

Health

National report

February 2008

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Payment by Results 2003-07

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Summary

Payment by Results (PbR) was first introduced in the NHS in 2003/04 to improve the fairness and transparency of hospital payments and to stimulate provider activity and efficiency. Rather than relying on locally negotiated contracts based on local prices and with a tenuous link to outputs, providers are paid for the number and type of patients treated, in accordance with national rules and a national tariff. Implementation of PbR has been phased over a four-year period to 2007/08. This has included buffering the financial impact on individual organisations. This report takes stock of the impact of PbR at the end of the transitional period.

PbR has undoubtedly improved the fairness and transparency of the payment system. It has also, perhaps, had a positive effect on activity and efficiency in elective care. Day cases have increased and the length of stay for elective inpatients has fallen. Both developments are consistent with the incentives under PbR. However, other policies have also encouraged such trends, particularly the need to meet waiting time targets, and detailed analysis suggests that other factors have also brought about the changes. We consider that PbR has at most contributed to these positive trends rather than driven them. Meanwhile, the negative impact on quality which some feared would result from PbR has not been realised.

Capacity constraints, limitations in the infrastructure underpinning PbR, such as information systems, and significant changes in the tariff during the first two years of the transition period may all partly explain why PbR has not had more impact on activity and efficiency. The policy is still bedding in, and its impact on activity and efficiency may be more pronounced once the transition period has been completed. It is also possible that PbR has had an impact on some individual hospitals or services, but that these improvements are disguised at the national level.

PbR has now been largely mainstreamed by the NHS. The change in the financial regime, in particular the increased level of risk to individual organisations, has encouraged both providers and commissioners to strengthen their financial management and information systems, as well as their overall planning, and performance and contract management. The relative fairness and transparency of a tariff-based system has supported this process. Together with the introduction of foundation trusts (FTs), PbR has resulted in a more business-like focus in the NHS. Organisations are beginning to use PbR as a tool to

identify inefficiencies and redesign care pathways in the interests of patients. This is more evident for provider trusts than for primary care trusts (PCTs).

PbR has encouraged a better understanding of costs among trusts. Trusts are increasingly devolving financial management to clinical departments and specialties within their organisations. Service-line management, which treats individual specialties as business units that make a profit or loss, and patient level costing, have both gained momentum. These have the potential to improve decision making and overall management within a trust. However, these approaches are not without their challenges and require commitment to cultural change throughout the organisation and adequate resourcing, which is not always present. Patient level costing, in particular, may not make sense for all organisations, and its merits should be evaluated on a case by case basis.

Overall, interest in information and improving data quality within the NHS has increased as a result of PbR. Completeness of coding and overall recording of activity has improved. The provision of more meaningful data, along with clearer financial incentives, has undoubtedly increased clinical engagement in financial matters. However, timeliness and accuracy of data are still barriers. There are several perceived limitations with the Secondary Uses Service (SUS), the NHS's primary data source for commissioning and payment purposes. These include unworkable deadlines and a perceived lack of national accountability, both of which need to be addressed. There are also outstanding inconsistencies and ambiguities related to data definitions, which continue to create problems at the local level and need to be clarified. At trust level, early findings from the Audit Commission PbR data assurance audits demonstrate that there is much to do to improve data quality. However, in general there is no evidence to date that trusts are 'gaming' the system to secure unwarranted payments.

PbR has encouraged PCTs to strengthen their commissioning function and to focus on demand management. On the whole, PCTs now have stronger arrangements in place for monitoring provider activity and performance and for engaging practice based commissioners in the process. However, practice is variable and there is much room for improvement. Demand management initiatives are increasing in number and scope. There has, in particular, been a reduction in avoidable admissions to hospital, which suggests that PCTs are achieving some success in this area, spurred on by PbR incentives. However, there are still significant weaknesses in commissioning, including contract negotiation and management, both of which are important for the effective operation of PbR.

It is clear that PCTs' commissioning capacity needs to be strengthened in order to manage the risks and take advantage of the opportunities that PbR has to offer. The Department of Health's (DH) World Class Commissioning initiative will help to address these weaknesses, along with support from strategic health authorities (SHAs).

