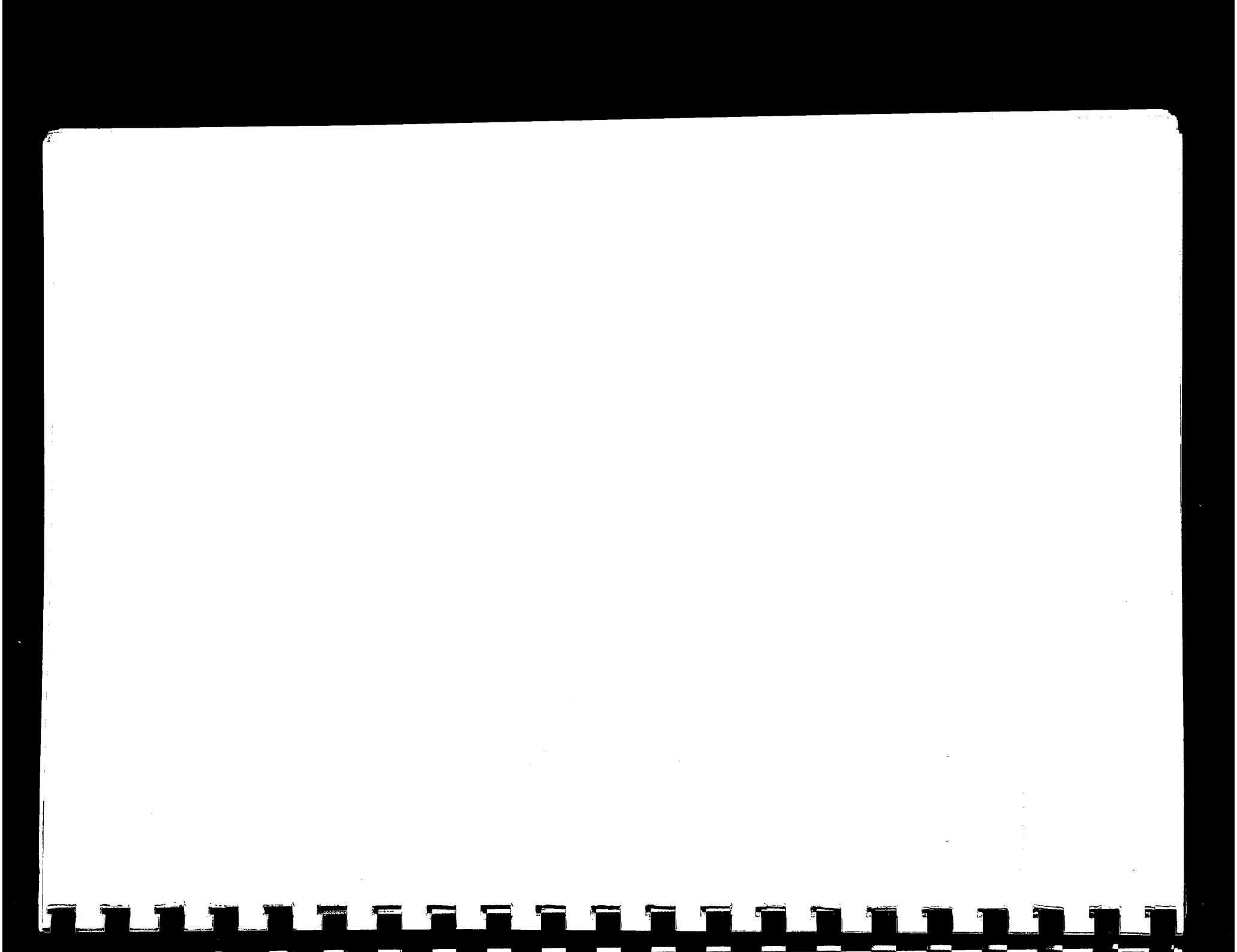
TO : KEITH FORD
KEVIN GAFFNEY
KATHY NEVILLE
MATTHEW BRYANT
FINANCIAL PLANNING SECTION
JAC KELLY
DAVID PANTER
IAN GREGORY
CLAIRE DAVIES
DARREN TUNE
LISA McFARLANE
CAROLINE LOWDELL
LEILA LESSOF

FROM : TERESA MACZUGOWSKA (ext 1429)

DATE : 3rd MARCH 1992

In addition to your monthly reports, detailing the latest position regarding the processing and payment of ECRs, please find attached an analysis of Projected Expenditure for 1991/92.
Figures are taken as at 18/02/92, as per your most recent reports.

Please do not hesitate to contact me if you have any queries or if you require any further reports.



EXTRA CONTRACTUAL REFERRALS
PROJECTED EXPENDITURE 1991/92

BUDGET

	Old Parkside	NE West	NICU Alloc	Total
Emergency	1106	448		1554
Elective	738	205		943
NICU	509		240	749
	2353	653	240	3246

EXPENDITURE

Emergency & NICU:

Actual Apr - July 778
Actual Aug - to date 378

Projected 12 mths @ 195 (Apr-July average) = 2340

Elective:

Actual Apr - July Paid 354 Auth 172
Actual Aug - to date Paid 98 Auth 485

Projected 12 mths @ 131 (Apr-July average) = 1572

3912

PROJECTED OVERSPEND: (666)

(Figs £000s)

APPENDIX 17

Portside

Sample page of the old KEIOR 7

EXTRA CONTRACTUAL REFERRALS

authorised commitment or paid (P)

PAGE NO. 1
04/09/91

AUTHORITY CODE	MONTH AUTHORISED	DATE OF ADMISSION	PATIENT	ELECTIVE	STATUS	PROVIDER	PROCEDURE	SPECIALITY	COST	KIPCODE
A00340	AUGUST	01/04/91		Y	A	CHURCHILL HOSPITAL	ON GOING RENAL CASE (P.A.)	RENAL	3624	61601 907147
A00003	APRIL	02/04/91		Y	A	QUEEN MARYS UNIVERSITY HOSPITAL	ORAL SURGERY	DENTAL SPECIALITIES	160	61206 871076
A00023	APRIL	13/04/91	H353800	Y	A	ST GEORGES GROUP	HAEMATOLOGY	PATHOLOGY & RADIOLOGY	1256	61503 872052
A00036	MAY	15/04/91		Y	A	HARROWLANDS UNIT (COST PER WEEK)	INTENSIVE NEUROLOGICAL REHAB	NEUROLOGY	700	61107 865090
A00058	MAY	19/04/91	H337537	Y	A	ST GEORGES GROUP	ORTHOPAEDIC / ARTHROSCOPY	ORTHOPAEDICS	2918	61202 872052
A00065	MAY	20/04/91	1189665	Y	A	ROYAL LONDON TRUST	T&O / REVISION	ORTHOPAEDICS	1937	61202 824051
A00052	MAY	29/04/91	1201067	Y	A	ROYAL LONDON TRUST	PTCA	MISC	1478	61999 824051
A00219	JULY	01/05/91		Y	A	NORTH MANCHESTER GENERAL HOSPITAL		PAEDIATRICS	1290	61101 982131
A00070	JUNE	02/05/91	533829	Y	A	WHITTINGTON HOSPITAL	DERMATOLOGY	DERMATOLOGY	1188	61104 820656
A00057	MAY	02/05/91	H063323	Y	A	ST GEORGES GROUP	PLASTIC SURGERY	PLASTIC SURGERY	1239	61208 872052
A00087	JUNE	04/05/91	F767310	Y	A	ST BARTHOLOMEWS HOSPITAL	OPTHALMOLOGY	OPTHALMOLOGY	237	61204 823092
A00094	JUNE	07/05/91	H368066	Y	A	ST GEORGES GROUP	CARDIOLOGY	CARDIOLOGY	3335	61103 872052
A00045	MAY	08/05/91		Y	A	ROYAL LONDON TRUST	MATERNITY	MATERNITY	1133	61301 824051
A00060	MAY	11/05/91	H353800	Y	A	ST GEORGES GROUP	HAEM / TRANSFUSION	PATHOLOGY & RADIOLOGY	1256	61503 872052
A00280	AUGUST	13/05/91		Y	A	ST MARES HOSPITAL		GENERAL SURGERY	0	61200 823121
A00188	JULY	13/05/91	H350076	Y	A	ST GEORGES GROUP		ORTHOPAEDICS	2918	61202 872052
A00158	JULY	13/05/91	M643416	Y	A	ST BARTHOLOMEWS HOSPITAL		GENERAL SURGERY	2634	61200 823092
A00016	APRIL	14/05/91		Y	A	ROYAL LONDON TRUST	REMOVAL OF SCREW	ORTHOPAEDICS	1937	61202 824051
A00157	JULY	14/05/91	M697447	Y	A	ST BARTHOLOMEWS HOSPITAL	GENERAL SURGERY	GENERAL SURGERY	2634	61200 823092
A00225	JULY	15/05/91	1619715M	Y	A	ST BARTHOLOMEWS HOSPITAL		GENERAL SURGERY	3120	61200 823092
A00092	JUNE	16/05/91	F716011	Y	A	ST BARTHOLOMEWS HOSPITAL	GYNAECOLOGY	GYNAECOLOGY	1862	61205 823092
A00044	MAY	20/05/91		Y	A	ROYAL LONDON TRUST	MATERNITY	MATERNITY	1133	61301 824051
A00359	AUGUST	20/05/91	F632907	Y	A	ST BARTHOLOMEWS HOSPITAL		GYNAECOLOGY	1862	61205 823092
A00017	APRIL	22/05/91	L066472P	Y	A	GUYS AND LEWISHAM TRUST	GASTRENTEROLOGY	OTHER MEDICAL	112	61125 943079
A00053	MAY	22/05/91	1220998	Y	A	ROYAL LONDON TRUST	ORAL SURGERY	DENTAL SPECIALITIES	950	51206 824051

