

Health

National report

 **audit**
commission



Introducing payment by results

Getting the balance right for the NHS and taxpayers

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| | |
|--|-----------|
| Summary and recommendations | 2 |
| 1 Introduction | 9 |
| 2 What payment by results means for the NHS | 12 |
| 3 The aims of payment by results | 16 |
| 4 The risks: the underpinning data | 20 |
| 5 The risks: financial management issues | 33 |
| 6 Conclusions | 45 |
| References | 46 |

The report also contains a centre pull-out section of questions for Board Directors

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Summary and recommendations

What is payment by results?

Payment by results involves a complete change to NHS funding. It is one of the most significant challenges facing the service and will require higher standards of financial management in primary care trusts, NHS trusts and foundation trusts. The system offers major opportunities and incentives that will benefit everyone. But it also carries major risks, which if not well managed will lead to financial instability and service difficulties.

Payment by results aims to support NHS modernisation by paying hospitals for the work they do, rewarding efficiency and quality. It does this by paying a nationally set price or tariff for each procedure, classified by Healthcare Resource Group (HRG), based on an average of all hospital costs for that procedure (reference costs). Separate tariffs will exist for elective and emergency care and, at least initially, some more specialised work will not be included. No local price negotiations will take place for work covered by the tariff (except where service changes result in significant efficiency gains). Unavoidable regional cost differences will be funded nationally. All contracts between primary care trusts (PCTs) and trusts will be 'cost and volume' with payment linked directly to the actual work done. Increases or reductions in activity will be charged at full rather than marginal cost.

The approach is similar to long-standing funding systems in other countries, including the USA, Canada and Australia. Indeed, the NHS is unusual in not having such a system for funding at least part of the costs of hospital care. The main aims of the scheme are to:

- support patient choice and encourage hospitals to respond to patient preferences;
- encourage commissioners to provide effective care in the most appropriate settings;
- fairly reward hospitals for the work they do;
- increase transparency of hospital funding; and
- impose a sharper budget discipline on hospitals, making sure that they keep costs within the national tariff and are responsible for any deficits.

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.

Payment by results is not a project with an end point. It is part of a dynamic and emerging set of changes that will have implications for many years. These changes include the introduction of national standards and inspection, patient choice, new contracts for NHS staff, diversification of the provider side through the introduction of NHS foundation trusts and private providers and the devolution of the main responsibility for commissioning services, and the money to go with it, to PCTs. These changes aim to produce a service which, while remaining fair to all, is more responsive to local needs and individual patients. NHS organisations will be more accountable locally, less reliant on central intervention and top-down performance management and more subject to checks and balances within a system, subject to effective external regulation.

The risks

There are significant transitional and longer-term risks associated with moving to the new arrangements. These risks involve both the quality of data on which the new system will be based and the new, powerful financial incentives that will apply.

The underpinning data

Payment by results requires good-quality data on costs and clinical activity to be available. The Department of Health (DH) needs reliable cost and activity data in order to set a fair, accurate tariff based on trust HRG and reference cost information. Trusts need good quality activity data for billing purposes and accurate knowledge of their costs. PCTs will be making payments based on information from trusts, and so need to know that it is correct and fair in terms of activity volume and case-mix. There are therefore strong incentives for NHS organisations to improve their data quality.

Yet in a review at the end of 2003/04, auditors found inaccuracies of 5 per cent or more in most trusts' reference cost submissions, with PCTs and mental health trusts having the highest level of inaccuracy. Because the tariff will not be applied to these organisations as providers for another four years, there is time to address these weaknesses. The level of inaccuracy in data from acute and specialist trusts is more concerning.

Auditors found some inaccuracies in costing information, but the main weakness was in activity data. At a significant proportion of trusts, more than 3 per cent of activity was uncoded, and there were other discrepancies. This represents a risk for trusts – in future, uncoded work will not be paid for. Many of the problems arose from outdated Patient Administration Systems, lack of clinical involvement and weaknesses in the recruitment, training and leadership of clinical coding staff.

Because payment is directly linked to work done, payment by results brings strong financial incentives for trusts. In future, admitting a patient for non-elective care will carry a payment, removing the financial disincentive to admit when costs are incurred

but no payment received. At the margin, this may alter admissions thresholds and procedures. It is important that payment rates are set at levels that do not encourage unnecessary admissions.

Payment will also be linked to the HRG to which the patient is assigned, so coding a patient to a more complex HRG may automatically generate a higher payment. Other differences in recording and coding activity could also generate higher payments, and changes in admission rates and ‘upcoding’ can generate significant financial pressures. Some PCTs have already experienced this. Other countries with similar financial arrangements have introduced stringent checks and penalties to make sure that providers’ coding is accurate and fair.

The data is already reliable enough to create a robust national tariff for most procedures, and it will continue to improve. But locally, the recording and coding of activity is less reliable than would be expected for payment purposes – both for provider and commissioner. What is more, there are currently no obvious safeguards to prevent adjustments in recording activity that are not the result of genuine clinical changes.

Financial management

PCTs face real risks. In the Commission’s view, this is the main area of risk in the implementation of payment by results. Essentially, the scheme imposes a commitment on PCTs to pay for work done at a nationally set tariff. But the level of demand for both elective and non-elective care is uncertain. Financial pressures arising from additional activity will also increase because PCTs will have to pay at full, rather than marginal costs, as they do currently. Block contracts, where funding is not adjusted for activity changes, and local price negotiations centred on affordability have been the two main ways in which PCTs have managed financial risk in the acute sector. These approaches will not be available in the future. When other funding changes are also included, PCTs will in future have no control over prices (except where service changes result in significant reductions in length of stay) and only weak influence over volumes for some 75 per cent of their funds.

How PCTs tackle these issues will be critical to financial stability, the delivery of targets and overall service improvement. Clinical engagement, effective partnerships, better knowledge and control over demand, the development of alternatives to hospital admission (which the system should encourage and facilitate), realistic budgeting and forecasting that is based on accurate and timely information will all be critical. However, recent Audit Commission reports *Achieving First-class Financial Management in the NHS*, *Quicker Treatment Closer to Home* on service redesign and *Transforming Primary Care* have all highlighted significant PCT weaknesses in financial management, information, redesigning services and engaging frontline clinicians (**Refs. 1, 2 and 3**). In addition to the challenges this poses for PCTs themselves, this is also the major challenge for the DH and strategic health authorities (SHAs).

For NHS trusts, including foundation trusts, the main financial risks lie in making sure that overall their costs are covered by the tariff payments – recognising that most trusts will need to manage the fact that they have some services above reference cost and some below. To manage this effectively, trusts will need better cost information and financial management systems.

The base data for setting the tariff will always be two years in arrears (for example the 2004/05 tariff is based on 2002/03 reference costs data) and must be adjusted for estimates of NHS cost pressures. These include qualitative gain, medical advances, the impact of National Institute for Clinical Excellence (NICE) guidance and inflation. The accuracy and transparency of this uplift, as well as the way in which the tariff takes into account, for example, more specialist work or differential capital costs, will be critical to its success.

Some trusts will also face pressures as they seek to reduce their costs in line with the national tariff, or if the volume of their activity reduces. Fifteen trusts will need to make savings of £10 million or more to bring them into line with the national tariff – in addition to any other efficiency gains required. Some may find this challenging, particularly as savings will be required across the whole of a trust's cost base, including fixed costs.

Finally, payment by results brings risks for the taxpayer; in particular, whether the tariff will lead to a more efficient NHS overall. Trusts with below average costs will get around £500 million extra in total (individual trusts will receive up to perhaps £30 million extra) because of the higher national tariff, for no additional work. To achieve value for money in this scenario, there will need to be real and demonstrable increases in the quality of services for patients. PCT allocations will be adjusted to take account of the change in prices so that equity is not affected, although some will find that the extra money they expected to receive to get them closer to a fair share of national resources will have to be spent in the acute sector rather than elsewhere because of higher tariff prices.

By itself, the tariff will not necessarily bring about greater efficiency unless the DH specifically sets the tariff at less than expected average costs. The only incentive for trusts to cut costs will be the foundation trust capital regime, which relies on trusts generating cash to finance borrowing. Nor will the tariff itself bring about improvements in quality. It will, however, sharpen questions about the affordability of levels of service and provision in some localities and about whether significant changes of approach are necessary.

There is also the risk that the historically strong financial control of the NHS may be reduced by the powerful dynamics introduced by this system. Wider experience with cash-limited funding that encourages providers to do more and be paid accordingly has shown that these arrangements, in the absence of local budget ceilings, can become unstable, with taxpayers facing either cuts in services or big increases in expenditure.

Perhaps more important than the technical processes of payment by results will be the behaviours of the participating organisations, in terms of how they seek to use the system. A high degree of co-operation and trust will be needed between trusts and PCTs in order for them to manage and avoid the risks set out above. This is preferable (and significantly cheaper) than heavy monitoring, regulation and arbitration systems. However, it can take considerable time and effort to achieve, and represents a significant challenge for PCTs and trusts alike.

Conclusions

Overall, payment by results has considerable potential to drive improvement in services, offering better incentives for both trusts and PCTs to provide efficient, effective and appropriate care than currently exist. It also offers greater fairness and transparency in funding.

But payment by results also carries risks and these must be managed effectively both nationally and locally. Its impact on patient care and on trust and PCT management arrangements will be significant – it therefore poses some critical financial management questions at both local and national level. Careful overall assessment of the risks and how successfully they are being managed, as well as the impact of the scheme on the service and on patient care, will be essential. The DH must continue to assess and refine the system. It is already doing this and recently announced that there will be a longer transition period, separate consideration of some specialist work and adjustments to the tariff to reflect early practical experience and concerns, all of which will help to smooth the scheme's introduction. But the major risks still exist.

The Audit Commission's statutory remit to carry out national studies of financial management in the NHS gives us an important and unique role in assessing how the NHS is managing the risks associated with payment by results, and getting the maximum benefit from the scheme and from the other financial changes being introduced. We will work with others to do this, holding an initial seminar on payment by results to see how experience can best be distilled and communicated. Through our appointed auditors, the Commission will also assist local audits of trust data and help individual trusts and PCTs to better manage their risks.

Recommendations

The DH should:

- Make sure that trust HRGs and reference cost data are regularly and independently reviewed.
- Put in place an effective system for auditing and scrutinising trust cost and activity data, drawing on international experience.
- Make sure that the tariff is set in an objective and transparent way that can be independently verified.
- Consider further the implications of payment by results for current asset bases and future capital expenditure. These issues have not yet been properly assessed.
- Implement a comprehensive training and support programme for PCTs and trusts.
- Continually assess the effects of the new arrangements during the transitional period and be prepared to make changes accordingly.

NHS trusts should:

- Urgently invest in and develop their ability to accurately record and code patient activity.
- Review their financial management and information systems to ensure that they equip them to manage effectively in the new environment.
- Secure greater clinical involvement in costing and coding, making sure that clinicians and coders work together, not in isolation.
- Think carefully before using individual speciality reference costs as the basis for decisions about savings or investments. These can be affected as much, or more, by weaknesses in costing or activity data as by differences in efficiency.
- All board members should ask themselves and their organisations the questions set out in the centre pull-out.

PCTs should:

- Actively monitor trust activity information, rigorously scrutinising and challenging apparent changes in activity or coding.
- Along with mental health trusts, start improving their costing and activity information now. The Commission made similar recommendations in its report, *Information and Data Quality in the NHS* (March 2004) (Ref. 4).
- Set realistic baselines and targets for hospital activity, with the help of frontline clinicians, recognising that poor planning and forecasting will lead directly to significant budgetary pressures.
- Get better information on GP practices, hospital admissions and service costs, in line with best practice set out in *Information and Data Quality in the NHS* (Ref. 4), *Quicker Treatment Closer to Home* (Ref. 2) and *Transforming Primary Care* (Ref. 3).
- Build their capacity on contract design, negotiation and financial management, working with the DH and SHAs to identify development and support needs to facilitate this.
- Agree contracts that include appropriate risk sharing between trusts and the PCT.
- Ensure that they have robust communication and liaison arrangements with trusts to enable them to manage their new relationships effectively.
- All board members should ask themselves and their organisations the questions set out in the centre pull-out.

