

Health

June 2005



Payment by results update

Key issues and questions for trust and PCT boards
to consider after the first year

Payment by results is an important focus of the Audit Commission's local audit work and our national work on financial management in the NHS. In July 2004, the Audit Commission published its report, *Introducing Payment by Results: Getting the Balance Right for the NHS and Taxpayers*, which gave an overview of how payment by results would work, and highlighted the benefits for, and risks, to the NHS.

This update highlights some important lessons about payment by results in 2004/05 taken from the early experiences of NHS foundation trusts and PCTs. It also identifies the priority areas for NHS bodies to address and raises questions for executive and non-executive members of PCT and acute trust boards. We will publish a full report covering these issues in more depth shortly.

Introduction

Payment by results is now a reality for most NHS bodies. Foundation trusts have been operating the system since April 2004 and NHS trusts, for elective care only, from April 2005. The intention is that all acute trusts will operate under payment by results fully from next April, although the full impact on funding will not be realised until 2008/09.

Of all the major changes facing the NHS at present, payment by results is arguably one of the most important. As well as providing incentives to stimulate productivity, it underpins the NHS modernisation agenda, facilitating patient choice and plurality of provision.

Under payment by results, providers of NHS services will be largely funded through a single rules-based system, where payments are directly related to the work they do. Acute hospital activity, classified according to healthcare resource groups (HRGs) will be

paid for at a national tariff. While the tariff will determine the price, PCTs and service providers will negotiate volumes, setting strict cost and volume contracts within the national framework. This approach is similar to payment models already used in many other countries, in Europe and beyond.

The Audit Commission's July 2004 report, *Introducing Payment by Results*, concluded that payment by results had considerable potential to improve services and efficiency, and provided greater fairness and transparency in funding. However, the financial incentives inherent in payment by results are strong, particularly for providers, and there will be serious consequences if the system does not work as intended.

Payment by results creates an unprecedented level of financial risk for both PCTs and trusts, and greater potential for financial instability across the NHS as a whole. It raises some critical financial management questions both nationally and locally.

Commissioners face:

- unstable demand, with limited ability to influence activity levels and a commitment to pay for acute activity at full price; and
- a strong provider-side incentive to increase activity.

Providers face:

- pressures to keep overall costs within the tariff, and to improve their productivity – those with costs that are currently above tariff face particular challenges; and
- the possibility of reduced activity as a result of commissioner demand management initiatives.

The risks are exacerbated by the pace of the implementation agenda, refinements to the tariff and overarching policy framework, and by concerns about the adequacy of NHS bodies' financial management arrangements and the quality of data underpinning payments.

Early experiences

Early experience under payment by results in 2004/05 reaffirms these risks. Our local work on the preparedness of NHS bodies to implement payment by results from April 2005 indicates that there are still areas in which arrangements are inadequate. These need to be addressed as a priority.

Payment by results:

- has brought greater clarity to financial arrangements, enabling NHS bodies to better plan and manage their business.

But....

- it is more complex, time-consuming and challenging to implement locally than NHS bodies expected;
- it exposes existing weaknesses in financial management, financial health and relationships across NHS bodies; and

- where there is inadequate preparation and a complex commissioning environment, this compounds the difficulties that NHS bodies have experienced.

Priority areas

Based on findings from the early implementers of payment by results, and examples of good practice, there are six key areas that boards should review. Four of these are common to all NHS bodies: organisational development, planning and reporting, partnerships, and contracts and monitoring. Demand management is particularly relevant for PCTs. Cost control and improvement is particularly relevant for trusts.

1. Organisational development

Trusts and PCTs need to be ‘fit for purpose’ in the new environment. This requires reviewing current structures (particularly finance and information functions) and ensuring that resource levels, processes and systems are sufficient. Early experience

shows that, regardless of their financial position, NHS bodies need to prioritise investment in their capacity to operate under payment by results. Early implementers have strengthened their analytical capacity and established closer links between information and finance. They highlight this as a particular success factor. At least one individual within the NHS body should understand the detail and mechanics of payment by results in depth. Trusts also need to have sufficient clinical coding capacity, as coding now has a direct impact on their income.

Payment by results will affect how patient services are provided and commissioned. It requires a change in organisational culture. Non-finance staff need to be aware of the implications of payment by results. Clinical and service managers, GPs (particularly under practice-based commissioning) and non-executive directors should all be engaged. Within trusts, greater ownership may be achieved through devolution of budgets to departmental level and beyond.