shows region, dist, (provider) & specialty

APPENDIX 18

23MARMB.LTR 1/10/SC

PARKSIDE
Health Authority
DISTRICT FINANCE

Telephone 071 725 1915

Ref: MB/SC

23 March 1992

Ms Mary Ann Scheuer
Senior Research Officer
King's Fund Institute
126 Albert Street
LONDON NW1 7NF

Dear Ms Scheuer

With reference to your letter of 11 March to Kathy Neville, I have set out below the details requested concerning the staffing costs of managing ECRs within Parkside Health Authority.

Post	Grade	%	Cost (£)
Purchasing Managers (on rota)	SMP11/SMP15/ A & C 8	7.5%	9,844
Purchasing Admin Assistant	A & C 6	40%	7,462
Purchasing Admin Assistant	A & C 4	70%	8,764
Director of Public Health	DDPH Band E	7%	4,763
Management Accountant	A & C 5	60%	10,150
Senior Management Accountant	A & C 6	30%	5,629
District Management Accountant	SMP17	15%	4,452
			51,064

The above costs include employers' on-costs (National Insurance and Superannuation) and are at March 1992 pay levels, ie take account of the full year effect of 1991/92 pay awards. I have also revised our estimate of the proportion of time spent by the above staff on ECR work.

You mentioned that you did not want overhead fixed costs included; there are, however, certain direct non-pay costs associated with this function (eg printing, stationery, telephone/fax lines). I would estimate these at £5,000 per year although this is a very rough estimate.

If there is any further information which you require, do not hesitate to get in touch.

Yours sincerely

Matthew Bryant

MATTHEW BRYANT
DISTRICT MANAGEMENT ACCOUNTANT

The Mint Wing, St Mary's Hospital, Praed Street, LONDON W2 1NY
Direct Line: 071-725 *Fax: 071-725 6571*

SOLIHULL HEALTH

BLR/jel/K1/ES Solihull Health Authority, 21 Poplar Road, Solihull, West Midlands, B91 3AH
Tel: 021-704 5191 Fax: 021-705 9541

Ms M.A. Scheuer
Senior Research Officer
King's Fund Institute
126 Albert Street
LONDON
NW1 7NF

18 March 1992

Dear Ms Scheuer

COST OF MANAGING ECRS

I have costed the time estimates given to you by Caroline Hyde-Price which equate in total almost exactly £10,000. The breakdown is;

Consultant in Public Health	£1,100
Director of Purchasing	£2,500
Deputy Director of Purchasing	£4,650
Secretary Grade 4	£1,750

Both the Consultant in Public Health and Director of Purchasing are Executive Directors of the Authority and the Deputy Director is on Senior Managers pay at a level appropriate to her status as deputy. I hope that this is sufficient for your needs without disclosing personal salary levels.

As regards time spent in my Department I estimate that about 2-2½% of my Principal Accountant is spent dealing with ECRs and approximately 10% of my PGO Clerk, who is on a Grade 4. In total these costs amount to a little over £1,600. In total for the District therefore, we estimate a figure of between £11,500 and £12,000 per annum and the current estimated number of ECRs for the year is 1,000. An average cost for the administration of each ECR can therefore easily be calculated.

However, in my view this does not tell the whole story since frequently ECRs have to be given a degree of priority which is not reflected in the time apportionment: in other words there is an opportunity cost to accepting the interruption of a phone call about an ECR, or the receipt of an urgent fax with the possible need to consult colleagues and/or general practitioners which distracts from the continuance of the routines which were undertaken before the reforms were put in place. We can not put a value on this but it would be wrong for it to be completely ignored.

Dear Ms Scu...er

COST OF MANAGING ...

I have costed t...
Price which ...
breakdown is;

Consultant ir...
Director of ...
Deputy Director ...
Secretary Cle...

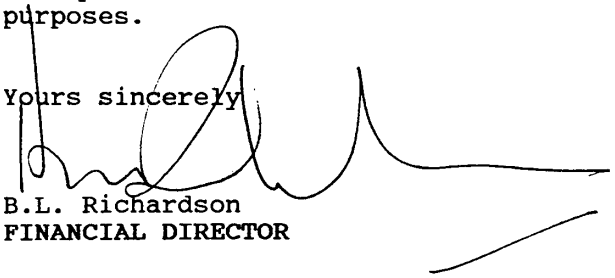
with the Chan...
are necessary ...
is on Senior Mana...
as deputy. I hop...
disclosing perso...

As requested time ...
[illegible] of my principal ...
approximately 10% ...
three posts and ...
Executive Director ...
[illegible] per annum and ...
The year is 1,000 ...
[illegible] can achieve ...

[illegible], in my view ...
[illegible] Echo Dev...
[illegible] ...ected in a ...
[illegible] ...ity/cost to a ...
[illegible] ...ce of the Trecor ...
[illegible] ...ublic colleagues and ...
[illegible] ...ce the continuance ...
[illegible] ...ure the reforms have put in ...
[illegible] ...ure that it would be wrong ...

I hope that this information will be sufficient for your purposes.

Yours sincerely



B.L. Richardson
FINANCIAL DIRECTOR

NORTH DERBYSHIRE HEALTH AUTHORITY
District Headquarters, Scarsdale Hospital,
Newbold Road, Chesterfield S41 7PF.
Telephone 0246 231255 Fax 0246 206672

Your Ref:
Our Ref: RMH/LBM
Please ask for: Mr. R. M. Hodges **Extension:** 4229

18th March, 1992

Ms Mary Ann Scheuer
Senior Research Officer
Kings Fund Institute,
126, Albert Street
LONDON NW1 7NF

Dear Ms Scheuer

Re: E.C.R. STUDY

I have re-examined our estimates of the time inputs devoted to E.C.R's and would wish to amend them slightly as follows:-

	%	£ per annum
Senior Assistant Director of Finance	10	3,200
Assistant Director of Finance	20	4,400
Admin/Clerical Grade 5	75	10,300
Admin/Clerical Grade 3	90	7,700

The estimates include the recording and processing of invoices up to the point where they are passed to our Creditor's Section which arranges the actual payment by either P.G.O. or bank account. At most this can only take approximately 5% of an Invoice Processing Clerk on Admin/Clerical Grade 2 at a cost of approximately £400 per annum.

I trust that this provides the information you require but please do not hesitate to contact me if I can be of further help.

Yours sincerely,

R. M. Hodges
Senior Assistant Director of Finance

SOUTH
BEDFORDSHIRE
HEALTH

District Offices
Bute House
7 Dunstable Road
Luton
Bedfordshire LU1 1BB

Telephone
Luton (0582) 37121
Facsimile 451718

17 March 1992

Mary Ann Scheuer
Senior Research Officer
Kings Fund Institute
126 Albert Street
London
NW1 7NF

Dear Mary Ann

COST OF MANAGING ECRs

In response to your letter of 11 March 1992 the staff costs of managing ECRs, based on the proportions of time spent on the ECR process as given in your letter, are as follows:-

			£
ECR Manager (Gr.5)	100%	:	14,300
PH Registrar/Consultant (KC11)	10%	:	4,500
Deputy Director of Finance (SMP8)	7%	:	2,900
Secretarial Support (Gr.3)	6.25%	:	700
			22,400
Temporary Clerical Support (Gr.2) (Feb - July)	40%	:	1,800
			£24,200

I hope this serves your needs

Yours sincerely

R.P. Kosin
Deputy Director of Finance
RK92.35

APPENDIX 19

P 42.