SHAs should:

- Work with the DH to ensure that PCTs and trusts are developing the necessary capacity to implement payment by results effectively, supporting training and other capacity building initiatives, particularly in financial management and commissioning.
- Support the DH, the Audit Commission and others in disseminating good practice to maximise the benefits that are achieved through payment by results.

1

Introduction

- 1 In October 2002, the DH published *Reforming NHS Financial Flows*, outlining plans to introduce payment by results – a new funding system for work done by the NHS in England (**Ref. 5**). At the heart of the proposals lay a move for hospitals to charge for all work according to nationally set prices that reflected the complexity of individual cases on the basis of HRGs. PCTs would contract at these prices on the basis of actual work delivered.
- 2 This is a shift away from the current system whereby block contracts for services are often negotiated that do not reflect actual volumes of work done and prices for activity are agreed locally. **Box A** sets out the key elements of payment by results.

Box A

Payment by results: the key elements

HRGs

- Tool designed to measure healthcare activity in a way that takes account of the mix and complexity of patients treated, based on their diagnosis.
- Existing set of HRGs will be used as the basis of activity units for which payment will be made.

National tariff for each HRG

- Based on average reference costs.
- Separate tariffs for elective and emergency patients.
- Tariff will be paid according to actual work carried out.
- Trusts will be compensated through national funding for unavoidable regional cost variations.

Baseline activity

The current agreed level of work carried out by providers for which PCTs will pay.

Adjustments (up or down) from the agreed level will bring matching funding adjustments at full cost, subject to agreed risk-sharing arrangements.

Finished consultant episodes (FCEs)

- HRGs will be counted using FCEs – the standard form of counting patient activity in the NHS (however, see ‘spells’ below).

Spells

- Providers will be paid for a ‘spell’ of care that may include a number of FCEs.
- An algorithm will be used to convert FCEs to spells.

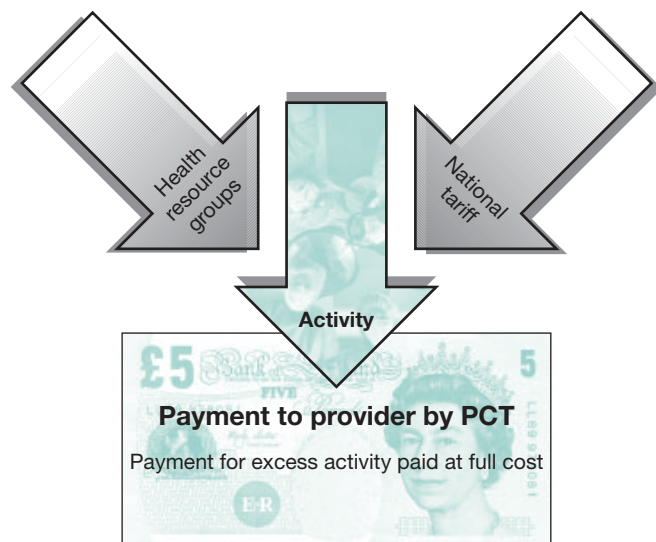
Source: Audit Commission

- 3 Exhibit 1 shows how these elements combine within the payment by results system. This shows a much closer relationship between the work carried out by providers and the money paid by PCTs.

Exhibit 1

Key elements of the payment by results system

Payment by results allows for a much closer relationship between the work carried out by providers and the money paid by PCTs.



Source: Audit Commission

- 4 Following a formal consultation period, the new system is now being implemented in phases. **Box B** shows the key points in the timetable.

Box B

Timetable for implementation

Implementation of payment by results will be phased to 2008/09.

| 2003/04 | 2004/05 | 2005/06 | 2008/09 |
|--|--|--|---|
| PCTs asked to commission limited number of procedures according to HRGs. | PCTs to use new arrangements to commission most work from NHS foundation trusts. | All acute and specialist trusts move onto the new system. Transitional phase to smooth potential financial instability. | Transitional phase complete. System now includes mental health and ambulance trusts. |

Source: Audit Commission

- 5 The implementation timetable allows for a four-year transition period, in recognition of the significant financial consequences for trusts and PCTs and the need for the NHS to adjust its finances to the new arrangements. The transition is expected to be complete by 2008/09, by which time mental health and ambulance services will also be funded in the same way.
- 6 In time all NHS work, including that carried out by the private sector, will be paid for according to the tariff. Trusts whose prices are currently above the national tariff will need to make savings. Those whose costs are below the national tariff will benefit from the (higher) national price. PCT funding will be adjusted to take account of the price change.
- 7 *Reforming NHS Financial Flows* sets out the aims of payment by results very clearly and states how the DH believes the NHS and its patients will benefit (**Ref. 5**). In the original consultation on this document, a number of risks were highlighted by NHS organisations, professional groups and others. The Audit Commission recognises that, as with any major policy change, key risks will have to be addressed both nationally and locally if the advantages of the new funding arrangements are to be achieved.
- 8 Drawing on learning from other countries that have introduced payment by results, academic research, examples from other sectors and our own work with PCTs and NHS trusts, this report is the first in a series that will chart the implementation of payment by results. It aims to prompt further debate about the benefits of the system and how, if necessary, it can be modified in order to ensure that its benefits can be realised.
- 9 The report goes on to suggest what PCTs, NHS trusts, NHS foundation trusts, SHAs, the DH and regulatory bodies, including the Audit Commission, can do to minimise the risks, helping to ensure that we get the balance right and enable payment by results to deliver on its considerable potential. We will follow up this work by holding a national seminar on the issues posed, assessing how early lessons can be disseminated for the start of the 2005/06 financial year.

2

What payment by results means for the NHS

- 10 Payment by results represents a radical change to the way that funds move through the NHS in England.
- 11 It is being introduced now to support the wider modernisation programme set out in the NHS Plan, which also includes better health needs assessment, new contracts for NHS staff, more patient-responsive services with faster access and higher quality (**Ref. 6**). It is also part of a move to devolve responsibility within the NHS, seen most clearly with the development of:
 - national standards, regulation and inspection;
 - Patient Choice;
 - diversification of the provider side (NHS foundation trusts and private sector providers); and
 - allocating 75 per cent of the NHS budget to PCTs and relying on the responsiveness of their commissioning arrangements to local needs.
- 12 The changes are intended to make NHS organisations more accountable locally and less reliant on central intervention, operating in an environment that is less subject to top-down performance management and more to checks and balances within a system subject to effective external regulation.

The proposals

- 13 A major aim of the change is to move away from the current system of block contracts, where prices are negotiated locally and providers are often paid a set amount, regardless of the amount of work they do. This will be replaced by a system in which PCTs commission the exact volume of activity they require, from a range of providers, at standard national prices adjusted for case mix. Legitimate regional variations in wages or other costs will be funded centrally. NHS funding will flow to the providers that patients have chosen, including where PCTs or others carry out daycase or outpatient activity themselves. Hospitals should be reimbursed fairly for all the work that they do, in a transparent manner. The costs of training and research will continue to be separately funded.
- 14 The key principles of payment by results are:
 - a standard national tariff;
 - tariff prices to reflect casemix; and
 - cost and volume commissioning.

A standard national tariff

- 15 The national tariff will be based on average reference costs – the most comprehensive estimate of costs for service provision currently available. There will be separate tariffs for elective and emergency patients, but not for different locations of care.
- 16 Prices in the national tariff will be adjusted for:
- cost pressures (the base data from which the tariff is derived will always be up to two years in arrears);
 - long stay outliers, or exceptional cases;
 - critical care costs; and
 - specialist work.

Within strict parameters, locally agreed variations to the tariff may be permitted where service changes result in significant reductions in the local length of stay, or where costs of new technology are not reflected in the tariff.

- 17 Over time, the tariff will be reviewed and become increasingly sophisticated so that it covers a wider range of work. There will also be greater clarity on what individual HRGs cover and better matching of costs to actual work done.

Reference costs and HRGs

- 18 NHS trusts have for some years identified the costs of individual procedures using a set method of allocating their expenditure. These ‘reference costs’ provide comparable information across all hospitals and procedures from which national averages can be derived. They now apply to PCTs as well. They form the basis for calculating the national tariff.
- 19 Casemix is a central feature of reference costs and it will also be central to payment by results. Casemix classification was first pioneered in the USA 20 years ago, through the development of Diagnostic Related Groups (DRGs). These are tools designed to measure and classify healthcare activity in a way that takes account of the mix and complexity of patients treated, based on their diagnosis, the procedures carried out and the care and resources involved. In addition to measuring casemix for management and research purposes, the DRG classification has been used increasingly as a basis for payment by countries around the world; beginning with the USA in the 1980s and followed by Canada, Australia, Singapore, New Zealand and France, among others.
- 20 The NHS equivalent of DRGs is the HRG classification. In England, some areas of the NHS are already using HRGs as a basis for adjusting payments to individual hospitals. Under payment by results, this will be extended to cover all hospital activity and made compulsory.

- 21 The existing set of HRGs will be used as the basis of activity units, as the DH believes them to be the most developed, comprehensive tools in England for classifying health services. Like reference costs, HRGs are currently counted using FCEs – the standard form of counting patient activity in the NHS. For the tariff, however, HRGs and individual FCEs will be linked to reflect a patient's spell in hospital, which may account for more than one FCE if, for example, a patient is transferred between consultants. This has implications for the calculation of the tariff. These are explored in Chapter 5.
- 22 HRGs will be reviewed regularly to ensure that they remain meaningful, manageable and accurate.

Cost and volume commissioning

- 23 Most agreements between commissioners and providers are still relatively crude, with commissioners paying a set amount for a block of activity based on what has been provided in the past. But some service level agreements (SLAs) do specify the exact volume and cost of services to be provided.
- 24 Under payment by results all service agreements will be like this, setting down the exact amount of work to be done (based on HRGs) and the exact price to be paid (based on the standard national tariff). They will also cover arrangements for risk sharing between the commissioner and the provider, for example, when caring for patients who stay in hospital substantially longer than average. The contracting arrangements between PCTs and hospitals are important – a continuation of block contracts would, for example, nullify the intentions of introducing payment by results as there would no longer be a close alignment between payment at a standard rate and the work actually done.

The timetable

- 25 As noted in the previous section (summarised in Box B) the implementation timetable is phased to 2008/09.
- 26 In 2003/04, the DH required that cost and volume SLAs were set for six specialities: ophthalmology, cardiothoracic surgery, ear, nose and throat (ENT), trauma and orthopaedics, general surgery and urology. Fifteen HRGs were identified for individual commissioning and monitoring, and PCTs and trusts were encouraged to manage referral and admission thresholds and priorities for admitting patients.
- 27 In 2004/05, the number of HRGs covered by the scheme will be extended to cover 48 HRGs, with cost and volume SLAs adjusted for all surgical specialities. In addition, the DH invited expressions of interest from PCTs and trusts to act as pilots in applying the national tariff. PCTs will commission all work from NHS foundation trusts using legally binding cost and volume contracts paid for at the nationally set tariff. Similar arrangements will apply to applicants for NHS trust status in July.

- 28 In 2005/06, the national tariff will be applied to all activity for which HRGs or other casemix measures are available. Almost all activity will be commissioned using comprehensive cost and volume SLAs (contracts for NHS foundation trusts).
- 29 From 2005/06 (2004/05 for NHS foundation trusts) onwards, the plan is to move gradually from the price charged currently by the provider to the national tariff, with the tariff being fully operational in 2008/09. This provides a transitional period to enable the effect of the difference between local prices and the nationally set tariff to be absorbed.

3

The aims of payment by results

- 30 The DH has set out some clear, specific aims for payment by results. We have reviewed evidence from a range of sources, including our own work with PCTs and trusts. As a result we have identified a series of issues that key stakeholders, including the DH, will need to address if the scheme is to succeed.

