



Health

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Payment by results

Key risks and questions to consider for trust and
PCT managers and non-executives

Introduction

Payment by results involves a major change to the funding of NHS providers. It is one of the most significant challenges facing the service, and will require higher standards of financial management in both primary care trusts (PCTs) and NHS trusts. The system offers major opportunities and incentives from which all can benefit. Getting it wrong however will mean financial and service difficulties.

This handbook provides a summary of the Audit Commission's full report on the introduction of payment by results, *Introducing Payment by Results: Getting the Balance Right for the NHS and Taxpayers*. It outlines the major risks associated with the new system, and highlights some key questions which board members should ask about their organisation's preparedness and capacity to successfully implement the new arrangements.

The system

The main aims of payment by results are to:

- support patient choice and encourage hospitals to respond to patient preferences;
- encourage commissioners to provide effective care in the most appropriate settings;
- reward hospitals fairly for the work they do;
- increase transparency of hospital funding; and
- impose a sharper budget discipline on hospitals.

The timetable for implementing payment by results is a challenging one. In 2003/04 PCTs introduced some cost and volume service level agreements, with more following in 2004/05, including all work commissioned from NHS foundation trusts. From 2005/06, the national tariff will apply to most activity in acute and specialist hospitals and almost all activity will be commissioned using cost and volume contracts. By 2008/09, trusts will need to have adjusted their financial arrangements to accommodate the tariff, and the new system will also apply to mental health trusts.

The critical elements of the system are:

- **Health Resource Groups (HRGs)** – a tool for classifying patient activity according to case mix and the resources used, to be used as the basis for measuring activity volumes under payment by results. There are about 500 HRGs. Similar classifications are used in many other countries.
- **Reference costs** – the average cost of providing a given HRG in each trust. Providers allocate their costs to each HRG according to a national manual.
- **National tariff** – the national (average) price for each HRG. There will be separate tariffs for elective and emergency care and providers will be compensated through national funding for unavoidable regional cost differences.
- **Cost and volume contracts** between PCTs and trusts which will reflect the actual work done. Increases or reductions in activity will be charged at full, not marginal, cost.

The risks

Payment by results offers major opportunities for driving improvement in the NHS, from which all can benefit. However, its aims are ambitious and, as with any major policy change, the new regime carries major risks, which if not managed could lead to financial instability, service difficulties and poorer outcomes for patients. PCTs, NHS trusts and foundation trusts alike will face significant challenges as they work to implement the necessary changes, particularly with financial management, data quality and commissioning.

In the Commission's view, the main risks lie with PCTs who will be committed to pay for all work done at full cost but with uncertain demand. There are clear parallels with prescribing expenditure but this represents only some 15 per cent of PCT expenditure. Secondary care accounts for over 50 per cent of PCT expenditure. Accurately forecasting and monitoring demand and positively influencing it through innovative service design, and working closely with and incentivising clinicians, will be critical tasks if financial stability is to be maintained.

Trusts too face risks. Costs will need to be kept within tariff income. The national tariff will include a national allowance for NHS cost pressures. Accurately forecasting income will be important. Those trusts with costs

that are on average above the national tariff will need rigorous cost improvement programmes. Conversely, for trusts with below average costs who may receive some £500 million cumulatively in additional funds, there will need to be real and demonstrable increases in the quality of patient care if value for money is to be achieved. The tariff may also not fairly meet the costs of some more specialised work, and the Department of Health (DH) is considering options to address this.

Locally and nationally, the success of payment by results rests on accurate data. Patient activity needs to be properly recorded to ensure that PCTs are fairly charged for the work done and that income is not lost. Costs must be accurately allocated as not all activity will be covered by the tariff. The Audit Commission's audit of HRGs and reference costs in all trusts and PCTs in the autumn of 2003/04 showed that in the majority of trusts, there was a discrepancy of more than 5 per cent between the reference costs and the accounts and between different data on activity from the same organisation. Patient activity was a particular weakness with 14 per cent of trusts having 3 per cent or more of their activity uncoded which under payment by results would mean no payment.

And for both PCTs and trusts, strong clinical engagement in the implementation of payment by results, the risks it poses and the changes which need to be made will be essential, as will the effective development of partnerships and trust.