NHSE Management Executive

Department of Health
Richmond House
79 Whitehall
London SW1A 2NS
Telephone 071-210 3000

31 January 1992

To: Regional Contracting Leads
(see attached list)

Dear Colleague,

DRAFT GUIDANCE ON EXTRA CONTRACTUAL REFERRALS AND ON DISTRICT OF RESIDENCE ISSUES

Introduction

Andrew Foster sent draft guidance on extra contractual referrals, including a standard authorisation form, to Regional General Managers on 20 November 1991 for comments. I am writing to bring you up to date with developments, and to seek more detailed views on revised guidance.

'Confidentiality' pilot sites

As many of you will know, the ME agreed to set up a number of pilot sites to look at ways of reducing the use of patient name in the contracting environment, and of ensuring the secure handling of named information where there is a 'need to know'. These pilots have three principal objectives:

- to assess the practicality of doing without name in the information that routinely goes from providers to purchasers in seeking authorisation for ECRs;

- to assess the practicality of doing without name on invoices for cost per case treatment (both for ECRs and cost per case contracts);

- to develop guidance on the establishment of 'safe havens' in providers and purchasers to ensure controlled access to patient information.

The ME's Information Management Group are overseeing these pilots, which are being set up in Northern, Yorkshire and West Midlands regions to run through February. East Anglian and South West Thames regions are also involved in considering the implications of the objectives.

ECR guidance and the standard ECR form

I attach at Annex A a revised version of the ECR guidance and the standard ECR form which reflect the helpful comments received on the earlier draft. This material is for use by the confidentiality pilot sites, so it is based on the approach that name is not passed routinely from provider to purchaser in the ECR authorisation process.

It would be helpful to receive any comments you may have on the draft material by Friday 28 February. Those comments, together with the lessons learnt from the pilot sites, will then feed into final guidance.

Guidance on district of residence issues

One of the main comments on the earlier draft ECR guidance was that it would be helpful to clarify some of the rules on district of residence issues, to help ensure a common approach across the country.

I attach at Annex B draft guidance on the main problem areas, together with an explanation of the thinking behind this in Annex C. Could I also receive comments on this by Friday 28 February.

If you have any immediate queries on any of this, please let me know,

Yours faithfully,

JAMIE RENTOUL
Performance Management Directorate
Room 126 Richmond House
Telephone 071 210 5827
Fax 071 210 5080

ANNEX A

DRAFT GUIDANCE FOR PILOT SITES

GUIDANCE ON EXTRA CONTRACTUAL REFERRALS

Contents

SECTION 1 - GENERAL PRINCIPLES IN HANDLING EXTRA CONTRACTUAL REFERRALS

Introduction

1. The term 'extra contractual referral' (ECR) refers to a referral to a provider unit for which there is no existing contract with the patient's district of residence. While the majority of referrals will be covered by existing contracts, it is inevitable that there will be occasions when clinicians will need to refer 'off-contract'. The approach to the funding of these referrals depends on whether or not they are classified as emergency extra contractual referrals. This is defined in paragraph 7 below.

2. Appendix 1 lists existing guidance on ECRs [not attached]. This guidance takes forward previous guidance in the context of the experience that has been gained in handling ECRs.

3. In dealing with ECRs, DHAs need to manage a process in which responsibilities are shared, ie. clinicians make decisions to refer outside contracts, but DHAs manage the budgets for these referrals. The process of handling ECRs is most effective where DHAs have established close working relationships with the clinicians making the referrals - both local GPs and consultants in their major contracted provider units making tertiary referrals.

4. DHAs need to ensure that local GPs are fully aware of the contracts for services which have been agreed on their behalf. As part of the authorisation process, GPs should also be encouraged to discuss any referral outside contracts with a named contact point in the DHA before referral. This individual should have the authority to approve ECRs. Such an approach is proving a useful means of building the DHA/GP relationship, though purchasers should not insist on such discussions prior to the

referral. Many DHAs are also discussing ECRs with the referring GP prior to authorisation. Again this is a useful way of getting closer to GPs and achieving a greater understanding of preferred referral patterns and perceived gaps in the contracted service.

5. In handling extra contractual tertiary referrals, the same principles apply. DHAs should ensure that their major contracted provider units are aware of the range of contracts covering treatments likely to be tertiary referrals. Where possible, providers should also give advance notice to DHAs of any intended extra contractual tertiary referrals.

General principles

6. It is important to emphasise the general principles which should govern the handling of ECRs. Previous guidance made clear that DHAs should develop sensitive procedures for handling ECRs. The following general principles should be applied to ensure that systems for managing ECRs are sensitive to the needs of delivering good quality health care:

i) the procedures for handling ECRs should be simple, quick and non-bureaucratic, and designed in discussion with local GPs and other clinicians;

ii) any system for handling ECRs should complement, and not distort, good clinical practice in deciding to admit or make appointments to see patients;

iii) as far as possible patients should not be aware of the administrative process of managing ECRs;

iv) information relating to individual patients should be handled on a confidential basis in dealing with ECRs. Access to such information should be on a 'need to know' basis [DN: Completed guidance will need to cross-refer to work on 'safe havens'].

SECTION 2 – EMERGENCY EXTRA CONTRACTUAL REFERRALS

Definition of emergency extra contractual referrals

7. Provider units do not need to seek prior authorisation from purchasers that the purchaser will take financial responsibility for the treatment of patients not covered by existing contracts if this is not practicable given the patient's condition. What is practicable, in terms of arranging authorisation, will depend on the circumstances of each case. In general, DHAs should accept that cases which have to be admitted within 24 hours (cases which would generally be classified as "emergencies" under the Korner definition) do not require prior approval. However, there will also be cases which, though not emergencies in this sense, may require urgent admission. It is sensible for DHAs to accept that agreeing a contract is not practicable where clinical need requires arranging of an appointment or admission within a working day (that is within 8 hours not counting periods out of office hours, public holidays etc.).

Notification of emergency extra contractual referrals

[DN: Is it helpful to push notification of emergency ECRs? At the moment this is non-mandatory and there are concerns as to whether it can be achieved. Possible guidance below]

8. Provider units should give rapid notification to the purchaser that one of their residents has been admitted for emergency treatment. This information should enable the purchaser to confirm responsibility for the patient and the sum that will be payable. To do this, the purchaser will need:

- a patient identifier
- patient address/postcode
- registered GP details
- treatment and tariff details

Provider units could use an amended version of the standard form for authorisation of ECRs to supply this information.

9. Where provider units have given notification, purchasers should send the provider unit an 'authorisation' code which can be used in all subsequent communications.

SECTION 3 - EXTRA CONTRACTUAL REFERRALS REQUIRING PRIOR AUTHORISATION

Definition

10. Where it is practicable to do so given the patient's condition, provider units should seek prior authorisation from purchasers that the purchaser will take financial responsibility for the treatment of patients not covered by existing contracts (see paragraph 1 above).

The authorisation process

11. For the operation of the contracting system in 1992/93, there is a need to develop a common view within the NHS about the information that needs to be exchanged between provider units and purchasers when authorisation of ECRs is sought. The attached standard form for the authorisation of ECRs (Appendix 2) defines this information in two parts - one for provider units to send to purchasers requesting authorisation and one for purchasers to respond. The following guidance notes explain the elements of the standard form and overall policy in handling the authorisation process.

The standard ECR form

SECTION TO BE COMPLETED BY PROVIDERS

PROVIDER DETAILS

12. Providers should have a named contact, identified within the organisation as the "ECR contact".

13. The "ECR contact", or a nominated deputy, should always be accessible during normal working hours. Telephone switchboards should know the name and extension of the "ECR contact" within their organisation. This applies equally to purchasers. Providers should ensure that all staff dealing with referrals have forms in which the provider details are already complete.

14. Where a provider unit management structure covers more than one hospital or unit, the unit which is proposing to treat the patient should be made clear.

PURCHASER DETAILS

15. Purchasers should ensure that their named contact, identified within the organisation as the "ECR contact", is known to all providers within the region and to all other regions. This individual should have clearly specified authority to approve ECRs.

16. Providers will need to complete the purchaser details according to their identification of the purchaser. The form should be addressed to a named contact in the purchaser organisation and marked "Extra contractual referral - Confidential".

PATIENT INFORMATION

17. All information which could be used to identify individual patients should be handled in a confidential manner. All NHS staff are under contract to regard such information as confidential i.e for authorised use within the NHS only. [DN: Final guidance will need to reflect the work on 'safe havens']

Patient identifier

18. When authorisation is sought the provider ought to be able to give the purchaser a unique reference to identify the ECR (the "local patient identifier" which, for the pilot sites, should be the hospital number)

19. To help maintain confidentiality, providers should issue a unique local patient identifier (LPI) i.e. hospital number which could be used to identify the ECR in any subsequent correspondence. Provider units will not supply name routinely when seeking authorisation of ECRs.