2. Planning and reporting

Payment by results tests financial planning, budgeting and reporting systems and the quality of the information and assumptions underpinning them. Reviewing, adapting and strengthening each area is essential. In particular, medium-term financial planning and forecasting needs to be much stronger in the new environment. Joint planning workshops across the health economy, open information sharing, and sharing analytical capacity are all useful ways that bodies can strengthen their planning and ensure that consistent assumptions are applied across the board.

In-year reporting arrangements covering activity and expenditure, which are essential for managing bodies' financial positions, should be reviewed and tested against the experience of early implementers. Where investment in new information systems is planned under Connecting for Health, trusts should assess the implications under payment by results of the likely disruption to

data flows and quality as patient data is migrated between systems, and plan accordingly. Failure to submit timely and accurate data can have serious financial consequences.

3. Partnerships

Evidence from early implementers shows that payment by results is testing relationships between acute trusts and PCTs, even in areas where relationships have been historically good. There are good reasons for this – PCTs and trusts face markedly different incentives, and where there is financial pressure within a health economy, payment by results has polarised interests and focused organisations' attention inwards.

Maintaining positive partnerships is crucial if payment by results is to work well and unproductive disputes (which were few in number 2004/05, but were nevertheless present) are to be minimised. Approaches that early implementers have used to maintain good partnerships include:

- focusing on building trust and maintaining transparency through open communication and information sharing;
- joint planning for the health economy based on realistic expectations and a recognition of each others incentives;
- developing a common understanding of clinical pathways; and
- in the case of foundation trust contracts, avoiding excessive reliance on the contract to the detriment of the relationship.

4. Contracts and monitoring

While only foundation trusts will have legal contracts in place, all trusts and PCTs are being encouraged to move towards a model contract-based agreement. Early experience shows that payment by results requires clarity and agreement on:

- the activity baseline, what it covers, and the classifications and coding practices to be applied;

- the business arrangements, particularly reporting arrangements and penalties, dispute resolution and monitoring processes; and
- risk management strategies (trigger points, readmissions targets, intra-PCT risk sharing arrangements for high-cost, high-volume services).

PCTs must have robust contract monitoring arrangements that focus on the appropriateness of payments and the accuracy of the underpinning data. The most advanced PCTs have robust systems to validate and analyse data, perform checks against patient records where there are concerns about data quality. They use utilisation reviews to check appropriateness of admissions and verify cost allocation between payment by results and non-payment by results services. They also have access to timely data and have engaged clinicians to validate the clinical pathways indicated by the data.

5. Demand management

Demand management (through referral management, service redesign and the development of alternative community-based services) is critical in limiting PCTs' financial exposure due to increasing acute activity.

The majority of PCTs have relevant demand management projects but some have been more successful – the Audit Commission's report on service redesign (*Quicker Treatment Closer to Home*) makes suggestions on how to do this well.

In developing demand management strategies, PCTs should:

- engage trusts (and trusts should engage with PCTs), to ensure there is a common understanding and vision;
- engage primary care clinicians, using practice-based commissioning to provide incentives;

- make realistic assumptions about the timing and extent of the impact on acute activity levels (for example, initiatives can often stimulate latent demand); and
- develop health economy-wide initiatives with SHAs.

6. Cost control and improvement

Cost control and cost improvement are vital for all trusts under payment by results. Even foundation trusts that are considered relatively efficient are finding that they need to focus on cost improvements under payment by results. Those that have costs above the tariff will face particular difficulties.

Trusts should ensure that their activity-based costing systems enable them to manage their costs in line with the national tariff and make sound decisions about investment and disinvestment in services and opportunities for improving productivity.

Questions for all NHS board members

Organisational development

- 1 Have we allocated sufficient time and resources and identified the skills required to implement and operate under payment by results?
- 2 Do members of staff at all levels, clinical and non-clinical, as well as non-executive directors, understand the implications of payment by results for the organisation and for their role?
- 3 Have we reviewed (and, where necessary, strengthened) the links between our finance and information functions?
- 4 Are we actively seeking to learn from early implementers of payment by results? Has this learning been shared with the board? Is this information being used in our planning for the payment by results roll-out?

- 5 What training do we still need to ensure a comprehensive understanding of the new environment?