Benefits to patients

Box C

Potential benefits to patients

Emergency patients

- Better-quality services and less delay as capacity adjusts to meet demand.
- Greater investment in ‘patient pathways’ approach to ensure appropriate care settings – for example, patients not in hospital for longer than necessary.

Elective patients

- Shorter waiting times and more choice on the setting for treatment, as full cost funding made available for activity.
- Maximum use of day surgery by providers.
- Better preventative monitoring of chronic conditions to avoid unnecessary admissions.

Source: Audit Commission

- 31 The benefits to patients that can be anticipated from payment by results are a combination of direct, fairly immediate benefits and those that are more general and will take slightly longer to accrue. These benefits will be slightly different for different groups of patients, although all patients stand to benefit from improvements in their care and outcomes, if the system is managed well. **Box C** sets out some of the likely benefits. Some will need to be brought about through a combination of measures, not simply through payment by results – for example, through the introduction of patient choice. The way in which funding incentives and other policy changes add to a coherent whole is critical for the benefits to be fully realised.
- 32 The DH expects the most direct benefits to patients to be derived from the expansion of patient choice in elective care, which this new system will support. Patients will be able to choose where to be treated, without funding being a factor, and providers will be funded for the actual work they do. This provides positive incentives for providers and should better match capacity to demand.
- 33 Early evidence from pilot schemes suggests that the actual shift of activity between providers is likely to be small even for acute inpatient procedures. However, the fact that patients can and will choose alternative providers, and that funding will follow these choices is likely to increase pressure for trusts to be more responsive to patients’ needs in terms of access and quality.
- 34 Wider benefits to patients, for example, through the provision of alternative forms of care outside hospitals, encouraged by the positive incentives in the system, will take longer to accrue but will be no less significant. However, deriving these benefits, particularly for patients with chronic diseases, where there may be a greater incentive for trusts to hospitalise in the new environment, will depend upon sophisticated commissioning by PCTs.
- 35 For many PCTs this will present a major challenge. Our previous work suggests that capacity within some, perhaps many, PCTs is inadequate to meet the commissioning and attendant financial management challenges (**Ref. 1**).

Box D**Potential disadvantages to patients if perverse incentives are not avoided**

- Variations in quality and access are exaggerated by trusts being unable to cut costs and maintain services or by PCTs that are unable to manage demand.
- Patients may not be able to choose to be treated at high reference cost sites.
- Patients are more likely to be admitted as they 'attract' a payment; with no incentive for trusts to work to keep patients out of hospital.
- Care is led by the financial incentives inherent in the tariff, rather than optimal clinical care, which may result in poorer outcomes if not carefully monitored.

Source: Audit Commission

36 This means that although there are undoubted potential benefits from payment by results, they could initially be realised unevenly between sectors and geographical areas, or in some cases never arrive, thereby exaggerating regional differences in the approach to care. The potential will only be realised if all concerned address the real issue of commissioning and financial management capacity in PCTs. The major challenge for the DH and SHAs is to ensure that PCTs have the necessary capacity to do the job demanded of them and to make the most of the opportunities offered by the new arrangements.

37 And, unless carefully managed, the powerful incentives and financial pressures in the system could lead to perverse changes. **Box D** sets out potential disadvantages for patients if these perverse incentives are not avoided.

Introducing fairness and transparency

38 The DH want the payment by results system to promote improved fairness and transparency in the funding provided for services. All parties will know the prices charged and there will be clear contracts. Currently, trust prices can vary for individual PCTs, they can be inconsistent and are rarely published. SLAs can also be obscure.

39 Costs can vary between geographical areas. The DH plans to use the Market Forces Factor (MFF), which is currently used for adjusting PCT allocations, as the basis for funding providers for unavoidable regional cost variations. Providers will be centrally funded to meet these costs. This will give transparency, but it will also mean less flexibility at the regional level.

Rewarding efficiency and quality

40 The DH anticipates that one of the key benefits of this system, when allied with the NHS foundation trust capital regime, which enables trusts to keep savings, is that it will provide incentives to reward the most efficient providers. It will allow PCTs to focus on how best to deliver services in the course of local negotiations instead of having to concentrate on price and, for whatever reason, support local hospitals financially.

41 We recognise the potential of payment by results to deliver these benefits when allied to other changes. However, our work suggests that implementing the system by making the tariff 100 per cent of cost may have the effect of initially exaggerating rather than reducing variations in quality by amplifying the deficits of those trusts with existing problems.

42 Also, the tariff itself will not reward quality. It simply rewards the work that is done. And there is no clear link between accepted good clinical practice, the content of the individual HRGs and the price being paid. A much more sophisticated tariff system would be required to produce such links. And, although patients may increasingly

choose hospitals for elective care on the basis of their quality, the information available about this, other than on waiting times, is sparse.

- 43 There is a further question as to whether the application of the average reference cost to the tariff will mean that trusts tend to drift to the average, encouraging mediocrity rather than greater efficiency and that the incentive to reinvest surpluses is either insufficient to encourage greater efficiency or is not reflected in reduced costs. One possibility is that the tariff may need to be set at lower than the average costs in order to encourage efficiency gains.
- 44 Trusts will also question whether they should continue to provide services for which their reference costs are comparably high, and whether they could do more work in specialties where reference costs are comparably low. Whether this will lead to real changes in services is debatable, but it highlights the importance of monitoring the real impact on services created by the incentives in the system, as well as the effects on quality and efficiency.

Encouraging better management of patients in the community

- 45 PCTs will have strong incentives to reduce or limit the number of patients requiring hospital care by providing better services in the community and, in particular, ensuring that patients with chronic diseases who are at high risk of being admitted to hospital receive more effective preventive care. This is a very important, and often understated incentive in the arrangements, which are often regarded as mainly supporting patient choice in elective care. There are, however, also greater incentives for trusts to hospitalise chronic disease patients, which PCTs will need to manage. To realise the benefits and take advantage of the incentives, PCTs need to have better information, closer engagement with primary care clinicians and greater skill in redesigning services, as outlined in our reports *Quicker Treatment Closer to Home* and *Transforming Primary Care* (Refs. 2 and 3).

Conclusion

- 46 In conclusion, the aims of payment by results are ambitious. The scheme promises to deliver fair funding to hospitals and other providers for the work that they do and it provides powerful incentives for cost control and possibly greater efficiency from trusts and for better management of care by PCTs. Delivering on these promises would mean significant benefits for all NHS stakeholders, not least patients.
- 47 However, in order for the aims to be met, the risks associated with the introduction of the tariff and the need for more sophisticated commissioning of services will need to be addressed effectively both nationally and locally. Many of these risks are inherent in the introduction of any such payment system and there is substantial international

experience on which to draw in implementing the changes. Some risks, however, derive from the particular circumstances of the NHS. For example, change has been easier where hospitals are already well used to billing a significant proportion of their work on a cost per case basis because they care for a mix of private and publicly funded patients. And some risks relate to the pace of change and the radical nature of the changes proposed. Some also relate to the design of the tariff and the overall policy framework and the way in which this can drive clinical care positively or negatively. There is always a danger of reducing the benefits of such a change through an overly complex framework which can cloud incentives. The next two chapters explore the significant risks associated with the new arrangements, focusing on two priority areas which we are well placed to comment on: data quality and financial management. These need to be urgently acknowledged and addressed by PCTs, trusts, SHAs and the DH if implementation is to be successful.

4

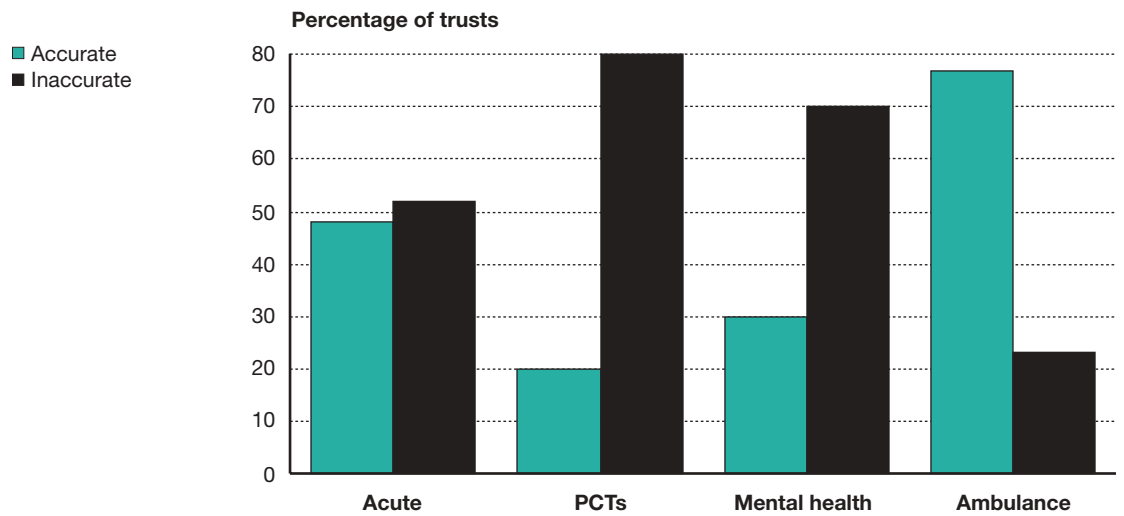
The risks: the underpinning data

- 48 Payment by results fundamentally rests on good-quality data about costs and clinical activity being available. For the DH, good-quality cost and activity data is essential in order to produce a fair and accurate tariff that relies on individual trust HRG and reference cost data. Trusts will use activity data for billing purposes (every recorded patient admission will count directly and in full towards the invoice to the PCT). They may also make decisions on savings and investment in individual specialties, based in part on their reference cost position and on the income they receive. However, this will require confidence in the accuracy of cost attribution between specialties, which in itself is less than straightforward.
- 49 In turn, PCTs will be making payments based on activity data provided by each trust. They need to know that it is accurate and fair.
- 50 Three main factors are involved:
- an accurate knowledge of costs;
 - accurate recording of activity (both the total and the type undertaken); and
 - consistent and fair allocation of costs to activity.
- 51 Towards the end of 2003, auditors reviewed the accuracy of reference costs at all NHS organisations. They looked at whether the costs reconciled to the accounts and financial returns, whether all relevant costs had been included and correctly analysed into direct, indirect and overhead costs in accordance with the NHS Costing Manual; whether activity data reconciled to other returns and the extent to which activity was coded according to treatment and diagnosis. Finally, auditors reviewed whether costs had been accurately allocated to coded activity in accordance with the NHS Costing Manual. This included reviewing the extent of clinical involvement in the process.
- 52 Overall, auditors found that in the majority of trusts, there was a discrepancy of 5 per cent or more in the accuracy of reference cost submissions (**Exhibit 2**). The level of inaccuracy was greatest in PCTs and mental health trusts. However, the tariff will have little or no application to these bodies as providers in the next four years and so there is some time to address the evident weaknesses. Of more concern is the level of inaccuracy in acute and specialist NHS trusts, where implementation of the tariff system in earnest started this year for NHS foundation trusts and will begin in 2005/06 for all other acute and specialist NHS trusts.
- 53 **Exhibit 3** shows the main areas that auditors considered led to problems in the accuracy of reference costs data. As can be seen, although costing information was of some concern, the accuracy of activity data was the greatest problem, with over one-third of trusts having material inaccuracies in their data.

Exhibit 2

Accuracy of reference cost submissions

The level of inaccuracy in submissions was greatest in PCTs and mental health trusts.