20. Where purchasers require the patient's name to discuss ECRs with GPs and for other aspects of ECR management, they will need to contact the provider unit directly. Provider units should be ready to provide the name rapidly when requested.

21. Purchasers may wish to contact the patient's GP or the referring clinician to discuss particular ECRs, for example if the DHA can identify an alternative referral which is equally efficacious to the patient prior to authorisation, or if the DHA is seeking a better understanding of referral patterns. The patient's name may be necessary for such discussions to take place.

[DN: Is it useful to have NHS number as well as the local patient identifier? Possible guidance below]

22. However where the GP or referring clinician has supplied the NHS number and indicated a willingness to index the referral to it, this number should be sufficient for the purchaser and referrer to discuss the case. The purchaser should use the NHS number in this way when it is supplied on the form unless otherwise advised by the provider.

Address and postcode

23. Information on the patient's address/postcode is crucial to the identification of the purchaser. This is needed by the purchaser to validate responsibility for the patient.

24. When a DHA has been wrongly identified as the purchaser by the provider, the provider should seek authorisation from the patient's correctly identified DHA as soon as the error becomes evident.

DETAILS OF REFERRING CLINICIAN

25. The purchaser needs sufficient information to be able to contact the referrer, and also to validate that the patient is not the responsibility of a GP fund holder.

26. Providers should supply information on the patient's registered GP on the form. This will be increasingly important for purchasers checking financial responsibility for the patient as the number of GP fund holders increases.

27. [DN: Can we provide any useful general guidance on the handling of tertiary referrals]

TREATMENT AND TARIFF DETAILS

Urgency

28. Urgent ECRs must be authorised within the timescale dictated by the urgency of the case. Purchasers are expected to accept clinical views of urgency and to work within these parameters; where it is not practicable to seek prior authorisation of an ECR because of the patient's condition, the case becomes an emergency ECR with automatic funding by the purchaser.

29. The standard form asks for an indication of urgency. There are varying degrees of urgency. A case may not be clinically urgent in the sense that treatment is needed within days, but treatment may be needed quickly, ie within 2 to 3 weeks. There may also be cases where, on the basis of good clinical practice, patients receive rapid follow-up appointments such that the provider only has limited time to seek authorisation. The form enables providers to indicate when a referral requires prompt authorisation, and the timescale within which this is sought. The following points should be recognised:

a) When authorisation is sought for an urgent case, all the information the unit has about the referral should be passed to the purchaser, including details about urgency and the timescale in which authorisation is required.

b) Many urgent referrals are made over the phone and some referrals are received in outlying out-patient clinics. All staff receiving referrals should know the details needed to complete the standard form, and should ensure that the details obtained on referral are as complete as possible. Copies of the standard form should be available to them, and a form for each ECR should be passed to the unit's contracts office as quickly as possible after the referral.

c) Where authorisation is required urgently, it should be sought by the quickest means available, ie one telephone call. Time spent on repeat phone calls seeking additional information should be kept to a minimum. Authorisation given over the phone should be followed up by a confirmatory letter.

d) When full information is not available, the provider should ensure that additional information about the case is given to the purchaser as soon as it is obtained.

30. For the majority of urgent referrals these procedures should ensure that the unit obtains timely authorisation. Purchasers should bear in mind that failure to respond within the necessary timescale may mean that the provider could be obliged to proceed to treatment without authorisation as an emergency ECR. Equally, providers should seek authorisation as quickly as possible on receipt of the referral.

31. It follows from the above that it is not acceptable for purchasers to set conditions whereby funding of an ECR is dependent on the request for authorisation being received an arbitrary period of time before admission or consultation.

Tariff

32. Provider units should include the estimated cost of the ECR, which should relate to the providers unit's published ECR tariff. The information on specialty/procedure should enable the purchaser to check the ECR tariff quoted.

STATEMENT TO BE COMPLETED BY ALL PROVIDERS

33. Providers should undertake to treat ECR cases with the same quality standards as will be given to the residents of major purchasers from that unit. These standards will include waiting times. Therefore providers should not give non-urgent ECRs priority over similar cases in that unit covered by existing contracts.

SECTION TO BE COMPLETED BY PURCHASERS

INFORMATION REQUIREMENTS

34. There will be cases where the provider is unable to supply full information on a particular ECR, for example due to the urgency of the case. In these circumstances purchasers should be prepared to ensure that lack of information in the authorisation process does not distort good clinical practice in deciding to admit or make appointments to see patients.

[DN: Can we give any further guidance on good practice in purchaser/provider communications on 'problem' cases?]

AUTHORISATION

Waiting time issues

35. Purchasers managing their financial responsibilities for ECRs may need to manage the timing of the commitment of funds on some referrals as they do for contracted services

36. It is recognised that DHAs need to manage the resources allocated to ECRs as they do for contracted services. DHAs will be able to use the "estimated date of admission" to assess when funds will need to be available for individual cases, and hence plan the commitment of their ECR budgets. The form enables purchasers to indicate that providers are authorised to proceed with treatment on or after a particular date.

Other authorisation issues

37. In 1992/93 there will still be some patients placed on waiting lists prior to 1 April 1991 whose treatment is not covered by a contract. Providers should notify purchasers before setting a date for treatment for such patients. Purchasers should accept financial responsibility for treatment to be given to these patients in all cases, as this is part of the transitional arrangements for the implementation of contracting.

38. There will also be cases where patients change address while on a waiting list and become the responsibility of a different purchaser. Providers should include as part of their standard information to patients a request that patients notify the provider of any change of address whilst on the waiting list. The provider would then need to contact the 'new' purchaser for authorisation, with a presumption that the purchaser will accept responsibility so as to maintain continuity of care.

39. Authorisation by purchasers is not something which runs out at the end of the financial year. Purchasers should review their commitments in the light of available information (including changing ECR tariffs), but there will be a presumption in favour of continued authorisation.

[DN: Can we add any further guidance on the handling of difficult cases, eg. follow-up outpatient appointments where clinical systems often give appointments in 3-4 days time and purchasers

fail to respond in the time available. Guidance should make clear that the system for handling ECRs should complement and not distort good clinical practice. Any other options for simplifying the process?]

40. Purchasers should be encouraged to authorise whole courses of treatment or a number of outpatient appointments for individual patients. This will enable the simplification of the authorisation process and allow purchasers to predict their commitments more readily.

REFUSAL OF ECRs

41. The grounds on which an ECR can be refused are very limited

42. Purchasers should respect the clinical judgement of GPs and other clinicians who decide on individual referrals. Occasions on which a clinician's choice of provider can be judged to be unwarranted are likely to be very rare. The only grounds on which refusal may be acceptable are as follows:

a) the patient is not the purchaser's responsibility, ie the patient is not a district resident or the patient is, for the treatment planned, a responsibility of a GPFH;

b) the referral is not justified on clinical grounds. In making such judgements the DHA should ensure that it takes appropriate clinical advice. This would include instances where such clinical advice has led to the development and agreement of clear referral protocols and the threshold has not been met.

[DN: Any further guidance on the role of the DPH in this? Need to make clear that refusal on clinical grounds requires clinical involvement]

c) an alternative referral would be equally efficacious for the patient, taking account of the patient's wishes.

AUTHORISATION NUMBER

43. If authorised, the purchaser will need to issue a unique authorisation number to keep track of those requests which have been granted

44. FDL(91)37 requires that a purchaser reference number for agreement to fund treatment (the authorisation number) is issued and included on invoices. Where possible, this should be included in the contract minimum data set.

NHS ME STANDARD ECR FORM FOR PILOT SITES — CONFIDENTIAL

EXTRA CONTRACTUAL REFERRAL: REQUEST FOR APPROVAL TO PROCEED WITH TREATMENT

SECTION FOR COMPLETION BY THE PROVIDER

FROM: PROVIDER DETAILS

1. Provider Unit .....
2. Address .....
.....
.....
3. Name of Contact .....
4. Telephone .....
5. Fax .....
6. Provider Code .....

TO: PURCHASER DETAILS

7. DHA of residence .....
8. Address .....
.....
.....
9. Contact Name .....
10. Purchaser Code .....

A resident of your health authority has been referred to us for treatment. As we do not have a contract with you for this treatment, we are requesting authorisation to proceed.

PATIENT INFORMATION

11. Patient identifier .....
14. Date of Birth .....
15. NHS Number (NB: if known).....
12. Patient's usual address.....
.....
.....
(NB: State if to be communicated separately)
13. Patient's postcode .....