There is a clear risk that the historically strong financial control of the NHS may be undermined by the powerful incentives that are inherent in the new regime. The DH has a vital role to play in ensuring that the payment by results framework is continually refined and evaluated and providing a supportive environment for implementation and capacity building. And drawing on the experience of other countries with similar systems, an effective monitoring and audit system needs to be in place to minimise manipulation or 'gaming' of the system and maximise the benefits.

The following questions are the ones we believe all Board members should ask about their organisation.

Questions for PCTs

The context

- 1 What is the reference cost position of our main providers compared with the average?
- 2 What is the overall position in the health economy – are we ‘overtrading’ with higher levels of activity and expenditure than is expected or can be afforded?
- 3 What is the strategy for activity and expenditure in the health economy and how does it relate to our own?
- 4 What baselines are we setting for elective and non-elective activity?

Commissioning

- 5 What changes are we planning for?
- 6 How does this compare with local and national historic trends?
- 7 What extra volume of activity should we plan for in order to meet waiting times targets?

- 8 How are 1, 2, 3 and 4 being reflected in budgets?
- 9 What risk analysis have we undertaken on possible changes in activity? What are the financial implications?
- 10 What is our strategy to limit (or reduce demand) for hospital care?
- 11 What analysis of data underpins this?
- 12 How are we resourcing this strategy – managerially and in the field?
- 13 What discussion/engagement is there with GPs?
- 14 What incentive/budgetary systems do we have to encourage frontline clinicians to manage demand?
- 15 What lessons have we drawn from the Audit Commission’s report on service redesign (*Quicker Treatment Closer to Home*) and other best practice?
- 16 What level of risk are we carrying with our contracts/SLAs with providers and what are the financial implications?
- 17 What are the arrangements for pooling risks, including on specialist services?
- 18 What are our arrangements for monitoring trust activity? And validating it?

- 19 Will our information systems provide the necessary up-to-date information on activity and spend so we can monitor contracts effectively and take any necessary action?
- 20 Do we have the necessary contract management systems and capacity in place?

Providing

- 21 What are the auditors' findings on a) the accuracy of our costing and b) the accuracy and completeness of our activity data?
- 22 What level of risk does this represent to the PCT?
- 23 What action are we taking as a result?

Questions for trusts

The context

- 1 What is our trust's reference cost position compared with the average?
- 2 What is the overall position in the health economy – are we 'overtrading' with higher levels of activity and expenditure than is expected or can be afforded?
- 3 What is the strategy for activity and expenditure in the health economy?
- 4 What is the implication for our capital programme?
- 5 How will our specialist services be funded?

Information on costs and activity

- 6 What are the auditors' findings on a) the accuracy of our costing and b) the accuracy and completeness of our activity data?
- 7 What level of risk does this represent? What action is being taken as a result?

- 8 What financial risk to the trust does this represent?
- 9 What proportion of our cases were coded unclassified? What action is being taken?
- 10 Are there recruitment turnover issues over our clinical coders. What is their training programme, how closely do they work with clinicians?
- 11 Have we achieved level 4 costing and if not what is our programme for getting there? (Level 4 costing gives detailed costs within specialties).
- 12 What further independent review of our activity recording and costing is expected/planned?
- 13 Will our information systems provide the necessary up to date information on activity and expenditure?
- 14 Are our financial management systems and processes adequate? How do they need to be improved?

For trusts above average reference costs

- 15 What is our strategy for addressing this?
- 16 What level of cost reduction does this imply?
- 17 What extra efficiency gains will we need to make? How will we achieve this?
- 18 How does this compare with our past track record?

For trusts below average reference costs

- 19 What are the implications of being paid at the national tariff?
- 20 How should extra funds be invested to deliver real and demonstrable improvements in patient care? How will we measure this?

Planning for 2005/06

- 21 What level of risk are we carrying in our contracts/SLAs?
- 22 How do our own estimates of cost pressures compare with those in the tariff and what are the implications?

- 23 What risk analysis have we done on the possible changes in activity levels (positive and negative) for elective and emergency care?

Engaging staff

- 24 What is our programme of engaging staff in the implications of payment by results and patient choice?

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

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