Beyond that, PbR policy, which has remained relatively stable since 2005/06, needs further development. The DH consulted in March 2007 on options for the future development of PbR and has recently published its response. However, on the basis of our work on PbR, we consider that four steps need to be taken.

First, **the information infrastructure needs to be strengthened, including diagnosis, procedure and casemix classifications.** The proposed Healthcare Resource Group (HRG) version 4 (HRG4), which is a more refined casemix classification system, will help with this, but not all trusts have yet upgraded their system to accommodate it. The quality of costing data used in calculating the tariff continues to be a major source of concern to the NHS and will hamper the move to HRG4. Both points might be overcome if the DH moved to a sampling approach, using cost data from accredited providers, supported by clear clinical costing standards and stronger quality assurance processes. The timeliness and quality of data available to PCTs through SUS for monitoring contracts and making payments under them also need significant improvement.

Secondly, **the national tariff should be made more flexible.** There should be greater scope for unbundling of individual tariff prices into separate components so that different care pathways can be more easily accommodated, for example when some postoperative care takes place away from the main hospital. Some progress has been made on this but PCTs can find it hard to introduce change where it is against the provider's interests. The introduction of HRG4 will help here, subject to resolution of the data quality points referred to earlier. At the same time, there should be greater flexibility to set local prices and currencies that take account of significant innovations in service delivery that are not currently supported by the tariff. This should be both mutually agreed by commissioners and providers and underpinned by clear national principles.

Thirdly, in order to increase the likely effect of PbR on efficiency, we consider that **it would be helpful to introduce some normative tariffs for selected HRGs.** These would be based not on average costs but on the costs that high performing efficient providers, offering a good quality service, might expect to incur. The introduction of such tariffs would need to be signalled in advance to the NHS.

Fourthly, there are continuing questions about whether capital costs are fairly reimbursed, whether quality should be specifically incentivised through the tariff, and how specialist services and unavoidable regional cost variations should be funded. All these need further exploration. However, a single payment system is unlikely to bear the weight of all of these requirements. The possibility of having **separate funding streams for capital and quality, for example, as is the case internationally, should be considered**, rather than it being simply assumed that the tariff should be adjusted for them. An incentive system is unlikely to work if the messages it is meant to convey are not clear to the recipients.

Overall, PbR has demonstrated its worth, even if it is yet to have a significant impact on activity and efficiency. However, the policy will need continual monitoring and refinement over the years if it is to deliver further benefits and support Lord Darzi's vision of fair, personalised and effective care, as reflected in the *NHS Next Stage Review*.

Recommendations

The DH should:

- Identify and explicitly prioritise the changes that will be most effective in achieving policy objectives, and ensure that the development programme for addressing these priorities is realistic, properly resourced and communicated to stakeholders.
- Ensure that timely guidance, support and direction continues to be provided to both commissioners and providers in a balanced way, including more effective mechanisms for receiving and providing feedback, particularly in relation to contract and information issues.
- Review and address the perceived limitations of SUS in supporting PbR, ensuring there is a clear vision for NHS data and organisations' responsibilities that is shared by NHS Connecting for Health and the Information Centre for Health and Social Care, and that the expectations of the NHS are consistent with this vision. Additional steps should be taken to ensure that guidance from these bodies is consistent.
- Invest in information systems to capture and report on community services and support the development of an appropriate payment mechanism.
- Monitor usage of the new standard contract and reinforce the move toward a consistent approach to contracting across the NHS, providing guidance as appropriate to ensure that balanced, fair contracts, that support nationally agreed principles, are negotiated.
- Use the tariff as a policy lever to drive desired behaviours, rather than purely as a reflection of average costs, signalling likely changes to the NHS well in advance.
- Explore the use of separate payment streams in addition to the tariff, for example to reward quality or to fund capital costs, where this is necessary to provide the right incentives to NHS bodies.
- Carefully monitor the implementation of HRG4 to ensure that the additional complexity of the payment classification is warranted and is not undermining policy objectives.