REFERRING CLINICIAN

16. Date of referral .....
17. Name of referrer .....

GP [ ]
GPFH [ ]
Consultant [ ]
Please specify [ ]

18. Correspondence address .....
.....
.....
19. Referring GP code .....
(If applicable)

20. Registered GP .....
(if different)
21. Correspondence address .....
.....
.....
22. Registered GP code.....
23. GPFH Yes [ ] No [ ]

DETAILS OF TREATMENT AND TARIFF

24. Consultant to whom patient referred .....
25. Specialty .....
26. Procedure .....
27. Treatment proposed:

out-patient [ ]
in-patient < 28 days [ ]
in-patient > 28 days [ ]
day case [ ]
other (please specify) [ ]

28. Priority:

admission to waiting list [ ]
urgent [ ]
urgency in days [ ]

29. Estimated date for:

Consultation .... New patient [ ] or follow- up [ ]

Admission ....

30. Estimated cost of ECR .... 31. Date by which approval needed.............................

32. Other comments:

STATEMENT TO BE SIGNED BY ALL PROVIDERS

33. If authorisation to this request is given, the price shall be as in our published tariff, and the quality standards will be as provided to residents of our major purchasers. I undertake to provide a full minimum data set to accompany the invoice produced during the month following that in which the patient is discharged or seen.

Date authorisation sought ....

Signed .... Name ....

Position ....

++

SECTION FOR COMPLETION BY THE PURCHASER

PATIENT IDENTIFIER

34. Patient identifier ....

INFORMATION REQUIREMENTS

35. Essential details complete, but further information as indicated to be provided as soon as possible [ ] List data items required ....

36. Authorisation cannot be given until essential information is provided as indicated [ ] List data items required ....

AUTHORISATION

37. You are authorised to proceed with treatment as:
out-patient [ ]
in-patient [ ]
day case [ ]
other [ ]

on or after the following date.......................

38. Please quote the following authorisation number when submitting an invoice for this treatment ....

39. Your request is refused for the following reasons

....

....

....

---

40. Signed .... Date ....

Name .... Position ....

Annex B

ESTABLISHING DISTRICT OF RESIDENCE/FINANCIAL RESPONSIBILITY FOR FUNDING NHS CARE IN DIFFICULT CASES

A & E SERVICES

Regulation 5 (1)(b) of the NHS Function (Directions to Authorities and Administration Arrangements) Regulations 1991 provide that the host district is responsible for securing access to Accident and Emergency Services, including ambulance services provided in connection with those services, on an all-comers basis. Any services other than those provided in an A & E department are chargeable back to the district of residence. Where DHAs are in doubt about the service they have been charged for in the case of an emergency, they should check with the host DHA to see whether their contract covers the provision of the treatment in question.

COMMUNITY HEALTH SERVICES - SCHOOL HEALTH SERVICES

DHAs are responsible for funding the provision of community health services, including the school health service, for the benefit of their residents. This can sometimes present difficulties where the school is on the boundary of a health authority and the cost of billing the district of residence for the service costs more than providing it. In these circumstances, we would expect health authorities to take the approach which makes most sense locally; for example, by adopting a knock for knock agreement with the neighbouring DHA(s) or by the host DHA accepting full responsibility where the number of pupils living outside their boundaries are small.

ECRs AND TREATMENT OF OVERSEAS PATIENTS

In relation to patients from overseas who are exempt from charges, the Department holds the contract and so funds treatment. In relation to patients from overseas who are not exempt, the patient or his insurer, remains responsible for meeting the cost of the treatment provided in the same way as before the implementation of the reforms.

Servicemen and their families who are stationed abroad but referred to England for NHS treatment are also funded by the Department under the terms of the regulations below.

The NHS (Charges to Overseas Visitors) Regulations 1989 (SI 1989 No. 306) are the regulations which govern the charges levied in respect of treatment given to overseas visitors. FDL(91)28 advises how hospitals and units can seek recompense from the Department when providing treatment to overseas visitors. The contact point within the Department dealing with the financial arrangements for funding treatment under these regulations is Peter McConn, IRU3C, Rm 313, Hannibal House Elephant and Castle, London SE1 6TE; his telephone number is 071-972-2650.

ECRs AND TREATMENT OF TERRITORIAL PATIENTS

Providers should continue seek prior authorization of all non-urgent ECRs of patients from Northern Ireland and Wales. The procedure for dealing with ECRs of Scottish residents is set out in Paragraph 6.8.5 of the NHS ME (Scotland)'s "Procedural Manual on Contracting" (attached).

[DN: We are pursuing with the NHSME in Scotland whether there is any standard information their health boards require when being notified of a non-emergency ECR.]

A list of purchasing contacts in Northern Ireland, Scotland and Wales was circulated to all Regional Review Coordinators on 31 May 1991. However, copies are available from Kate Obaizamomwan on 071-210-5783 on request.

MOD HOSPITALS

Hospitals maintained by the MOD are not bodies with which "NHS contracts" can be negotiated. However, there are local agreements between the districts and MOD hospitals whereby civilians can be referred there for treatment. Each MOD hospital has a baseline of activity which reflects the training and education needs of its staff. Treatment provided up to this baseline is free to the DHA with whom the MOD hospital has an agreement. However, treatment provided over and above this baseline or treatment provided to residents of DHAs who are not party to the agreement are chargeable to the district of residence.

FDL(91)114, issued in September 1991 gives more detailed advice about the financial relationship between the NHS and Defence Medical Services. Marc Taylor, Room 539, Richmond House on 071-210-5858 is the contact point in the Department.

[MUNCHAUSEN SYNDROME PATIENTS

DN: We want to include guidance on this and your views/comments are sought on the options for handling these or other cases where the patient gives a false or non-existent address. Annex C, paragraph f, gives two options we have identified for handling these types of cases on which your views are sought.]

PATIENTS WHO MOVE WHILST WAITING FOR IN-PATIENT TREATMENT

Paragraph 3(d) of the Directions to Authorities in relation to the exercise of their functions (EL(91)45) provide that the district in which the patient is resident on the date s/he is admitted for in-patient treatment is responsible for meeting the costs of their care. Where a patient moves whilst waiting for in-patient treatment, the district in which he is resident on the date he is admitted to hospital will be responsible for meeting the cost of his in-patient treatment and care.

PRISONERS

Paragraph 3 (a) of the Directions to Authorities in relation to the exercise of their functions (EL(91)45) provide that prisoners

continue to be the responsibility of the DHA where they were usually resident immediately before they were detained. If a previous address cannot be established, the district in which they committed the crime for which they were arrested and detained, becomes the district of residence.

SPECIAL HOSPITAL PATIENTS

Where special hospital patients are discharged into the community, the district in which they are receiving community care will become their district of residence and so be responsible for funding all their health care needs. This should not however deter districts from accepting patients from special hospitals into community care as this should be decided solely on the basis of the patient's best interests.

Where a special hospital patient is transferred to another hospital (i.e. a hospital which is not being centrally funded) for ongoing in-patient treatment, their district of origin (i.e. the district in which they were resident on the date of admission of in-patient care) becomes responsible for meeting the cost of this treatment.

TEMPORARY RESIDENTS - e.g. students, children at boarding school, members of the armed forces stationed in the UK.

Regulation 5(a) of the NHS Functions (Directions to Authorities Administration Arrangements) Regulations provides that where there is any doubt about where a person is usually resident, he should be treated as usually resident at the address he gives to the body providing him with treatment. This applies to temporary residents (these include students, children at boarding school and members of the armed forces). They remain free to give their perception of where they consider themselves resident in the same way as most other patients receiving NHS treatment.

6.8.5 Dealing with Extra-Contractual Referrals

For emergency referrals, providers do not need to check with the Board of residence prior to treatment. The provider will be confident of being reimbursed in accordance with its tariff.

For non emergency extra-contractual referrals within the NHS, providers will be required to inform purchasers within a week of receiving the notification of referral and in any event before treatment starts. The purchaser may only challenge the proposed referral if it is wholly unjustified on clinical grounds or that a different referral arrangement would be equally effective for the patient, taking into account their wishes. Payment for such a referral will be made based on the timetable outlined in section 6.8.1.

This procedure differs from that required in England and Wales where Health Authorities as purchasers require providers to obtain approval before treatment commences. This procedure will continue to apply to extra-contractual treatment by Scottish providers for patients of English and Wales health authorities.

The ME have such an approval system available for use in Scotland to be used nationally or selectively if GPs abuse this freedom and ignore contracts placed by their Boards.

Non emergency extra-contractual referrals to private sector providers will continue to require purchaser approval before treatment commences.

To facilitate the smooth progress of invoicing for extra-contractual referrals, providers and purchasers have been required to draw up a list of contracts for liaison and agree arrangements for handling the referral. Discussions of financial or other contract arrangements must in no way serve to delay the provision of treatment, in line with the urgency of the patients concerned.

6.8.6 Mechanism for Preventing Delayed Payment

Unreasonable delay in payment might occur for two reasons:

* slowness in processing payment;
* deliberate delay to overcome cash limit problems.