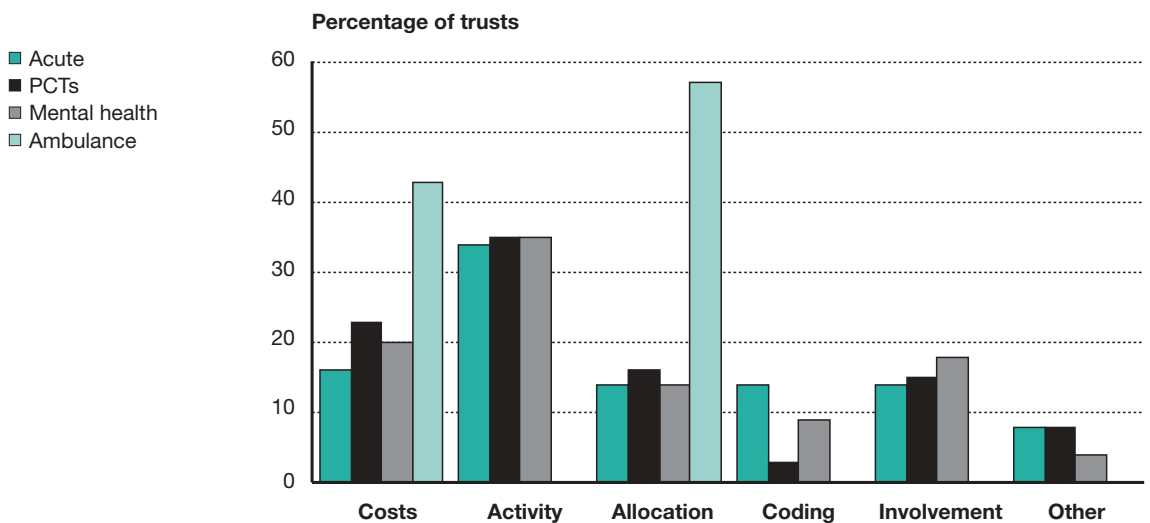


Source: Audit Commission

Exhibit 3

Analysis of problem areas in 2002/03 reference cost submissions

The accuracy of activity data was the greatest problem.



Source: Audit Commission

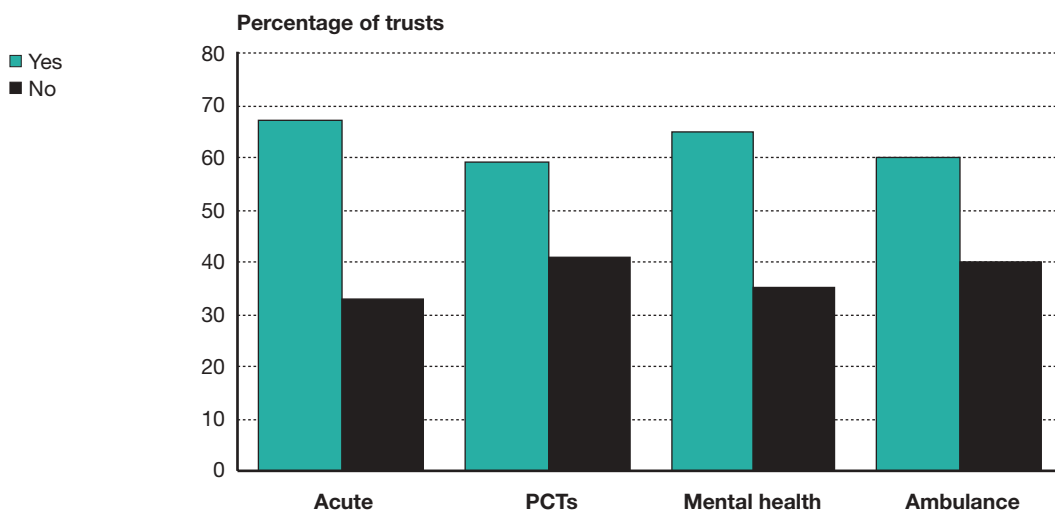
Costing

54 To assess accuracy of costs, auditors reviewed whether the costs in the reference cost submissions reconciled to the accounts (**Exhibit 4**). They also assessed whether all relevant costs had been included (**Exhibit 5**) and whether they had analysed them in accordance with the NHS Costing Manual (**Exhibit 6**).

Exhibit 4

Do the costs within reference cost submissions reconcile to the accounts?

In over one-third of all trusts, the reference cost submissions and the accounts do not reconcile.

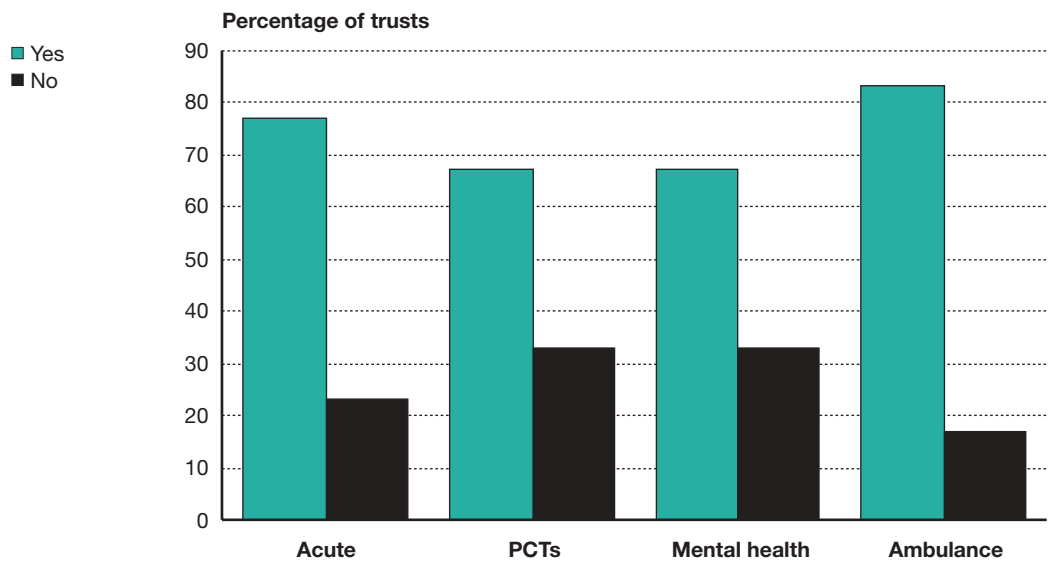


Source: Audit Commission

Exhibit 5

Have all relevant costs been included within the reference costs submissions?

PCTs and mental health trusts most frequently excluded relevant costs.

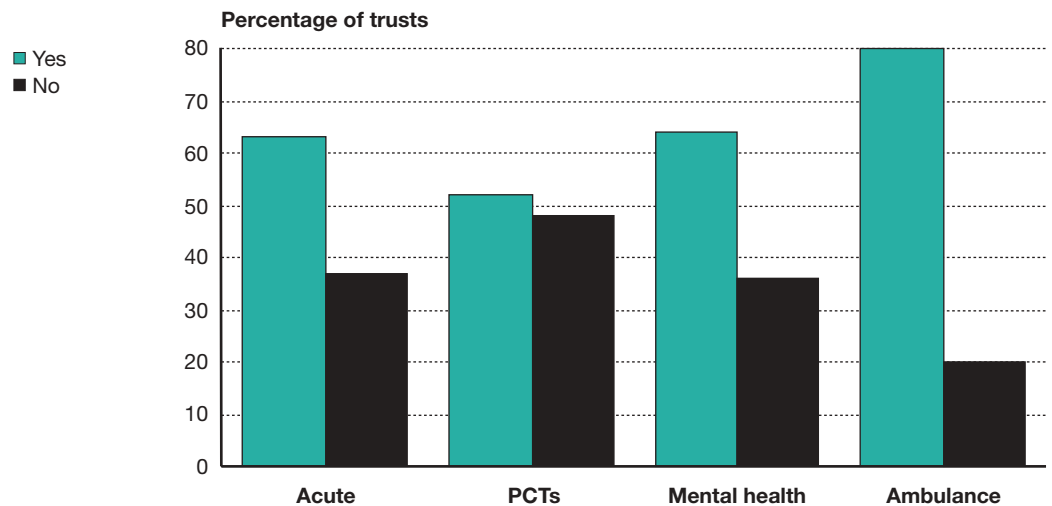


Source: Audit Commission

Exhibit 6

Have trusts analysed their direct, indirect and overhead costs in accordance with the NHS Costing Manual?

Compliance with the NHS Costing Manual on analysis of costs could be improved across the board.



Source: Audit Commission

55 Exhibits 4, 5 and 6 show a broadly similar picture. In each area assessed by the auditors, there was a fair proportion of inaccuracies and considerable opportunity for improving costing. This may not be a significant issue for the compilation of the national tariff, given that it is the summation of over 200 submissions. However, for individual trusts, it may be of considerable importance if decisions are to be made on service changes, areas for saving or the allocation of additional resources. Differences in individual HRG reference costs may be as much due to inaccurate costing as to real measures of efficiency. We consider this point further below, looking at how trusts might address the risks associated with the introduction of payment by results and the tariff.

Activity

56 Accurate data on both volume and type of activity is fundamentally important, both for trusts to assess their costs and the pressures they are under and manage their clinical work, and for billing purposes under payment by results. Inaccurate activity data will lead to inaccurate billing – a risk for both trusts and PCTs.

57 Auditors reviewed whether activity data used for reference costs reconciled to other data returns, such as those reported in internal performance reports, data submitted to the DH via central returns and activity submitted through the Nationwide Clearing Service (NWCS), which then forms part of the Hospital Episode Statistics (HES) data. These returns often rely on trust patient administration systems (PASs). Auditors also reviewed the level of uncoded activity.

Data returns

58 Auditors found that data often did not reconcile to the activity levels included in reference cost submissions and trusts could not explain the reasons for any variances identified. Activity data in 17 per cent of trusts was considered materially inaccurate.

59 Activity data at PCTs and mental health trusts was more unreliable than that for acute and specialist trusts. Auditors found that community services data recorded at PCTs was often inaccurate and that many PCTs did not have adequate systems in place to collect accurate and reliable data for their community services. Under the new framework, PCTs will need to consider more explicitly where to provide patients' treatment. Financial pressures may lead to limiting acute based activity and increasing community and primary care activity. Such decisions will need to be made on the basis of accurate and reliable activity information.

60 Similarly, problems with activity data were encountered at mental health trusts, where systems were often assessed as poor. This concurs with the findings from other data quality work carried out by auditors and reported in March this year in *Information and Data Quality in the NHS (Ref. 4)*.

- 61 Improving the accuracy of activity data is clearly important. However, one consequence of this might be an apparent increase in activity as trusts put effort into recording their activity more accurately. In theory, PCTs will be required to pay for additional activity even if it is purely the result of better recording with no actual increase in output or quality. This has the potential to create significant financial pressures at PCT level, and approaches to address this, such as creative risk-sharing arrangements, will need to be explored.
- 62 The timeliness of information will be as important as its accuracy under the new system. In year financial control will depend heavily upon access to up-to-date information on expenditure and activity. Significant delays beyond a period end will not be acceptable.

Patient Administration Systems

- 63 Many trusts rely on their PASs for their activity data. Payment by results will increase the importance of the PAS to trusts, making it a fundamental information and financial system. It will in effect become the trust's invoicing system.
- 64 Previous data quality work by auditors has assessed the effectiveness of PASs at trusts. The findings of this work were included in our data quality report published in March (**Ref. 4**). In summary, auditors concluded that:
- PASs are often more than ten years old and not designed to process the range of data required today;
 - trusts find it difficult to extract key performance data from systems; and
 - problems with IT systems were a potential contributory factor to reporting errors.
- 65 The NHS is trying to modernise its information systems through the National Programme for IT. But in the short to medium term, trusts will be relying on activity information, and their income, generated by systems that are clearly no longer fit for purpose.
- 66 Recent 'choice pilots' undertaken in London illustrated some of the problems that may occur in tracking patients for billing purposes. Payment by results, and patient choice, will operate on a much larger scale when rolled out.
- 67 Trusts will need to carefully consider any steps they might take in the short- to medium-term to strengthen their PASs and how they are used. And all stakeholders will need to recognise the inherent limitations in current systems.