All providers of acute NHS services should:

- Ensure that robust information and reporting systems are in place that meet all internal and external requirements within the minimum reporting deadline of 30 days following the end of the month, and that local information systems are in place to complement SUS as necessary.
- Embed and promote service-line management and reporting, paying particular attention to the use of surpluses and how this will be managed within the organisation.
- Understand the costing data they require to manage the business, and invest in improving internal costing systems, considering the business case for introducing patient level costing systems where appropriate.
- Prioritise the implementation of the OPCS-4.4 classification system for procedures, to improve coding internally and to support the introduction of HRG4.
- Engage in discussions with commissioners about changing patient pathways, demand management and use of local flexibilities, such as unbundling the tariff into its component parts.

All PCTs should:

- Further develop commercial, legal and contracting skills, identifying gaps in line with the developing World Class Commissioning competencies, to improve their ability to operate in the PbR environment.
- Ensure that 2008/09 contracts contain appropriate incentives and penalties to support appropriate, high quality care, for example, readmissions targets, and that information requirements are clearly specified and enforceable. Progress against these targets should be reported regularly.
- Adopt a robust yet proportionate approach to monitoring and challenging provider activity and costs under contract, prioritising investment in practice level information systems so that practices can engage in the planning and monitoring of hospital activity.
- Actively monitor provider actions in response to the Audit Commission's PbR data assurance audits, and use the findings from these audits to supplement existing information on potential data quality issues.

- Focus on demand management (care and resource utilisation) initiatives and alternatives to hospital care that offer value for money, are realistic, and have strong clinical buy-in. Ensure that sufficient resources are devoted to these initiatives and that realistic assumptions are factored into financial plans and contracts.
- Take the lead in exploring, with providers, the use of local flexibilities, including unbundling, and the development of local tariffs for services currently excluded from the scope of PbR and new currencies that, for example, take account of significant innovation in service delivery currently not supported by the tariff.

All SHAs should:

- Work with PCTs to develop appropriate demand management strategies and support service redesign, spreading good practice within the region and championing issues of national policy with the DH.
- Support PCTs in developing their commissioning and contracting capability.

All PCTs, trusts and SHAs should:

- Develop genuine partnerships across the local health economy and with local government, working towards a consistent strategy and agreement on, for example, care pathways, planning assumptions and data definitions.

1

Introduction

This report continues the Audit Commission's commentary on the implementation of PbR, tracking the NHS's experience with this key reform since its introduction in 2003/04. It highlights the issues the NHS has faced, is currently experiencing and will have to contend with in the future. This is particularly timely as the transition phase of PbR will be complete by March 2008. It makes recommendations for the DH and NHS bodies about the continued implementation of the reform and provides examples of notable practice.

Background

- 1 PbR was introduced in 2003/04 as a single rules-based approach to paying for acute and specialist hospital services in the NHS. It is intended to support the wider NHS system reform agenda, underpinning the introduction of FTs and patient choice by directly linking provider payments to the activity they undertake, enabling the money to follow the patient. The main aims of PbR¹ are set out in **Box 1**.

Box 1

Main aims of Payment by Results

- to enable faster access to more appropriate, patient responsive services;
- to drive efficiency;
- to enable commissioners and providers to focus on quality; and
- to ensure fairness and transparency of funding.

Source: Department of Health

¹ These are based on the requirements of a new financial framework set out in *Reforming NHS Financial Flows: Introducing Payment by Results* (DH, October 2002). Formal aims for the policy have not been published by the DH.

- 2 The initial focus of PbR has been on hospital-based care, although the intention is to cover the majority of acute services, regardless of the setting in which they are provided. A national tariff is set annually for each type of service, with services classified by HRGs.¹ Commissioners are then obliged to pay for healthcare provided to their residents at this tariff. The move from locally negotiated block contracts, based on a compromise between provider costs and what commissioners could afford to pay, and with only a tenuous link to outputs, now means that hospital payments better reflect the volume and complexity of healthcare provided. However, the price of those services and procedures outside the scope of PbR remains subject to local negotiation.
- 3 The introduction of PbR has had major implications for NHS organisations. It has required changes in financial, information and risk management. As we have noted in previous reports (**Refs. 1 and 2**), providers and, particularly, commissioners face greater financial risk and reduced financial control. While similar payment systems operate in other countries, PbR is more ambitious in its pace of implementation and the scope and scale of activity it covers. Consequently, the levels of risk and complexity experienced by the NHS are greater under PbR than elsewhere.
- 4 With the price set nationally, contract negotiations focus on the volume of activity to be provided. Without the protection of fixed value block contracts, providers need to maintain a certain level of activity and ensure that costs do not exceed the national tariff in order to remain financially viable. Conversely, commissioners are required to pay for all activity at the national tariff, although thresholds do apply for emergency care, and bear the financial risk of increases in hospital activity, which they can only partially control. This, combined with broader system reforms such as the introduction of FTs and moving care closer to home, dramatically increases the importance of demand management and strong commissioning.