Planning and reporting

- 6 Are we engaged in joint analysis and planning across the health economy and using this to underpin our own financial and operational planning?
- 7 How have we made and challenged the assumptions underpinning our short- and medium-term planning?
- 8 Have we reviewed our arrangements for reporting financial and activity information (on quantity and quality) internally and externally against the experiences and practices of the early implementers, and made any changes required?

Partnerships

- 9 What steps are we taking to maintain or develop strong partnerships in light of the early implementers' experiences?

Contracts and monitoring

- 10** Do contract parties have a clear understanding of reporting requirements, dispute resolution procedures and monitoring arrangements?
- 11** Do we have agreed baselines and a clear understanding of how activity will be counted and coded on a consistent basis with the baseline?
- 12** Have we thoroughly assessed the risks to the organisation under payment by results and are strategies for managing them built into our contracts and agreements? Are the risks reported to the board on a regular basis in a useful format?

Question for acute trust board members

Organisational development

- 13 Have we reviewed (and, if necessary, strengthened) our arrangements for clinical coding?

Planning and reporting

- 14 What proportion of our activity is coded as unclassified (u-codes) at the end of each reconciliation period? What are we doing to improve the timeliness and accuracy of our clinical coding?
- 15 Will we be investing in new information systems under Connecting for Health? Have we considered the implications of migrating data between systems for data quality, regular reporting and invoicing?

Contracts and monitoring

- 16** How are we providing assurance to PCTs on data quality and appropriateness of payments to support PCT monitoring under payment by results, and thereby minimise disputes?

Demand management

- 17** Are we engaged in demand management initiatives and aware of the implications for our organisation?

Cost control

- 18** What is our current reference cost position and how has it changed over time?
- 19** What improvements have we made since auditors last reviewed the accuracy of our costing and the accuracy and completeness of our activity data?

- 20 How do our own estimates of cost pressures compare with the tariff and what are the implications?
- 21 Do we understand our current cost structure? Where are local costs more or less than tariff and do we understand why?
- 22 What estimates have we made on the level of cost improvement/productivity gain required in the medium term? What steps are we taking to achieve this and are these sufficient?

Questions for PCT board members

Organisational development

23 Have we reviewed our analytical capacity to ensure it is sufficient to commission effectively under payment by results?

Partnerships

24 How can we work with other PCTs to improve the balance of power, increase capacity, transfer learning and skills and share the risks inherent in payment by results?

Contracts and monitoring

25 Have we reviewed our monitoring arrangements to ensure that they are sufficiently robust to provide us with assurance on the quality of data and appropriateness of payments?

- 26 Do we need to increase investment in our information systems or increase analytical resources to make better use of the available data? Or can we put shared arrangements in place with other PCTs?
- 27 Could we further strengthen our risk management arrangements through joint contracts or agreements with other PCTs?
- 28 Do we have formal arrangements in place to ensure that trust reporting is timely and that contingencies and penalties are in place in the event it is not?
- 29 How will we audit data quality, costs and appropriateness of admissions and treatment where concerns are raised and cannot be resolved through queries to the trust?
- 30 What steps are we taking to check the appropriateness of patient pathways implied in the data?

Demand management

- 31 Do we know our priority areas for limiting or reducing demand for hospital care? What is our strategy? What assumptions and data underpin this? Are we considering the quality of patient care as well as cost, in these proposals?
- 32 How successful have our existing demand management initiatives been?
- 33 How are we currently engaging GPs and other clinicians in initiatives and how can we improve this?
- 34 How are we going to ensure that the acute trusts support, and are involved in, our plans to redesign services?
- 35 What ideas and plans do GPs have for demand management and service redesign and how can we support them under practice-based commissioning?

Questions for SHAs

- 36 Have we undertaken a recent health economy wide review of the impact of payment by results on providers and commissioners?
- 37 How 'fit for purpose' are the health bodies in our economy to operate in the payment by results environment? Are they sufficiently prepared?
- 38 How are we helping those bodies that are less prepared to strengthen their arrangements?
- 39 Are we supporting joint planning and analysis across the health economy?
- 40 What else can we do to support demand management and service redesign across the health economy? For example, would it be helpful to adopt SHA-wide referral systems?

Contact your local auditor to discuss further the risks associated with the introduction of payment by results for your organisation.

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