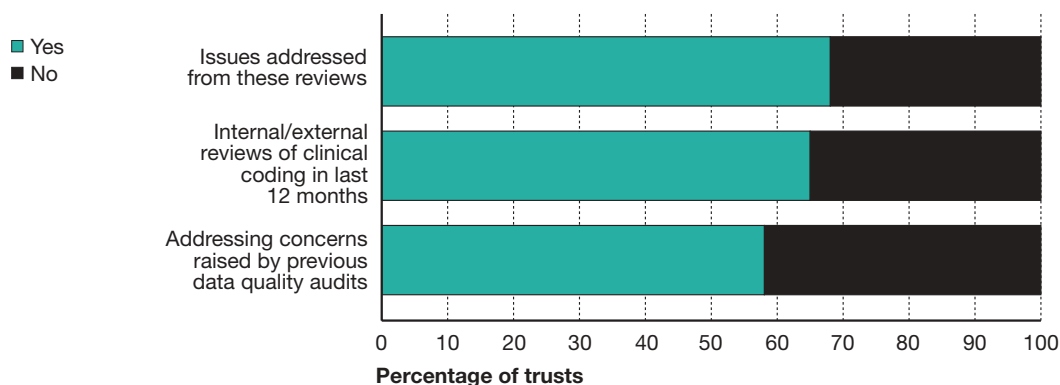
Clinical coding

68 Auditors reviewed whether trusts were conducting independent reviews of their coding systems and acting on the results and also whether findings from previous reviews of data quality were being acted upon. The majority were (**Exhibit 7**), and this is encouraging.

Exhibit 7

Trust action on clinical coding

The majority of trusts were conducting independent reviews of their coding systems and acting on the results.



Source: Audit Commission

69 Of particular concern, however, was the number of trusts with significant proportions of unclassified activity (**Exhibit 8**). Fourteen per cent recorded three per cent or more of their activity as unclassified (that is, where no treatment code was allocated to the patient). The DH has noted that unclassified activity will not be paid for under payment by results, representing a significant financial risk to those trusts concerned. But this also amounts to a significant incentive to PCTs and trusts to improve their data. This may be increased further by building incentives into the payment system. In some countries a proportion of payment (typically 5 per cent) is withheld against submission of accurate data. Experience elsewhere is that, with a financial incentive in place, the data quality improves significantly.

70 Overall, trusts are improving the quality of data. But they still have some way to go to match the standards necessary to underpin payment by results. Work over the last three years by auditors as part of the data quality reviews has confirmed that most trusts' clinical coding arrangements need to be improved. Auditors detailed comments were outlined in the March 2004 report, *Information and Data Quality in the NHS*. In summary, they concluded that:

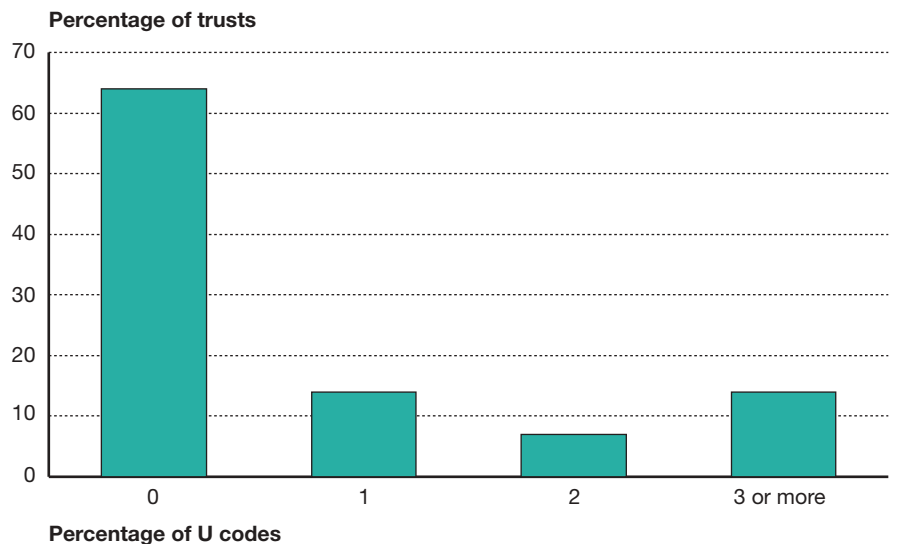
- acute trusts generally had in place policies and procedures relating to coding, but this was not the case at many PCTs or mental health trusts;

- clinical coding audits were being utilised at only a small number of acute trusts; and
- the perception of clinical coding staff was that few people were interested in the quality of coding.

Exhibit 8

Percentage of unclassified data reported in reference cost submissions

Fourteen per cent of trusts recorded 3 per cent or more of their activity as unclassified.



Source: Audit Commission

- 71 Accurate clinical coding cannot be achieved without close co-operation between clinicians and coders, with the former validating data entered by the latter. Clinical involvement was an issue again referred to in our data quality report, which reported that only 8 per cent of medical staff surveyed said that they had any involvement with clinical coding (Ref. 4).

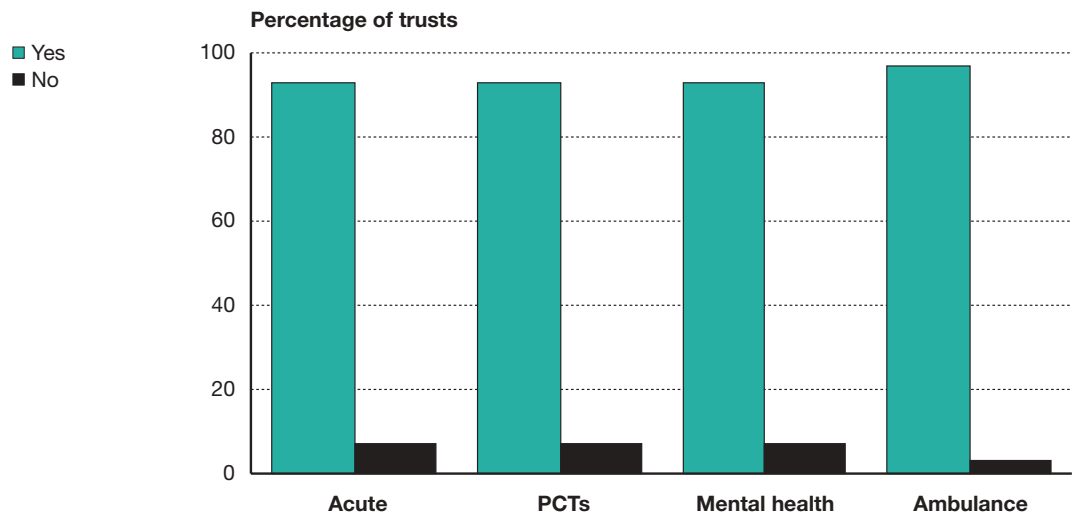
Cost allocation

- 72 Auditors also reviewed whether cost allocation had been carried out in accordance with the NHS Costing Manual. The Manual had been followed in nearly all cases in acute and specialist NHS trusts, but the picture varied in PCTs and mental health trusts (Exhibits 9 and 10, overleaf). Most acute and specialist trusts had achieved 'level 4' costing, which provides the greater degree of breakdown between procedures for effective operation of the tariff.

Exhibit 9

Can trusts demonstrate that they have matched specialties, services or programmes to their appropriate direct costs?

The vast majority of trusts showed appropriate matching between direct costs and specialties.

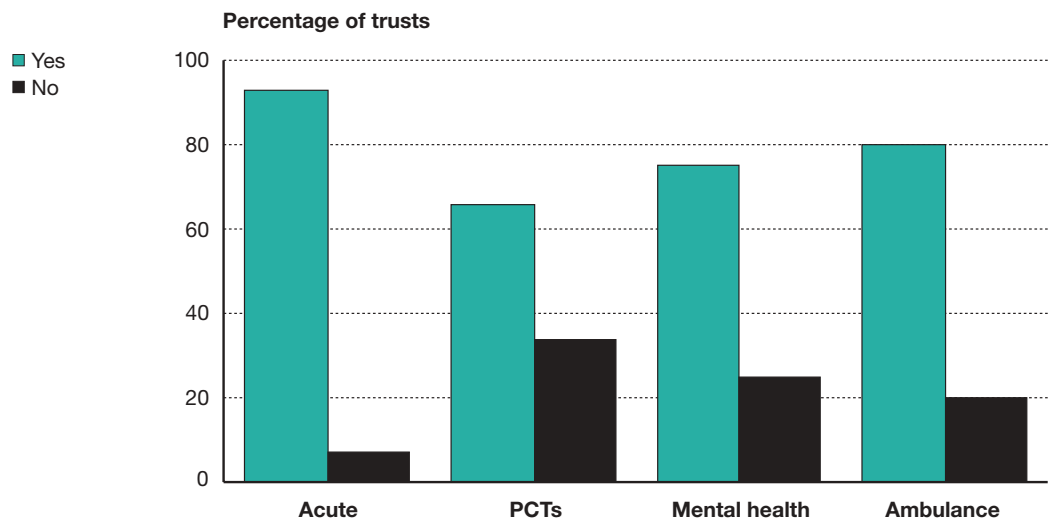


Source: Audit Commission

Exhibit 10

Have indirect costs and overheads been allocated in accordance with the NHS Costing Manual?

PCTs and mental health trusts have the greatest opportunity to improve allocation of indirect costs and overheads.



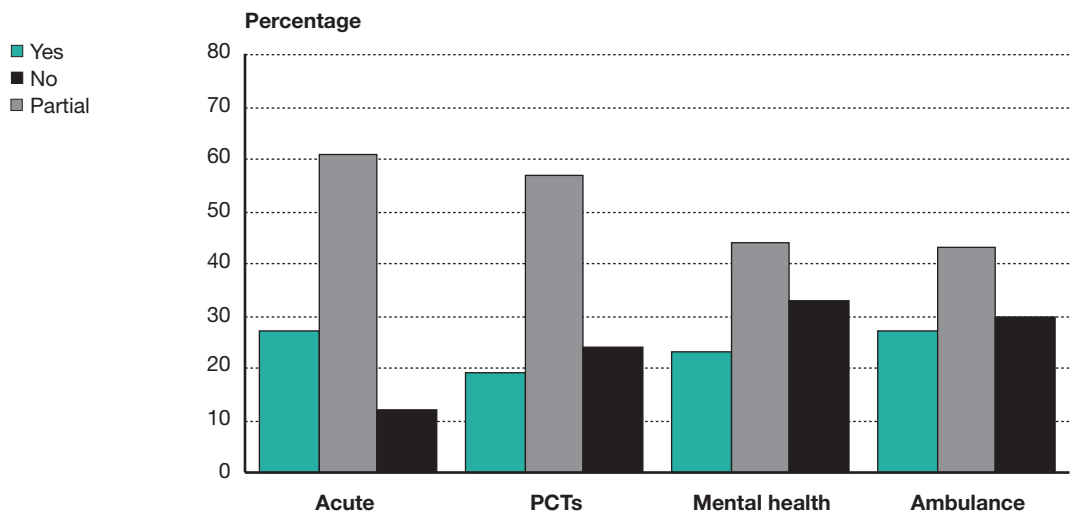
Source: Audit Commission

73 Auditors also reviewed the degree of clinical and managerial involvement in the costing process. Getting clinical endorsement of the costs and data will be critical for ensuring that the costings are accurate and that those most involved in daily budgeting (who may be making service changes on account of the new financing system) recognise the validity of the data. The results (**Exhibit 11**) echo those on clinical coding. There is considerable room for improvement in this area.

Exhibit 11

Have managers and clinicians been involved in the costing process?

There is considerable room for improvement in clinical and managerial involvement.