¹ HRGs are standard groupings of clinically similar treatments that use similar levels of healthcare resource. They are underpinned by diagnosis and procedure classification systems such as ICD10 and OPCS, which reflect current clinical activity performed in the NHS.

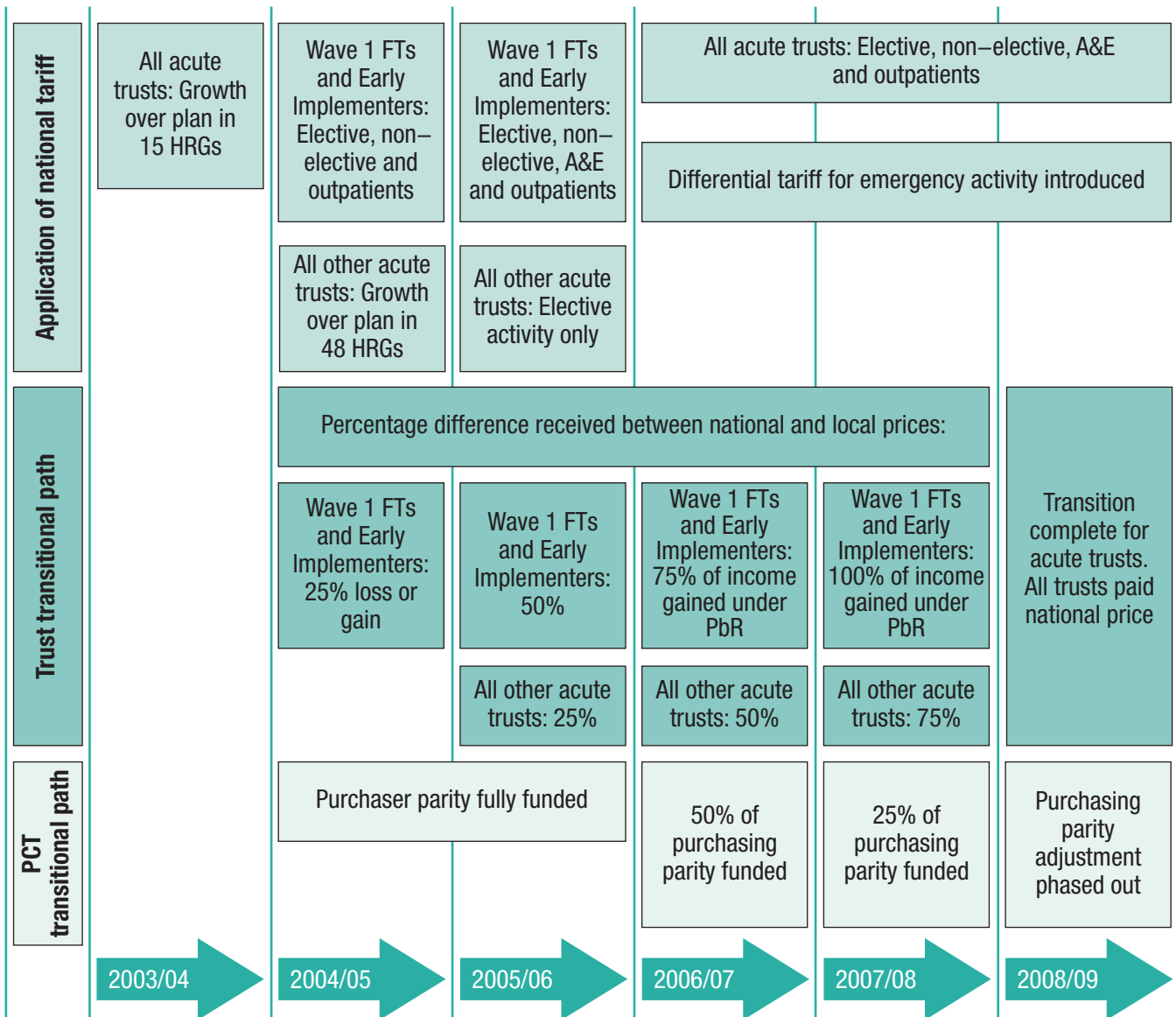
5 Implementation of PbR has been phased over the last four years, both in the scope of activity and its application to different types of providers: the early implementers^I, FTs^{II} and NHS trusts. The financial impact of the transition from local to national prices has been smoothed, with most providers subjected to a maximum 2 per cent loss or gain in income per year as a result of price changes. The purchasing power of PCTs has also been partially protected during the transition to full PbR, with PCTs receiving additional non-recurrent funding based on the differences between the local prices charged by trusts pre-PbR and the national tariff under PbR.^{III} **Figure 1, overleaf**, outlines the roll-out of PbR across the NHS, with transition complete by March 2008 for acute trusts. Despite initial plans to extend PbR to mental health and community services, this has not yet happened, but is expected to be a focus of policy development in the future.