Annex C

ESTABLISHING DISTRICT OF RESIDENCE IN DIFFICULT CASES

a) A & E Services

Background

Legislation requires host DHAs to contract on an all comers basis for A&E services, including ambulance services provided in connection with them (Regulation 5 (1)(b) of the Function regulations).

Issues

Problems have arisen about which services are chargeable back to the district of residence. The legislation - Regulation 2 (3) of the Function Regs - says that references to A & E services mean those services provided at A & E departments of hospitals and do not include any subsequent treatment connected with the provision of those services. The situation has arisen where, for example, some providers are billing patients' district of residence for x-rays of fractures, where the services of the fracture clinic do not fall within the A & E department, whereas others are charging the host district because they are provided within the A & E Department.

Recommendation

We have resisted defining 'A & E services' as they vary considerably depending on the size of the unit providing them. The most sensible approach is for purchasers who are charged on an emergency ECR basis for anything other than in-patient treatment, is to check with the host district that the treatment is not covered by their block A & E contract. The ME will continue to monitor this policy to ensure that it is operating sensibly.

b) Community Services - School health service

Background

Each DHA has a responsibility for ensuring that community health services are provided to schools within their boundaries. However, they are only responsible for funding the provision of these services to their residents.

Issues

Where schools are on the boundaries of health authorities, the cost of billing the various districts of residence is sometimes more than the provision of the service themselves.

Recommendation

This does not seem to be a very widespread problem; WMRHA seem most concerned about it as they have cross boundary flows to and from Wales. The most sensible approach seems to be one which works best locally e.g. a knock for knock arrangement or the host

district accepting full financial responsibility where the number of pupils living outside its boundaries are small. These arrangements should be negotiated locally rather than being prescribed by the centre.

c) ECRs and treatment of overseas patients

Background

In relation to patients from overseas who are exempt from charges, the Department holds the contract and so funds treatment. In relation to patients from overseas who are not exempt, the patient or his insurer, remains responsible for meeting the cost of the treatment provided in the same way as before the implementation of the reforms.

Issues

Although the regulations governing who is responsible for funding these cases have been in existence since 1982, some providers still seem to be unaware of where funding responsibility lies.

Recommendation

Remind regions of the guidance already issued in FDL(91)28 and of the NHS (Charges to Overseas Visitors) Regulations 1989.

d) ECRs and treatment of territorial patients

Background

Whilst Northern Ireland and Scotland have yet to implement contracts for health services within their boundaries, they, as do Wales, remain financially responsible for meeting the costs of any treatment their residents receive in english hospitals.

Issues

Despite collating and circulating the purchasing contact points in the various health boards and health authorities, there is still some confusion about whether territorial's should be charged for the NHS services their residents receive in England. Furthermore, when contracts for health are implemented in Scotland in April this year, the procedure for handling ECRs involving Scottish residents will be slightly different. Paragraph 6.8.5 of the NHS ME (Scotland)'s "Procedural Manual on Contracting" (attached)sets out the arrangements.

Recommendation

Remind regions of the arrangements for handling ECRs involving residents of Wales and Northern Ireland, and set out the new procedure for residents of Scotland. In addition, it would be useful to remind regions of the list of purchaser contacts in Northern Ireland, Scotland and Wales circulated by the ME at the end of May last year.

APPENDIX 20

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
Mersey	Southport & Formby	404	0.93	89	176	349	62	15.35
Mersey	South Sefton	560	0.81	110	240	382	-74	-13.21
Mersey	St Helen & Knowsley	394	0.35	110	372	526	334	84.77
Mersey	Liverpool	1136	0.58	27	467	1049	327	28.79
Mersey	Wirral	503	0.43	211	663	908	755	150.10
Mersey	Chester	397	0.62	72	288	467	310	78.09
Mersey	Crewe	329	0.45	116	360	581	361	109.73
Mersey	Halton	189	0.43	35	117	235	116	61.38
Mersey	Macclesfield	868	1.35	114	189	355	-356	-41.01
Mersey	Warrington	301	0.43	70	206	300	97	32.23

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
NE Thame	Basildon & Thurrock	1059	1.3	264.8	308.8	374.8	205	19.36
NE Thame	Mid Essex	1097	1.27	240	270	301	-16	-1.46
NE Thame	North East Essex	1300	1.35	62	110	258	-34.7	-2.67
NE Thame	West Essex	800	1.03	150	136	339.9	147.4	18.43
NE Thame	Southend	866	1	90	267.8	387.5	104	12.01
NE Thame	Barking, Havering &	1307	0.9	311	472	417	304	23.26
NE Thame	Hampstead	1259	2.44	70	428	660.9	312.9	24.85
NE Thame	Bloomsbury & Islingt	4176	2.49	47.2	391	602.6	-2613	-62.57
NE Thame	City & Hackney	2423.3	2.44	264.7	151.1	512.8	-1185.2	-48.91
NE Thame	Newham	1639.1	1.72	228.3	475.6	603.3	251.1	15.32
NE Thame	Tower Hamlets	1949	2.62	80	281	1096	18	0.92
NE Thame	Enfield	1102.7	1.19	275.7	87.3	807.7	458.3	41.56
NE Thame	Haringey	2546	2.88	137	412	26.2	-1299.4	-51.04
NE Thame	Redbridge	898.8	1.05	154.9	224.6	280.8	154.9	17.23
NE Thame	Waltham Forest	1019	1.16	50	419	314	-94	-9.22

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
W. Midland	Bromsgrove	528	0.9	55	108	372	0	0.00
W. Midland	Hereford	677	1.3	115	333	508	11	1.62
W. Midland	Kidderminster	246	0.7	35	70	226	0	0.00
W. Midland	Worcester	1106	1.5	240	520	795	63	5.70
W. Midland	Shropshire	1839	1.5	396	1068	1475	202	10.98
W. Midland	Mid Staffs	704	0.8	108	374	578	0	0.00
W. Midland	North Staffs	1065	0.7	77	518	822	163	15.31
W. Midland	South East Staffs	850	1.1	167	515	804	150	17.65
W. Midland	North East Warwicks	847	1	190	343	603	-97	-11.45
W. Midland	South Warwickshire	563	0.7	48	189	419	0	0.00
W. Midland	East Birmingham	1039	1.5	77	315	800	0	0.00
W. Midland	North Birmingham	644	1.2	64	240	464	0	0.00
W. Midland	South Birmingham	1547	1	122	706	1245	0	0.00
W. Midland	West Birmingham	1039	1.2	137	364	779	0	0.00
W. Midland	Coventry	1025	1.1	157	464	683	-33	-3.22
W. Midland	Dudley	627	0.7	100	308	528	0	0.00
W. Midland	Sandwell	453	0.5	96	235	377	0	0.00
W. Midland	Solihull	745	1.3	166	433	631	72	9.66
W. Midland	Walsall	601	0.7	98	316	464	-137	-22.80
W. Midland	Wolverhampton	756	0.9	90	273	511	-245	-32.41

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
N Western	Lancaster	450	1.12	74	231.4	309.2	0.00	0.00
N Western	Blackpool	1373.4	1.61	313.1	635	887	0.00	0.00
N Western	Preston	416.3	1.05	84.5	197.5	287	33.30	8.00
N Western	Blackburn	601.2	0.82	92.4	357.7	502.9	0.00	0.00
N Western	Burnley	555	0.85	119	261	416	0.00	0.00
N Western	West Lancs	357	1.18	58	111	183	60.00	16.81
N Western	Chorley	490	1.08	81.1	248.4	377.5	0.00	0.00
N Western	Bolton	690	1.04	138	358	542	0.00	0.00
N Western	Bury	381	0.82	77.9	214.1	289	0.00	0.00
N Western	M Manchester	389.2	0.7	27	148	224.7	0.00	0.00
N Western	C Manchester	374.2	0.84	51	205	296.1	0.00	0.00
N Western	S Manchester	538.1	0.88	86.9	296.9	462.1	0.00	0.00
N Western	Oldham	608	1.07	64.5	230.5	456	0.00	0.00
N Western	Rochdale	420	0.76	74.3	235	367	0.00	0.00
N Western	Salford	709.3	0.92	124	290.2	505.3	35.50	5.00
N Western	Stockport	787.3	1.19	118	373.8	582.5	0.00	0.00
N Western	Tameside	424	0.68	40.6	158.1	243.2	0.00	0.00
N Western	Trafford	720.8	1.24	93.2	375.6	582.3	0.00	0.00
N Western	Wigan	511.4	0.64	120	286	406.9	0.00	0.00