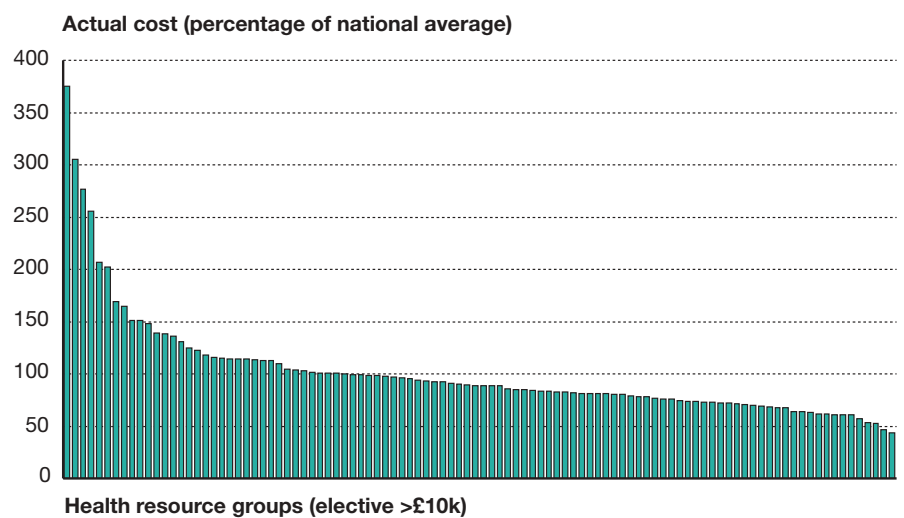
Source: Audit Commission

74 It is also important to consider that while trusts' overall reference cost position may be 'fair' (although commentators have some concerns about this), reference costs are a less reliable guide to performance in individual specialties. The degree of variation within a trust is much greater than between trusts. **Exhibit 12, overleaf**, for one sample trust shows a six-fold variation in reference costs between major HRGs. The overall reference cost index varies by less than +/- 30 per cent for acute trusts and the great majority are within +/- 10 per cent of the overall ref cost average, many falling well within that range. Although reference costs may give a feel for efficiency within trusts, they are not yet reliable enough to form the basis of management decisions. Nor do they necessarily have the buy in of clinicians and managers who will need to implement any local decisions.

Exhibit 12

Reference costs for individual HRGs at a typical trust

The reference costs vary substantially within trusts – far more than the variation in overall costs between trusts.



Source: Audit Commission

Accuracy and fairness

- 75 Payment by results carries powerful financial incentives for trusts, as payment is linked directly to the work done. It will recognise, for example, that admitting a patient for non-elective care may carry a payment, thereby removing the financial disincentive to admit where the costs would be incurred but no funding received. At the margin, this may alter admissions threshold and procedures. Payment will also be directly linked to the HRG to which the patient is coded. Coding a patient to a more complex HRG may automatically generate a higher payment. Other differences in recording and coding activity could also generate extra payments. Changes in admission rates, 'upcoding' and other 'gaming' techniques, such as manipulating the number of spells, can generate significant financial pressures.
- 76 For example, there are two HRGs for acute myocardial infarction (heart attack) – one with and one without complications. The non-elective 2004/05 tariff rates are £2,828 and £1,735 per spell respectively. Currently only 20 per cent of cases are coded as having complications, but if the coding moved to be more even (say 50/50) then costs would rise by 17 per cent (about £16 million) even before any uplift for genuine cost pressures. Such a movement may reflect real clinical changes resulting in increased costs, but it may also reflect changed coding practice. Further, this change may be a result of genuine improvements in coding practice as a result of new incentives for accurate coding, or deliberate 'gaming' to increase income. There are over 500 HRGs,

often covering similar conditions, such as that for acute myocardial infarction, where the choice of code will affect payment.

- 77 There will always be flexibility in the choice of coding for clinical work, especially for patients presenting with complex or multiple pathologies. Trusts will have a strong incentive to ensure that this is recorded accurately and that they receive their entitled income. Whether this is done manually or using software packages, such as those used in the USA, it will inevitably become an 'industry' for NHS trusts.
- 78 Given the importance of accuracy and fairness, a key question is what 'checks and balances' will exist to prevent trusts unfairly inflating their income, while ensuring that they receive their due payment.
- 79 Other countries with similar financing arrangements have put in place stringent checks and penalties to ensure that providers' coding is accurate and fair. In Australia, for example, hospitals are subject to random audits of clinical coding whereby a sample of patients' notes is subject to independent recoding and detailed data analysis and benchmarking is undertaken to identify potential 'gaming'. In some states of Australia, penalties are incurred if submitted data are inaccurate. In Norway, payments cease if 'upcoding' rises above a certain level. No such arrangements to ensure accurate and fair coding have yet been put in place in the NHS and it is unlikely that PCTs themselves will be in a position to do this effectively.
- 80 The DH has indicated that statutory audit aimed specifically at preventing or identifying gaming can have an important role to play here and we are discussing this with them. Such an approach may also need to be supported by a consistent and clearly understood system of sanctions for 'gaming' by trust. These could include a range of fines against organisations abusing the system up to sanctions against boards or their directors.

Conclusions

- 81 The quality of data poses significant risks to the implementation of payment by results, with associated consequences for financial stability. Although costing information in acute and specialist trusts may be accurate enough to generate a national tariff, it is less reliable at individual trusts and particularly individual specialty level, where apparent differences in performance may be accounted for by how costs have been identified and allocated. These difficulties may be compounded by different operational practices within trusts, which make like for like comparisons less certain.
- 82 Activity data is generally less reliable than costing information. Again, although the data may be adequate to prepare a national tariff it is much less reliable locally. Differences in recording activity can change a trust's overall position and have significant effects on individual specialties.

83 More broadly, the recording and coding of activity is generally less reliable than would normally be expected for payment purposes – both for provider and commissioner. And there are currently no obvious safeguards to prevent changes in recording of activity that are not the result of genuine clinical changes.

84 In these circumstances we recommend that:

- trusts should urgently invest in and develop their ability to accurately record and code patient activity;
- trust activity and reference cost data should be subject to regular independent review;
- trusts should secure greater clinical involvement in costing and particularly coding, ensuring that clinicians and clinical coders work together rather than in isolation;
- trusts should be careful about using individual specialty reference costs as the basis for decisions about savings or investment;
- PCTs should actively monitor trust activity information, rigorously scrutinising and challenging apparent changes in activity or coding;
- PCTS and mental health trusts should set in hand programmes of action now to improve their costing and activity information. We made similar recommendations in our March report (**Ref. 4**);
- the DH should put in place an effective system for auditing and scrutinising trust data, drawing on international experience; and
- the DH should ensure that coding guidelines are fully modified and updated to reflect the payment by results regime and that appropriate training is available for all coders.

5

The risks: financial management issues

- 85** This section considers the main financial risks that must be addressed if payment by results is to be implemented successfully and its potential to improve services and value for money realised. All NHS bodies face some risks. For NHS trusts and NHS foundation trusts the risks mainly involve ensuring that costs are contained within the tariff payments (at least on average) and that activity that should result in income due to the trust is properly accounted for and billed. Some trusts will also face pressures as they seek to reduce their costs in line with the national tariff and also if they see a reduction in the volume of their activity (although overall the government is planning for a significant expansion in healthcare, including in elective care and diagnostics, which payment by results will help to drive).
- 86** PCTs in particular face very significant risks. In the Commission's view, this is the major risk area. Payment by results essentially imposes a commitment on PCTs to pay for work done at a nationally set tariff, but they face uncertain levels of demand in both elective and non-elective care. The financial pressure arising from additional activity will also be greater because PCTs will be obliged to pay at full rather than marginal cost, as they would expect to do currently. The introduction of payment by results and the changes to the GP contract will mean that PCTs will have no control over prices for some 75 per cent of their funds (except where service changes result in significant reductions) and only weak controls on volumes. Block contracts and local negotiations with acute sector providers centred on affordability have been the main ways in which PCTs have managed financial risks. This will no longer be possible. How PCTs tackle the issue of certain payment and uncertain demand both in the contracts and SLAs they set with trusts and in how they influence demand and change to potentially more cost effective patterns of service will be critical to financial stability, the delivery of a wide range of targets (especially in non-acute care) and overall service improvement. Payment by results offers them both incentives and opportunity to do this, provided PCTs develop the necessary capacity to operate effectively under the new regime.
- 87** The taxpayer also faces some risks, principally whether the tariff will achieve greater increases in overall efficiency in the NHS. This will depend primarily on how trusts respond to the new set of incentives implicit in the tariff – particularly whether those trusts whose costs are currently below average gravitate to the national mean, as represented by the tariff, and how they spend the extra money they will receive under the tariff. Also, the historically strong financial control of the NHS might be reduced by the strong dynamics that this system introduces if the correct checks and balances are not in place.

- 88 Many of these risks can only be managed successfully locally, but the DH also has a key role to play in the way that it sets the tariff and the rules for its use (both of which can help to drive positive change) and in how it oversees implementation.
- 89 We look first at the risks created by the cost changes inherent in setting and moving to a nationally set tariff and secondly at the risks associated with changes in the volume of patient care, which will be influenced by patient choice and sharpened by payment by results.

The cost risks

- 90 The cost risks can be grouped into two categories: those associated with the move to nationally set prices and those associated with the way in which the tariff is set.

Moving to a nationally set price – deficits and surpluses

- 91 From 2004/05 for NHS foundation trusts and from 2005/06 for NHS trusts, acute providers will receive 80 per cent or more of their income through the standard national tariff. If this were done overnight, many would receive substantially more or less income than they do at present. This could result in many providers having either a large surplus or a large deficit. The potential impact of payment by results is much greater than current surpluses and deficits. Seventy-six per cent of trusts are within +/- 10 per cent of the national tariff. However, 32 trusts have costs over 10 per cent above or below tariff. We estimate that some trusts stand to gain (or lose) significant sums. Fifteen trusts stand to gain over £10 million with the highest gainer perhaps receiving nearly £30 million and the greatest loser perhaps nearly £50 million per year compared with current costs.
- 92 The most expensive trusts, according to the DH's reference costs, tend to be specialist units, like children's or orthopaedic centres. It is likely that this is partly because the cases they treat are more complex; but also because they tend to use more complex technology on other cases. Whether or not their higher costs are unavoidable, the introduction of the standard national tariff will force a debate around the issue. In fact the DH is already looking at ways to adjust the tariff to take account of more specialised work that may not be properly reflected in the tariff and has created a special 'risk' pool for 2004/05 for specialist work undertaken by the first wave of NHS foundation trusts, which are the first group of hospitals to experience payment by results in full. Some specialist work may also be excluded from the tariff until more refined HRGs are available.
- 93 It would be wrong to argue that specialist trusts cannot achieve efficiency savings. For example, specialist tertiary centres tend to work on a more elective basis, so they should be able to schedule beds and theatres more reliably.

- 94 Even after excluding specialist trusts, there are still a significant number of trusts with high costs: for example, five general and acute providers have reference cost indices of over 112 per cent. The DH recently decided that trusts will move towards the tariff in four equal steps with the maximum saving required in any one year of 2 per cent. This is on top of any other efficiency gains required. It is a more feasible transition path than that originally proposed, but it will still be challenging for some, and special arrangements may need to be made for the outliers which would not have achieved the required efficiency gains during the transition period if the 2 per cent limit is applied.
- 95 Prices in the standard national tariff will reflect full average costs. Many costs in the NHS are fixed over the short to medium term and cannot be 'controlled' by trusts. This has been recognised in the NHS by the use of marginal costing for extra or reduced activity levels. Fixed costs cause total costs to rise (or fall) more slowly than activity. For example, in a service where fixed costs represent one-half of total costs, a 10 per cent rise in activity (and as a result, income) leads to a smaller cost increase of just 5 per cent.
- 96 A trust's ability to respond to the challenge posed by the introduction of the tariff or activity changes depends on the proportion of its fixed costs, and how long it will take before the fixed costs can be changed. Costs associated with capital, for example private finance initiative (PFI) contracts, can last for many years.
- 97 In the short to medium term, a trust may have to find all its savings from its variable costs, despite the fact the funds being withdrawn reflect its average full costs. This is the usual position where organisations need to improve efficiency. However, some European countries that have introduced tariffs have introduced a funding system that is partly fixed and partly tariff, to mirror their fixed and variable costs. By doing this, they soften the impact of gearing, making the system more stable. Given that many trusts may be locked into a large and relatively fixed capital assets base or funding a PFI scheme, a mixed system of funding (as opposed to all tariff) has some attractions. The DH may need to consider a more flexible approach to these issues in the future. The consequence of such a system, however, would be the need for extremely clear definitions and boundaries between fixed and non-fixed costs; strict costing guidance and monitoring.
- 98 Those trusts with below average reference costs will receive more funding under payment by results. In some cases this can be significant: as noted earlier, 15 acute trusts could receive over £10 million each in additional funding. Seven of the first wave NHS foundation trusts are in this category and they can expect to benefit by a total of £100 million under the tariff. The Commission estimates that the total extra funding for all the trusts gaining for their current level of activity is some £500 million. They will need to spend these funds on real and demonstrable improvements in the quality of patient care if good value for money is to be achieved. Quality of overall patient care in the service, and NHS productivity, will increase greatly if this can be done successfully while those trusts that have to make cost reductions see no diminution in the quality and quantity of service.