^I PbR Wave 1 early implementers were 20 trusts that became FTs on 1 April 2004 and five NHS trusts that applied for, but at that time did not achieve, FT status. They began to use the national tariff from 2004/05.

^{II} For the analysis in this report, FTs are those acute trusts that achieved FT status in the earlier stages of transition (waves) by 31 March 2006.

^{III} *The Operating Framework for the NHS in England 2008/09*, DH 2007 describes flexibilities open to SHAs in specific circumstances where they will have the discretion to provide support in addition to tariff income or to recover support that was previously given, for example, managing the financial impact at the end of PbR transition.

Figure 1
The implementation of PbR in England



Source: Audit Commission

- 6 This report examines the NHS's experience with PbR since it was introduced. It builds on our previous two publications, *Introducing Payment by Results* (**Ref. 1**) and *Early Lessons from Payment by Results* (**Ref. 2**), which explored the benefits and risks associated with the new policy, and the various approaches to implementation. Since then, much time and energy has been invested in making PbR fully operational. This report seeks to draw on that experience, looking at how PbR has affected the NHS and in turn how the NHS has responded. In addition, we consider the future direction of PbR and the challenges to the NHS over the period to 2010/11, based on the DH's recent consultation (**Ref. 3**).

Methodology

- 7 To inform this report, we conducted detailed, semi-structured interviews at seven FTs (which account for almost one-third of all early implementers), six of their associated commissioning PCTs and four SHAs.^I A letter outlining emerging findings from our research was sent to a wider selection of 57 trusts and PCTs, including our site visit organisations, to ascertain whether the findings were consistent with their experiences. We achieved a 35 per cent response rate (20 returns).^{II} To obtain a national picture of the impact of PbR, we analysed activity, reference cost and accounts data from 2003/04 to 2006/07. Relevant findings from national studies on practice based commissioning (PBC) (**Ref. 4**), the engagement of clinicians in financial management (**Ref. 5**), and the broader package of NHS system reform^{III} have informed our conclusions. We have also drawn on findings from the Audit Commission PbR data assurance audits undertaken in 2007/08, and the pilots undertaken in 2006/07, which explored the validity of the underpinning data to support the accuracy of payments under PbR.
- 8 The following chapter gives a national perspective on the impact of PbR, focusing on whether and how the aims of the policy have been met. **Chapter 3** provides details on how PbR has created benefits as well as barriers at the local level. **Chapter 4** sets out the areas where further work is still required on structures underpinning PbR and the priorities for future development of the policy. **Chapter 5** summarises the report's key conclusions. Examples of notable practice and case studies are included throughout the report.

^I The organisations visited also participated in the fieldwork for *Early Lessons from Payment by Results* (accounting for PCT mergers in three cases), apart from two PCTs and the SHAs which were only visited for this research.

