

MEETING: Advisory Committee on Resource Allocation

DATE OF MEETING: 21 October 2015

TITLE OF REPORT/PAPER:

ACRA(2015)24BA : Unavoidable smallness due to remoteness - identifying remote hospitals

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ACTIONS REQUIRED:

At the last meeting, ACRA asked us to present the final list of remote sites and if an adjustment were made in the target formula, how would the funding reach providers.

This paper covers these two issues.

UNAVOIDABLE SMALLNESS DUE TO REMOTENESS: IDENTIFYING REMOTE HOSPITALS

1. At the last meeting ACRA asked us to finalise the list of remote sites and, if an adjustment were to be made to target allocations, how would the funding reach the providers.

Remote sites

2. Under the current criteria, for a provider to be considered remote the following conditions must be met.
 - a) Smallness condition – the catchment for the hospital, defined by identifying the closest site for each LSOA, must be fewer than 200,000 people.
 - b) Remoteness condition – the LSOA population served must be more than 60 minutes from the second closest provider
 - c) The site provides 24/7 Accident & Emergency facilities (tier 1).
3. The methodology and data sources were fully set out in the paper for the last ACRA meeting (ACRA(2015)18A). In summary, travel times are estimated using travel time software and are calculated from the LSOA population weighted centroid to the provider. The population estimates used to define the population served are the mid-2013 ONS population estimates.
4. For a site to be considered for an adjustment, at least 10% of its catchment population must be remote.
5. Table 1 gives the list of providers meeting these conditions. There have been two changes since the last ACRA meeting. The first is that Hexham has been removed as a candidate as it no longer provides 24/7 A&E services following the opening of the Specialist Emergency Care Hospital in Cramlington. Hexham was below the 10% threshold anyway. This has knock-on effects for the percentage of other providers' populations who are remote, but does not lead to any additional small provider now having more than 10% of its population defined as remote (including Cramlington). Nor is any provider removed from the list due to its population served crossing the 200,000 threshold.
6. At the last meeting the small number of LSOAs more than 60 minutes travel time from any provider were included in the size of the population served but excluded from the count of the provider's remote population. They have now been included in the count of the provider's remote population. This does not change the list, though does increase the proportion of North Devon's population who are remote from around 80% to 90%.

Table 1 : List of small, remote sites

Sites with significant remote populations				
Site Code	Site Name	Not Remote	Remote	Prop Remote
60338	St Mary's Hospital		138,393	100.0%
40208	North Devon District Hospital	15,089	154,763	91.1%
41302	Cumberland Infirmary	45,409	142,037	75.8%
42186	Furness General Hospital	44,661	68,600	60.6%
41305	West Cumberland Hospital	80,998	49,894	38.1%
42671	Pilgrim Hospital	139,668	51,009	26.8%
41122	The County Hospital, Wye Valley NHS Trust	145,801	39,771	21.4%
864773	Scarborough Hospital	173,952	22,052	11.3%

7. There are no providers which miss the criteria due to the size of their population served being only just above 200,000. The next smallest providers with more than 10% of their population remote are The Queen Elizabeth Hospital in King's Lynn which serves a population of 252,000 and the Royal Cornwall Hospital (Treliske) which serves a population of 422,000.

Funding streams

8. If an adjustment is were to be made to allocations, the funding may reach the provider in a number of ways, though the position is complex.
9. The Health and Social Care 2012 Act provides for local modifications to be made to national prices when it would otherwise be uneconomic for a provider to provide the service at the national tariff price. NHS England and Monitor have responsibility for agreeing the method to be used by Monitor to determine local modifications to national prices. Local modifications are intended to ensure that health care services can be delivered where they are required by commissioners for patients, even if the cost of providing services is higher than the national price.
10. Local modifications should be agreed locally. If this is not achieved, the provider may make an application to Monitor to determine whether the price should be increased. Agreed local modifications also have to be approved by Monitor.
11. Where there are no mandatory national prices, prices are set locally. This is the case for some acute services, as well as all mental health, ambulance, primary care, and community care services.
12. Monitor's current rules for agreeing local modifications differ from the basis for the proposed adjustment to allocations. This would be a matter for NHS England and Monitor to address.