- 99 The DH intends to revise PCT allocations so that they take account of the revised prices. In theory, the overall effect should be neutral and should not affect equity. However, it will result in some PCTs moving nearer to or further from their target allocations. And, in some cases, those PCTs that are currently below target and are expected to spend additional money on community provision may find that they have reached their target and that the extra funds will be needed for the acute sector because of the rise in prices caused by the tariff.
- 100 Funding during the transition will rely on data collected from the NHS about local usage and prices. This will be a demanding exercise – particularly given our findings on reference costs and activity set out in the previous chapter. It will also present opportunities for gaming, given that the data provided locally will determine whether a PCT or trust receives extra funds.

Setting the tariff

- 101 A significant task in setting the tariff is to update the base data to reflect current year prices. The national tariff for 2004/05 is based on reference cost data for 2002/03, as this is the last year for which full information is available. This means that an estimate of cost pressures for both 2003/04 and 2004/05 needs to be added. This is not simply a measure of inflation. It has to include, for example, the costs of medical advances and the implementation of NICE guidance, as well as estimates of increased NHS costs, for example, differential pay settlements in the NHS.
- 102 The DH has uplifted the 2002/03 figures by a total of 11.2 per cent for the two years and applied this differentially across the tariff according to the mix of costs associated with each HRG. Their overall assessment of cost pressures was 12.2 per cent but the DH assumed that all trusts would achieve a 1 per cent efficiency gain in line with its Public Service Agreement (PSA) target. The size of the uplift is as great a risk factor for most trusts as their difference from the national tariff (most acute trusts are within 6 per cent of average costs). As payment by results provides no room for manoeuvre through local negotiations on price, the objectivity and accuracy of the uplift are critical, as is trusts' ability to keep their costs in line with the national tariff, on average.
- 103 This represents a significant shift from the current position, where flexibility at the margins on, for example, activity, cost or timing of developments has been used extensively to smooth service changes by covering double running or set-up costs. The DH is considering making some funds available centrally to help to meet double running costs or to fund developments in their initial period but the arrangements and sums available for this are not clear. However, payment by results may promote more creative or entrepreneurial approaches to service redesign without central support.

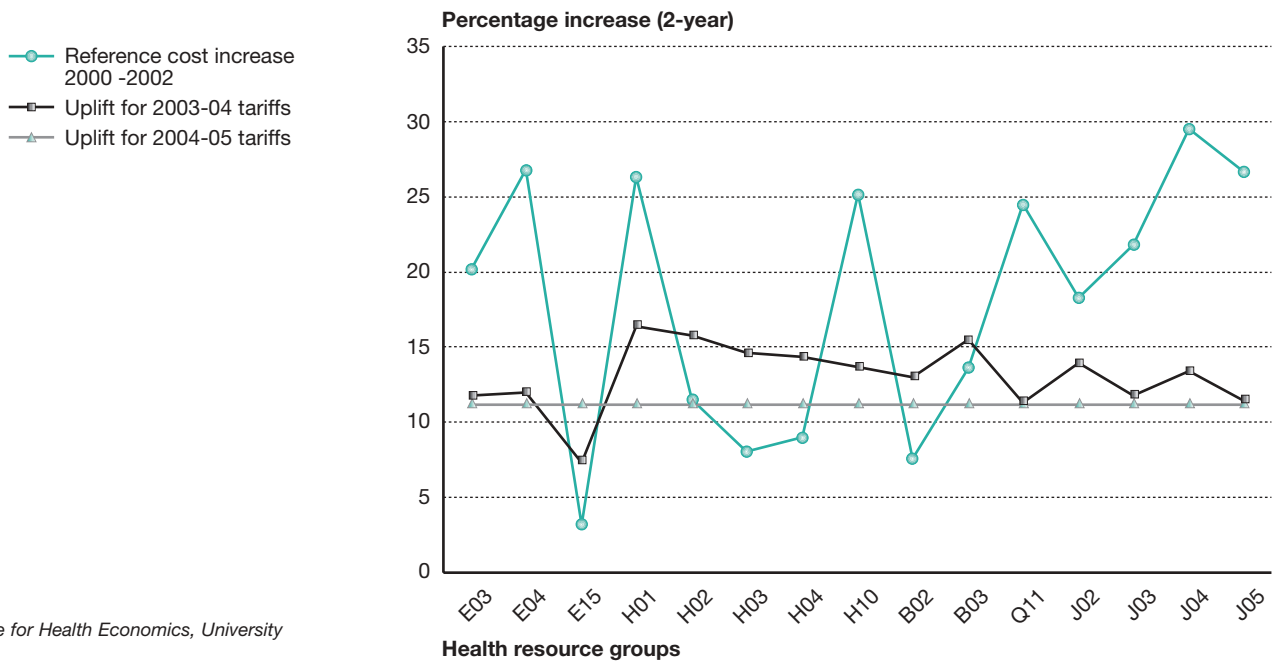
104 Although costs between years will clearly differ, evidence from previous years suggests that ensuring cost increases are covered by the uplift may be challenging. Reference costs between 2000 and 2002 generally increased by more than 11.2 per cent, the uplift for 2002/03. The accuracy with which the tariff uplift is applied to individual HRGs is also a factor. The equivalent uplift applied to the 15 HRGs selected for tariffs in 2003/04 was also more in all but one case. (Exhibit 13).

- 105 Other important factors must be considered in setting the tariff. Nationally these include:
- Defining clearly what is covered by each HRG and the tariff so that costs and services cannot be shifted into non-tariff areas and PCTs charged accordingly, adding to the pressures upon them. However, currently, it is not possible to define the specific elements of care within any given HRG because it is not a standard cost-based tariff – it is the average of all patterns of care and their consequent costs. There is no ‘standard’ pathway of care for a given HRG. If there were, at least for high volume high cost cases, it would give PCTs and trusts a much better basis upon which to understand local reference costs and explore opportunities for local adjustments.

Exhibit 13

Reference cost increase and tariff uplift

The uplift is generally less than recent cost increases.



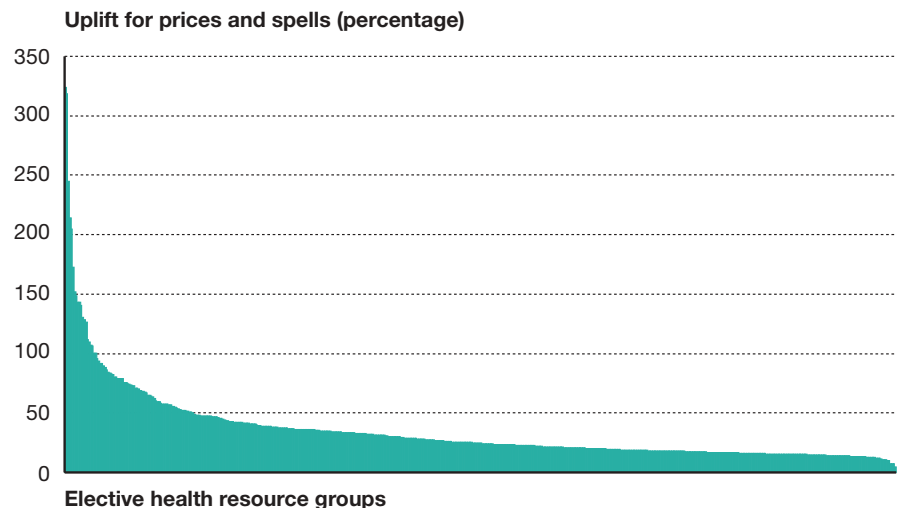
Source: Centre for Health Economics, University of York; DH

- The ability of PCTs to split tariffs into the elements of care pathways to reflect, for example, the transfer of parts of the patient pathway out of the hospital setting into the community, an important area of potential disagreement at the local level. DH guidance on this says that this should only be done where service redesign has resulted in a significant change in the length of stay compared with the national average for a given HRG. It is not clear how this would work where the change has already been made before the tariff was introduced.
- Defining and costing more specialist work. This is a significant issue for both trusts and PCTs. Such work can involve high fixed costs and volatile patient numbers. It may also affect relatively few patients, which means that there is relatively little data on which to base the HRG and tariff. For example, there were fewer than 30 cases in each of the major burn HRGs in 2002/03. Such patients may also have highly variable costs and treatment may be ongoing rather than linked to hospital spells. The current HRG classification system may also bundle together specialised and non-specialised work, although the specialised work is only undertaken by some units. For example, four specialised liver procedures are bundled together with non-specialised activity but only 31 out of 159 providers performed the specialised work in 2002/03. The current HRG system may therefore be too crude to ensure that specialised work is fairly funded under the tariff although the classification could be adapted to recognise these differences, through splitting HRGs, for example. This has led to concern among some providers about the potential impact on their income. PCTs are also concerned about whether they are paying too much for some work and about whether they will find themselves incurring additional costs outside the tariff to fund individual patients. More specialist work may need to be funded separately. The DH has found that it needed to create a 'risk' pool of £40 million for the first wave of NHS foundation trusts in order to cover the uncertainties of the tariff for more specialised work. It is now reviewing which specialist work should be excluded from the tariff until more refined HRGs are available.
- Keeping pace with medical advance. Medical knowledge continues to develop. For example, some treatments can now be provided as outpatient services, whereas in the past they were only provided on a daycase or inpatient basis. In other cases, medical advances have expanded or improved the treatment which can be provided. NICE makes recommendations on whether new treatments are clinically and cost effective and there are clear expectations that positively recommended treatments will be funded locally. Unless the tariff keeps pace with these developments there will be clear disincentives for trusts to innovate and provide expensive new treatments unless the work can be defined as outside the tariff and the costs shifted to PCTs. HRGs and associated costing need to be sensitive to these points and to keep pace with the expansion of knowledge. The DH has decided to allow PCTs to make additional funding available where new technology has been introduced that is not covered by the tariff.
- Converting the basic measure of HRG activity of individual FCEs into 'spells' to account for those patients who transfer between consultants during their hospital stay. This is done by multiplying each HRG by a factor according to a typical number of FCEs per spell. As **Exhibits 14 and 15** show, the factor varies widely across HRGs.

Exhibit 14

Uplift for prices and spells for elective HRGs

Some HRG costs have been more than doubled to convert FCEs to spells.

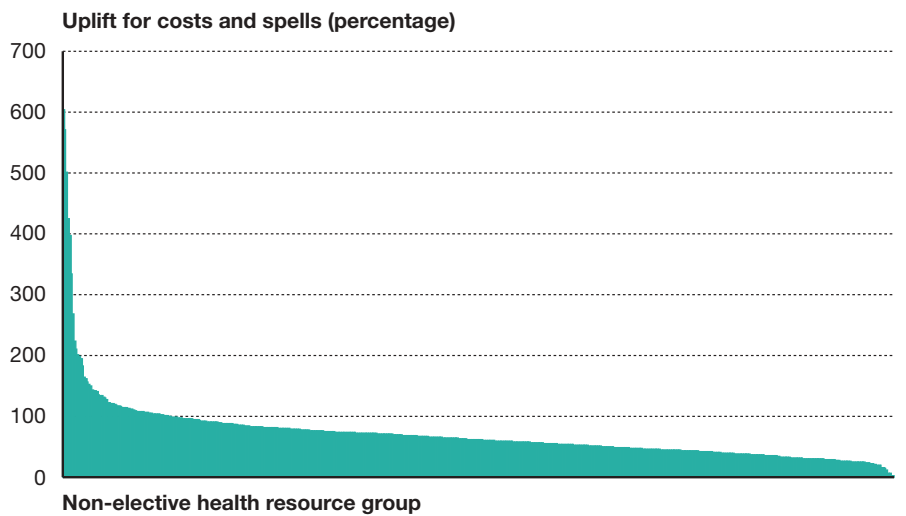


Source: Audit Commission

Exhibit 15

Uplift for prices and spells for non-elective HRGs

The variation is even more pronounced for non-elective HRGs.