^{II} Please see Appendix 1 for the geographical spread of those organisations who participated in this study.

^{III} Audit Commission joint report with the Healthcare Commission, to be published in 2008.

2

The national picture: the impact of Payment by Results

- 9 PbR has a number of important and ambitious aims, which we set out in **Chapter 1**. In this chapter, we explore progress toward these aims and the overall impact that PbR has had on the NHS to date.
- 10 To obtain a national picture, we have analysed hospital activity and accounts data from 2003/04 to 2006/07, and reference cost data to 2005/06 (the latest year for which such data are available). Isolating the impact of PbR from other parallel changes, such as the introduction of FTs, is not straightforward, as previous analyses have shown. To identify trends attributable to PbR, we reviewed differences between the early implementers of PbR and other acute trusts, and between FTs (which until 2006/07 were operating a fuller version of PbR) and other acute trusts. We looked for step changes in the data following the phasing in of PbR for non-elective and elective care, and we also examined the 15 HRGs that were initially included in the scope of PbR.
- 11 Our methodology is straightforward, and, while more complex and sophisticated analysis can be done, the questions it raises are valid. Our findings are similar to analyses undertaken by the Health Economics Research Unit (HERU) at the University of Aberdeen (**Ref. 6**) and the University of York (**Ref. 7**), although with the former there are different conclusions where Scotland has been used as the comparator. Although these analyses did not extend to 2006/07, both considered trends over a longer period of time and applied a more sophisticated methodology.
- 12 When PbR was introduced, it was expected to encourage acute providers to increase their activity in order to gain more income¹ and to keep their costs below the national tariff price. In response, PCTs were expected to take steps to reduce the number of admissions to hospital and to seek other, more cost-effective, means of providing care. While PbR is intended to enable commissioners and providers to focus on quality rather than price, it could have a negative impact on quality if trusts look to reduce their costs through reductions in service quality or if PCTs seek to reduce hospital admissions

¹ In practice, this incentive is not straightforward as the response will depend on capacity constraints, the pattern of demand and marginal costs.

inappropriately. Finally, PbR is intended to improve the fairness and transparency of payments.

- 13 We found that PbR has probably had a positive impact on day case rates and, as a result, has led to an increase in elective activity in the NHS. It has not had a noticeable impact on non-elective activity. At most, it has reinforced existing trends to increase short-stay emergency admissions. Despite the strong incentives in place, the impact of PbR on efficiency, other than through its impact on day cases, is more questionable. It may have had an impact on the length of stay of elective inpatients, but length of stay overall is falling and is primarily a continuation of existing trends. PbR does not appear to have impacted on quality of care, as measured by mortality and readmissions within 28 days.
- 14 We conclude that, while PbR has to some extent stimulated day cases in the NHS and reductions in lengths of stay for elective inpatients, and has undoubtedly improved the fairness and transparency of the payment system, it has not been a primary driver of changes in efficiency or quality to date. This finding is supported by our qualitative research. Most organisations did not believe that PbR had had an impact on these areas and were sceptical about whether it would do so in the future. These findings contrast with those of HERU (**Ref. 6**) that there has been an increase in both elective and non-elective activity due to the introduction of PbR and that unit costs, as measured by length of stay, have fallen more quickly where PbR was implemented, due to efficiency gains. However, these conclusions are based primarily on comparisons between England and Scotland, which may not be valid given the extent of the differences in healthcare provision and health policy implementation between the two countries. Where they have compared FTs and other acute trusts, their findings are consistent with ours.
- 15 There are various possible explanations for the, as yet, limited impact that PbR has had at the national level. Increases in activity will have been limited in places by capacity constraints and affordability at PCT level. Indeed, this may be seen as a positive outcome in some respects. However, the apparent lack of impact on efficiency is potentially a more serious issue, particularly given the incentives to improve in this area. As yet, the infrastructure required to make PbR work effectively is not yet in place (see **Chapters 3 and 4**), which in some cases will have affected organisations' ability to respond to the incentives PbR offers. Initial instability in the tariff and a limited understanding of costs and cost drivers has discouraged some trusts from making key business decisions about changing activity patterns, and prevented them from identifying and acting on inefficiencies, including

shortening lengths of stay. It is also possible that PbR has had some impact on efficiency locally among those organisations that had the greatest room for improvement, but that this impact is not apparent at the national level. Those trusts that have increased their day cases and reduced their length of stay, for example, were those that had the most improvement to make in response to the incentives of PbR. Conversely, the early implementers of PbR, who were selected, in part, on the basis of their comparative efficiency, had less potential to improve, which may be why we cannot identify a noticeable impact on this group.