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
SE Thame	Bexley	555	0.8	98	277	416	0	0.00
SE Thame	Brighton	873	0.9	233	467	667	0	0.00
SE Thame	Bromley	1568	1.5	445	832	1176	0	0.00
SE Thame	Camberwell	652	0.8	178	334	719	0	0.00
SE Thame	Canterbury	879	0.9	45	340	651	0	0.00
SE Thame	Dartford	756	1	164	397	604	0	0.00
SE Thame	Eastbourne	774	0.9	158	346	636	0	0.00
SE Thame	Greenwich	979	1.1	191	487	791	0	0.00
SE Thame	Hasting	1399	2.4	456	690	1049	0	0.00
SE Thame	Lewisham & N S	1061	0.8	157	474	864	0	0.00
SE Thame	Maidstone	945	1.6	171	410	647	0	0.00
SE Thame	Medway	1323	1.5	90	477	975	0	0.00
SE Thame	S E Kent	1729	2.1	359	750	1344	0	0.00
SE Thame	Tunbridge Wells	1067	1.8	260	543	910	0	0.00
SE Thame	West Lambeth	903	1	105	230	645	0	0.00
SE Thame	Regional Specialties	523	0.6	250	559	104	0	0.00

Region	District	Total Final ECR Budget (plan)	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
Trent	North Derbyshire	1139	1.08	159	607	972	129	11.33
Trent	Southern Derbyshire	1860	1.12	471	867	1471	294	15.81
Trent	Leicestershire	2241	0.84	318	1154	2204	200	8.92
Trent	North Lincolnshire	1977	2.14	417	1128	1850	219	11.08
Trent	South Lincolnshire	1512	1.46	369	819	1256	199	13.16
Trent	Bassetlaw	813	2.64	155	401	593	20	2.46
Trent	Central Nottingham	1075	1.23	123	470	840	335	31.16
Trent	Nottingham	1690	0.84	317	800	1419	200	11.83
Trent	Barnsley	1664	2.29	138	521	1166	0	0.00
Trent	Doncaster	1368	1.57	260	580	1035	0	0.00
Trent	Rotherham	117	1.47	251	554	871	0	0.00
Trent	Sheffield	1906	0.88	477	949	1430	0	0.00

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
Wessex	East Dorset	1295	0.84	308	589	1164	-125.00	-9.65
Wessex	West Dorset	1663	2.34	193	695	1294	165.00	9.92
Wessex	Portsmouth	1800	1.13	96	692	1118	284.00	15.78
Wessex	Southampton	1485	1.1	240	708	1079	375.00	25.25
Wessex	Winchester	986	1.52	163	513	765	288.00	29.21
Wessex	Basingstoke	1200	1.84	260	450	850	162.00	13.50
Wessex	Salisbury	802	1.93	250	425	600	-40.00	-4.99
Wessex	Swindon	1512	2.16	274	681	1134	447.00	29.56
Wessex	Bath	2397	1.9	354	909	1798	1297.00	54.11
Wessex	Isle of Wight	867	1.94	131	635	635	344.00	39.68

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
Yorkshire	1	643	1.21	103	319	545	-76	-11.82
Yorkshire	2	841	0.74	90	366	654	9	1.07
Yorkshire	3	619	1.02	149	378	621	-309	-49.92
Yorkshire	4	388	0.71	72	164	300	0	0.00
Yorkshire	5	314	0.5	108	265	442	-369	-117.52
Yorkshire	6	672	1.42	104	343	484	50	7.44
Yorkshire	7	572	1.31	124	283	467	-48	-8.39
Yorkshire	8	799	1.06	113	265	819	-301	-37.67
Yorkshire	9	614	0.59	128	403	723	-408	-66.45
Yorkshire	10	1210	0.48	272	751	1196	-390	-32.23
Yorkshire	11	475	1.42	149	394	617	-339	-71.37
Yorkshire	12	533	0.95	114	218	447	-145	-27.20
Yorkshire	13	366	0.77	47	259	436	-184	-50.27
Yorkshire	14	738	1.13	182	412	673	-150	-20.33
Yorkshire	15	615	1.31	49	305	392	110	17.89
Yorkshire	16	768	0.94	162	402	621	-76	-9.90

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
SW Thame	NW Surrey	787	1.15	109	320	523	90	11.44
SW Thame	W Surrey / NE Hants	1945	2.82	451	1012	1459	0	0.00
SW Thame	SW Surrey	1387	2.17	133	370	883	0	0.00
SW Thame	Mid Surrey	652	1.10	100	305	458	42	6.44
SW Thame	E Surrey	793	1.19	142	402	633	-16	-2.02
SW Thame	Chichester	1014	1.79	48	189	383	229	22.58
SW Thame	Mid Downs	1055	1.29	183	456	549	332	31.47
SW Thame	Worthing	732	0.95	158	425	728	-239	-32.65
SW Thame	Croydon	911	0.87	159	414	839	-174	-19.10
SW Thame	Kingston & Esher	1265	1.98	176	408	929	2	0.16
SW Thame	RTR	1212	1.31	240	660	1018	-524	-43.23
SW Thame	Wandsworth	2830	2.96	208	723	1514	13	0.46
SW Thame	Merton & Sutton	1069	0.86	124	507	762	-62	-5.80

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
South Wes	Bristol & Weston	1383	1.05	150	425	669	-335	-24.22
South Wes	Cheltenham	901	1.23	124	431	797	220	24.42
South Wes	Cornwall	2065	1.26	515	1001	1498	-22	-1.07
South Wes	Exeter	1020	0.9	267	567	930	236	23.14
South Wes	Frenchay	2829	3.53	605	767	1209	-1221	-43.16
South Wes	Gloucester	1800	1.72	442	713	1196	-214	-11.89
South Wes	North Devon	433	0.9	108	261	1256	1141	263.51
South Wes	Plymouth	2458	2.25	588	252	633	1595	64.89
South Wes	Somerset	1311	0.97	194	644	1111	322	24.56
South Wes	Southmead	774	0.98	193	447	551	-50	-6.46
South Wes	Torbay	919	1.03	234	808	1275	648	70.51

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
East Anglia	Cambridge	918		140	518	1110	112	12.20
East Anglia	Huntingdon	600		150	250	428	0	0.00
East Anglia	Peterborough	972		243	475	750	0	0.00
East Anglia	West Norfolk	1085		270	440	749	146	13.46
East Anglia	Norwich	1644		251	626	1043	0	0.00
East Anglia	Gt Yarmouth	563		84	278	492	0	0.00
East Anglia	East Suffolk	578		69	216	520	0	0.00
East Anglia	West Suffolk	1008		180	492	738	0	0.00

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
Oxford	Aylesbury Vale	731	1.76 ~~1.6~~	77	198	555	0.00	0.00
Oxford	East Berkshire	2258	2.15 ~~2.61~~	331	1027	1758	0.00	0.00
Oxford	West Berkshire	1246	1.28 ~~1.11~~	340	780	980	0.00	0.00
Oxford	Kettering	1011	0.88 ~~1.55~~	149	344	872	0.00	0.00
Oxford	Milton Keynes	1497	2.54 ~~3.35~~	184	728	1317	0.00	0.00
Oxford	Northampton	2485	2.67 ~~2.97~~	207	978	1798	0.00	0.00
Oxford	Oxfordshire	1991	1.13 ~~1.46~~	358	1056	1767	0.00	0.00
Oxford	Wycombe	1397	1.74 ~~2.21~~	272	727	1037	0.00	0.00

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
Northern R	Hartlepool	194.8	0.41	55.8	156.4	251.7	114.36	58.71
Northern R	North Tees	262.5	0.53	58.9	235.1	370.7	229.72	87.51
Northern R	South Tees	995	0.92	138.1	468	816.4	133.2	13.39
Northern R	East Cumbria	828.8	1.3	140.1	306.6	562.4	1.4	0.17
Northern R	South Cumbria	1150.8	1.92	220	567	921.9	9.95	0.86
Northern R	West Cumbria	766.7	1.67	59.9	324	585.4	280.32	36.56
Northern R	Darlington	369.3	0.85	70.7	215.6	380	133.33	36.10
Northern R	Durham	714.7	1.44	344.4	460	484.8	19.6	2.74
Northern R	North West Durham	483	1.62	47	182	326	0	0.00
Northern R	South West Durham	590.6	1.12	89.03	325.5	484.4	55.2	9.35
Northern R	Northumberland	539	0.54	60	227	433	6	1.11
Northern R	Gateshead	476	0.67	43.6	250	380	23.9	5.02
Northern R	Newcastle	729.8	0.55	248	448	653	168	23.02
Northern R	North Tyneside	505	0.75	121	264	441	95	18.81
Northern R	South Tyneside	423.3	0.72	83.4	209.1	332	50	11.81
Northern R	Sunderland	619	0.55	185	383	680	271	43.78

Region	District	Total Final ECR Budget (plan) £000	Total Final ECR Budget (plan) as % of district allocation	Total ECR expenditure at Quarter 1 £000	Total ECR expenditure at Quarter 2 £000	Total ECR expenditure at Quarter 3 £000	District's Forecast over/underspend at year-end £000	Forecast as percentage of total planned budget
National Average		1005.28	1.25	170.84	433.14	724.92	28.46	6.23
Minimum		117.00	0.35	27.00	70.00	26.20	-2613.00	-117.52
Maximum		4176	3.53	605	1154	2204	1595	263.51

e) MOD hospitals

Background

Hospitals maintained by the MOD are not bodies with which "NHS contracts" can be negotiated. However, there are local agreements between the districts and MOD hospitals whereby civilians can be referred there for treatment. Each MOD hospital has a baseline of activity which reflects the training and education needs of its staff. Treatment provided up to this baseline is free to the DHA with whom the MOD hospital has an agreement. However, treatment provided over and above this baseline or treatment provided to residents of DHAs who are not party to the agreement are chargeable to the district of residence.