Source: Audit Commission

- 106 The conversion to a spell-based tariff is not therefore a minor adjustment, but a major change. It inevitably introduces more uncertainty about the accuracy of the tariffs because of uncertainty over the adjustments themselves. In particular:
- They may not represent actual national average spell costs. Reference costs are FCE-based and the algorithm for converting FCEs to spells is based on older HES data from 2001/02.
 - The number of episodes per spell may vary legitimately from trust to trust. For example, a patient with multiple pathology, admitted as an emergency admission to a general hospital without some specialist services may have fewer episodes in the spell than at a larger trust (for example, a teaching hospital).
- 107 Local factors that can affect costs and may add to pressure on hospitals include:
- Capital costs that differ between hospitals according to their mix of old, fully depreciated assets and new assets, which may also have differential costs according to whether they have been funded by public capital or PFI. Capital costs account on average for 8 per cent of the tariff, but for individual hospitals they can vary from 4 to 15 per cent.
 - Differential costs reflecting, for example, local labour markets, currently reflected in PCT allocations by the MFF.
 - Deprivation – where there is a statistically significant correlation with slightly longer lengths of stay for similar procedures, which may be reflected in higher costs for hospitals.
- 108 The tariff, the rules governing its use, the additional payments that may be made and contracting between PCTs and trusts all need to be set and operated consistently. All aspects need to be set objectively and transparently aiming for a balance between simplicity and responsiveness. The arrangements also need to have a strong sense of being fair overall and they must be supported by managers, clinicians and academics. Consistency over the longer term will also be particularly important for NHS foundation trusts and any private sector providers covered by the tariff, as their capital programmes and borrowing will have been determined on the basis of assumptions about the tariff and its operation.

The volume risks

- 109 The new framework intends to reward hospitals fairly for the work that they do. This means that trusts should receive additional income if activity increases but, conversely, will suffer losses if fewer patients are treated (holding casemix constant). Payment by results means that additional activity is paid for at full rather than marginal cost. Income is also withdrawn at full cost. There are therefore powerful incentives for trusts to keep activity up and to increase both volume and complexity. Patient choice also means that hospitals need to be fully responsive to patient preferences.

- 110 PCTs have very strong financial incentives to manage demand better, provide appropriate care more cheaply in the community and limit, or reduce, the number of admissions to hospital. They must set realistic baselines for trust activity and realistic targets for change. Contracts and SLAs with trusts, which must be set on a cost and volume basis according to DH rules, need to have appropriate risk-sharing arrangements for non-elective work. (The DH has insisted that elective work should be contracted for on a strict cost and volume basis in order to ensure that patient choice is fully supported by funding flows). Failure to do all of these things will lead to financial instability.
- 111 Importantly, to achieve this PCTs will need to implement timely and accurate management accounting systems that track patient progress and associated expenditure. Only in this way will they be able to monitor performance against budgets in real time, rather than retrospectively.
- 112 The financial pressures that will result from a rise in emergency admissions from whatever cause are substantial. For example, emergency cases admitted through trusts' own accident and emergency departments cost an estimated £3.6 billion per year. A 10 per cent increase in a trust's tendency to admit via this route, given the financial incentive to do so, could cause substantial financial pressure of around £1.2 million on the average PCT.
- 113 The consequences of setting inappropriate baselines and targets in order to make sure that the budget balances at the start of the year can be significant for individual PCTs. Anecdotally, PCTs have found that emergency admissions rose by 6-8 per cent in a year because of the way that baselines and budgets were constructed. Similarly, different (and better) counting of activity can also affect the picture. For example, some PCTs with NHS foundation trusts have seen very significant increases in same day and 24-hour length of stays resulting in major cost pressures. The DH now intends to introduce a separate tariff for such admissions.
- 114 Yet, there are significant opportunities and incentives for PCTs to reshape services to offset some of these increases. The King's Fund has estimated that in one PCT, 1 per cent of patients account for 46 per cent of inpatient costs, and more generally, 5 per cent of patients account for 42 per cent of overall inpatient days. Targeting care on this group could bring significant benefits to PCTs and patients, with the cost risks falling on hospitals. The gearing is such that successfully targeting 0.5 per cent of patients could lead to a 4 per cent reduction in hospital admissions, equivalent to £900 million nationally or £2.6 million for the average PCT.
- 115 There are parallels here with prescribing expenditure and the way in which PCTs approached managing a budget where there was a certain commitment to pay but uncertain and growing demand. In 2001/02 health authorities set budgets averaging 3.1 per cent against national forecasts of 10 per cent. Some set budgets for real reductions in expenditure. Drug costs rose by 10.7 per cent, £385 million over the

budgets originally set. This left health authorities with significant financial problems. Budgets have since been set more realistically. However, drug costs account for only about 15 per cent of PCT expenditure. Spending on acute care accounts for about 50 per cent.

- 116 More generally, PCTs have invested in recruiting prescribing advisers to help to reinforce cost-effective prescribing practices with GPs. Similarly, there are incentive schemes and practice-based budgets against which GPs can assess their performance. And there is comprehensive, readily available, well-analysed data against which performance can be monitored and benchmarked. These important features are often absent or weak for patients being referred to secondary care. As our recent study on service redesign, *Quicker Treatment Closer to Home* noted, PCTs often had poor data and limited management capacity and they sometimes struggled to engage GPs and other frontline clinicians (**Ref. 2**).
- 117 It will be important to engage with primary care clinicians in the management of referrals and the implementation of alternatives to secondary care referrals. A number of studies and pilots are seeking to develop PCTs' approach to demand management and also their capacity to do it. However, where this is poorly developed, the key to financial stability will be setting realistic baselines, targets and budgets that are based on national and local historic trends. In year control will also require timelier information and better forecasting.

Training and support

- 118 We have commented previously on concerns about the management capacity in PCTs; but we should also make the general point that the introduction of such radical change must be accompanied by robust training and support arrangements for all concerned, if implementation is to be effective.
- 119 This is particularly important because the success of payment by results will depend as much on how partner organisations behave and interact with each other as on the technical niceties of the system.
- 120 Consequently, it should be a priority to develop a more systematic approach to capacity building. Training and support programme should encompass all affected staff groups, but especially executive and non-executive board members. Maximum learning from the experience of PCTs commissioning from the first foundation trusts should be extracted and a programme of training, for example, using simulation-based approaches should be introduced, ideally facilitated by the DH and SHAs.

Planning, capital developments and PFI

- 121** The introduction of payment by results may well have profound implications for the planning of new facilities, especially for PFI proposals. The issues include:
- the ability to provide the necessary commitment to future patient flows and income streams;
 - the affordability of a solution that replaces a fully depreciated capital infrastructure;
 - the affordability of PFI options whereby all costs flow through the revenue stream; and
 - the cost of project development and project management costs.
- 122** Over time the system may even begin to influence design itself (such as ward layout) and there will be a continuing need to ensure that clear quality criteria are maintained to avoid cost-reducing designs from undermining advances in areas such as privacy and dignity for patients. The potential impact of the tariff on significant capital developments, particularly when allied with patient choice and changes in the pattern of care to encourage more treatment outside hospitals, has not yet been fully assessed. Further adjustments may be required as a consequence.

Conclusions

- 123** Payment by results raises significant financial management issues for the NHS. The most significant issues relate to PCTs, which, in general, are not sufficiently developed to tackle them, as outlined in our report *Achieving First Class Financial Management in the NHS (Ref. 1)*. Those who can bring together the necessary information and skills will find, however, that they have a powerful tool for improving services.
- 124** Demand management through active monitoring of referrals, more accurate assessment of patients against the likely risk of their admission to hospital and targeting intensive community support on those judged at highest risk, as well as longer-term re-engineering of services, will be the key activities for PCTs. Our recent report, *Quicker Treatment Closer to Home (Ref. 2)*, sets out many of the methods and activities that PCTs need to employ. These include, among others:
- ensuring that the SLAs clearly specify the level of activity to be delivered in a cost/volume contract;
 - providing GPs with comparative data on referral rates, to encourage debate and greater consistency;
 - developing clear corporate priorities for specialties to be redesigned, following on from capacity planning and patient feedback;
 - setting clear objectives for new pathways in terms of activity levels; and
 - improving the information on demand, to prioritise and target redesign on subspecialties.

- 125 For NHS trusts, the volume risks are real, but probably less pressing, as they rest on a reduction in activity caused by patients choosing other hospitals for their elective care or on PCTs successfully managing and then reducing demand for non-elective care. Avoiding financial instability will require the development of mature, partnership-based relationships with commissioning PCTs, though this will present a challenge for trusts with large numbers of PCTs commissioning services from them.
- 126 But there are other critical issues and risks for trusts and for the NHS as a whole. The changes are intended to impose a 'hard budget discipline preventing hospitals from passing on income losses or cost inflation to their local PCTs, either formally in prices or informally via deficits that local purchasers in practice had to underwrite' (**Ref. 7**). Cost control to match national assumptions and accurate recording of activity will both be critical. However, this will not be sufficient unless the DH makes accurate and reliable estimates of the cost pressures facing the service and sets the tariff in an open and transparent way that the service considers to be fair overall.
- 127 Both NHS trusts and PCTs need to ensure that clinicians and frontline managers understand and fully buy into the implications of payment by results and how the organisation intends to address them. For trusts, clinical engagement will be essential for improving efficiency, controlling costs, accurately recording activity and correctly coding it and deciding how to spend any additional money to achieve demonstrable improvements in the quality of care. For PCTs, effective demand management and changes in the pattern of services depend fundamentally on how GPs and other frontline clinicians go about their daily clinical work.

6

Conclusions

- 128 Every NHS organisation has a responsibility to prepare thoroughly for the introduction of payment by results and the associated development of patient choice. Boards must assure themselves that their PCT or trust has done this. The questions in the centre pull-out section should be posed by boards and audit committees to assess the implications of the changes and how well the organisation is preparing for them.
- 129 The Audit Commission will play its part in helping the service implement the changes:
- through our appointed auditors, we will undertake detailed reviews of preparedness and of risk management strategies at NHS bodies;
 - we will hold an early national seminar to consider how best to assess the early lessons from the introduction of payment by results;
 - we will follow this report with a further review of early contracts and contract management in those PCTs commissioning from NHS foundation trusts in order to provide guidance and practical help based on experience to all PCTs and NHS trusts that will move fully to the new arrangements from April 2005; and
 - we will continue to review nationally the development of payment by results and the setting of the tariff, including assessing how the main estimates of cost pressures work in reality on the ground.

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Introducing payment by results

Questions for Board Directors

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 questions 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 are in place to encourage frontline clinicians to manage demand?
- 15 What lessons have we learnt 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 spending so that 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 issue?
- 16 What level of cost reduction does this imply?
- 17 What extra efficiency gains do we need to make? How will we achieve this? How does this compare with our 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 How are we engaging staff in the implications of payment by results and patient choice?



Achieving First Class Financial Management in the NHS: A Sound Basis for Better Healthcare

This paper reviews the current state of financial management in the NHS. Drawing on case studies and information, it identifies where and how improvements need to be made and sets out the major challenges in financial management that the NHS will face over the

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National report, 2004, ISBN 1 86240 492 5, £25, stock code HMP3211

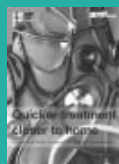


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