Issues

Some DHAs remain unaware of the funding arrangements for treatment provided to their residents at MOD hospitals.

Recommendation

Finance division issued guidance in September 1991 - FDL(91)114 - about the financial relationship between the NHS and Defence Medical Services. It would seem sensible, therefore, to remind RHAs of its existence so they can draw it to the attention of DHAs experiencing difficulties in this area.

f) Munchausen syndrome patients

Background

The regulations state that the patient will treated as usually resident at the address which he gives to the person or body providing him with treatment - reg 2(5)(a) of the Function Regs. Munchausen syndrome patients or "hospital hoppers" habitually present at A and E departments with an apparent acute illness giving a plausible history which usually turns out to be false. Some give 'false' addresses ie addresses which exist but are business premises or unoccupied premises or addresses where no one of the patient's name lives there. Others give non-existent addresses.

Issues

Some DHAs are unwilling to fund the treatment given to munchausen syndrome patients where they have found that the address given is false or non-existent. Indeed one health authority has written to all UGMs saying that it will not fund the treatment of a munchausen syndrome patient giving a particular address within its DHA.

It is understandable that DHAs will not want to fund the treatment of patients who they consider are not their responsibility. However, providers do accept the names and addresses of patients in good faith and the refusal on the part of the DHA to meet the cost does appear to cut across the

principle of the patient being the arbiter of his district of residence. Furthermore, it seems overly bureaucratic for purchasers to be checking the validity of addresses patients give.

Options for handling

The approach we adopt in resolving where financial responsibility rests where patients give a false or non-existent addresses needs to be consistent with current policy on resolving district of residence queries. Its operation also needs to be fair so that its effect does not disadvantage patients from receiving treatment and does not place an undue burden on the resources of particular health authorities. Two options have been identified.

Option A

Take the view that the address the patient gives is conclusive.

This is most consistent with the legislation and the principle that the patient is the arbiter of his district of residence; it is our Solicitors preferred option for handling these cases. However, its effects might not be as random as we would wish; DHAs could be paying for expensive emergency ECRs where the patient may be not resident within their boundaries.

Option B

Distinguish between a non-existent address and an address which exists even if the patient is not known to live there.

The regulations could be interpreted as meaning that where an address did not exist, a patient could not be considered as being usually resident there. If a previous address could not be determined under Reg 2 (5)(b) - because for example the patient had been discharged - responsibility for funding would then pass to the DHA in which the hospital giving treatment was located (Reg 2 (5)(c). However where the address was false ie it existed but no one of the patient's name lived there, responsibility would continue to rest with the DHA in which the address was located.

The result of making this distinction would tend to spread out funding responsibility for these patients more evenly than Option A. However, it would also cut across the principle of the patient being the arbiter of his district of residence and might encourage more purchasers to check the validity of addresses resulting in more complexity in handling ECRs.

Action

Comments/views are sought on the options proposed.

g) Patients who move whilst waiting for in-patient treatment

Background

The Directions provide that the district in which the patient is

resident on the date s/he is admitted for in-patient treatment is responsible for meeting the costs of their care. The rules were framed this way to remove any incentive to transfer high cost in-patients from one district health authority to another.

Issues

Providers are not always aware that patients have moved until the day they are admitted for treatment. If they do not have an existing contract with the new district of residence, they should seek prior authorization to treat. It is not always possible to do this on the same day and so providers have to decide whether to disappoint the patient or risk providing treatment without authorization. Some providers would like automatic approval to treat ECRs which occur as a result of patients moving whilst on a waiting list.

Recommendation

The question of which non-urgent ECRs should be given automatic authorization should be left to DHAs to decide following discussions with local GPs. Establishment of new rule to deal with these cases would involve an amendment to the Directions. With the move towards purchasers establishing criteria for automatic authorization of ECRs, it seems likely that most will include these types of referrals within their protocols. We could draw attention to this in any good practice we issue in this area.

h) Prisoners

Background

The Directions (paragraph 3 (a)) provide that prisoners continue to be the responsibility of the DHA where they were usually resident immediately before they were detained. If a previous address cannot be established, the district in which they committed the crime for which they were arrested and detained, becomes the district of residence. These rules ensure that an unfair burden is not placed upon the resources of those health authorities with prisons located within their boundaries.

Issues

Some purchasers and providers are unaware of these rules for establishing prisoners district of residence. However, those who are familiar with rules have identified problems with our approach. Some units providing routine diagnostic tests on prisoners on admission have found that the cost of billing and invoicing each district of residence where the prisoner is treated as an ECR is greater than the cost of the tests themselves. Furthermore, some DHAs with pressures on their ECR reserves are trying to insist that prisoners are treated within their existing contracts. This has lead to complaints from the Prison Service.

Recommendation

Restate our policy on establishing district of residence for prisoners. This should enable DHAs to take the health needs of prisoners more fully into account when determining their ECR reserves for next year. Continue to monitor that our approach is working sensibly especially in the area of diagnostic testing.

i) Special hospital patients

Background

In general when patients are discharged from long-stay hospital care into the community, the district where they settle becomes their district of residence. In the case of MI and MH patients moving into community care, this new district of residence will be faced with considerable costs for their ongoing care. For some of these patients, there are arrangements for continuing payments to be made by the district of residence but these arrangements do not apply to Special Hospitals.

Issues

Districts are not currently charged for the treatment which their residents receive in the special hospitals since they are funded from a central top-sliced budget. This means that there is a financial incentive for districts to refuse to accept patients from special hospitals into community care, whereas this should be decided solely on the basis of the patient's best interests. There is also some uncertainty about the rules, causing some districts to believe that the district where the hospital is situated should pay for the ongoing care of patients discharged from it.

Recommendation

Special hospitals will not always be centrally funded and DHAs will become responsible for meeting the costs of their patients in these hospitals. The problem outlined above is, therefore, a transitional one. Introducing new rules to establish financial responsibility for discharged special hospital patients does not seem the best way of handling this funding problem for a number of reasons.

i. The old long stay MI/MH rules are already complicated and not very well understood; different rules for special hospital patients would add further confusion.

ii. New rules would only apply until special hospitals entered the internal market.

iii. the establishment of new rules would involve a temporary amendment to the Directions.

Finance division are aware of the problem and are seeking ways to ensure that no district has a financial incentive either to accept or reject a patient for community care within the existing rules. This seems the most sensible way of handling this short

term problem.

i) Temporary residents

Background

Temporary residents (these include students, children at boarding school and members of the armed forces) are free to give their perception of where they consider themselves resident in the same way as most other patients receiving NHS treatment.

Issues

DHAs and RHAs, particularly those with large student or military populations, have complained that by allowing these patients to make an arbitrary decision about where they consider themselves resident makes it difficult for them to plan their purchasing strategies effectively.

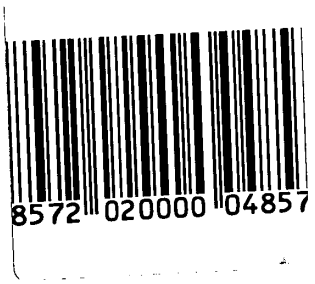
Anecdotal evidence suggests that some RHAs/DHAs are operating their own rules for establishing the district of residence of students. For example, they are using the registered GP or term time address as a means of determining district of residence.

We have resisted making students and members of the armed forces or other temporary residents an exception to the general rule as this would cut across the general principle of the patient being the arbiter of his district of residence. Any rule which we apply in these cases will be arbitrary.

Funding is based on census data. For students, this has meant that the University DHA should receive weighted capitation funding. Clearly districts of 'parental' residence will consider that they lose out if the student states that they are resident at the parental address. However, it is difficult to envisage a system which does not have some difficulties.

Recommendation

Restate our policy that temporary resident's should continue to be free to give their perception of where they consider themselves resident.



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