- 16 Finally, it is worth noting that the underlying intention of PbR was to engender a positive change in behaviour among local NHS bodies. As we explore in **Chapter 3**, PbR has been relatively successful in this regard, even if this is not measurable at the national level.
- 17 The remainder of this chapter addresses the individual aims of PbR in more detail.

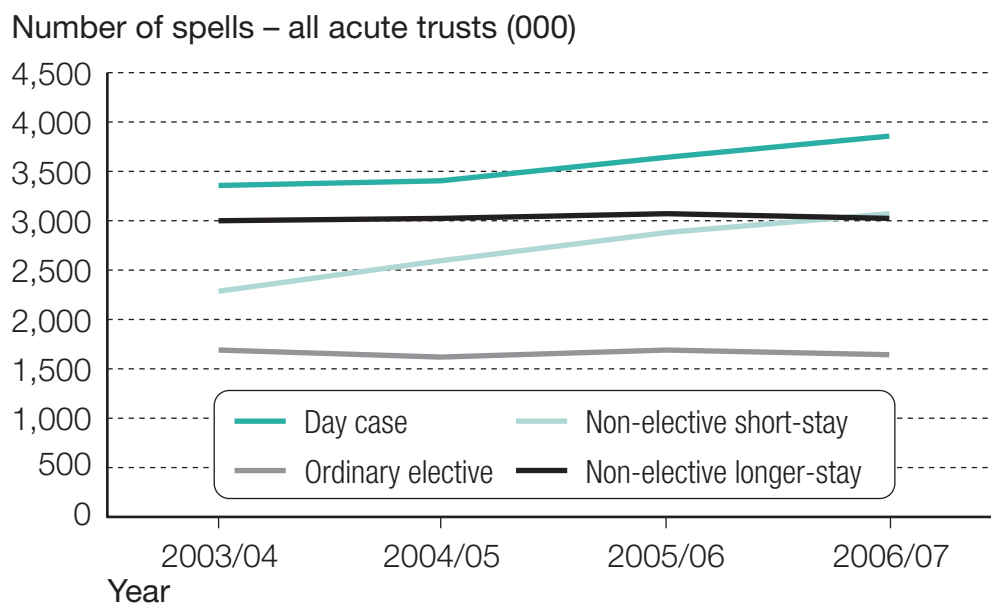
Aim 1: Faster, more appropriate patient care

- 18 PbR was intended to stimulate elective activity and reduce waiting lists by giving hospitals an incentive to treat more patients where the tariff is greater than the marginal cost of providing the treatment. In practice, this incentive is also present for non-elective care, although it has been diluted by the introduction of a differential tariff for emergency care at the beginning of 2006/07.¹ One of the early concerns about PbR was that it would result in greater hospitalisation when the overall policy direction for the NHS is to move care closer to home. However, our analysis of hospital activity, for non-elective activity in particular, suggests that this has not happened.
- 19 Between 2003/04 and 2006/07, total NHS hospital inpatient activity increased by 10.3 per cent. Activity within the scope of PbR increased at a higher rate of 12.1 per cent, with the greatest increase in 2005/06. As we are interested in the impact of PbR on activity trends, the remainder of the analysis in this chapter concentrates on activity within the scope of PbR.
- 20 As illustrated in **Figure 2**, the growth in inpatient activity has been driven primarily by short-stay patients, that is, short-stay emergency admissions and day cases. These are

¹ The introduction of a differential tariff for emergency activity in 2006/07, which will continue to apply in 2008/09, whereby activity over or under planned levels is paid for or subtracted at 50 per cent of the tariff, has helped to dilute the incentive for increasing emergency activity.

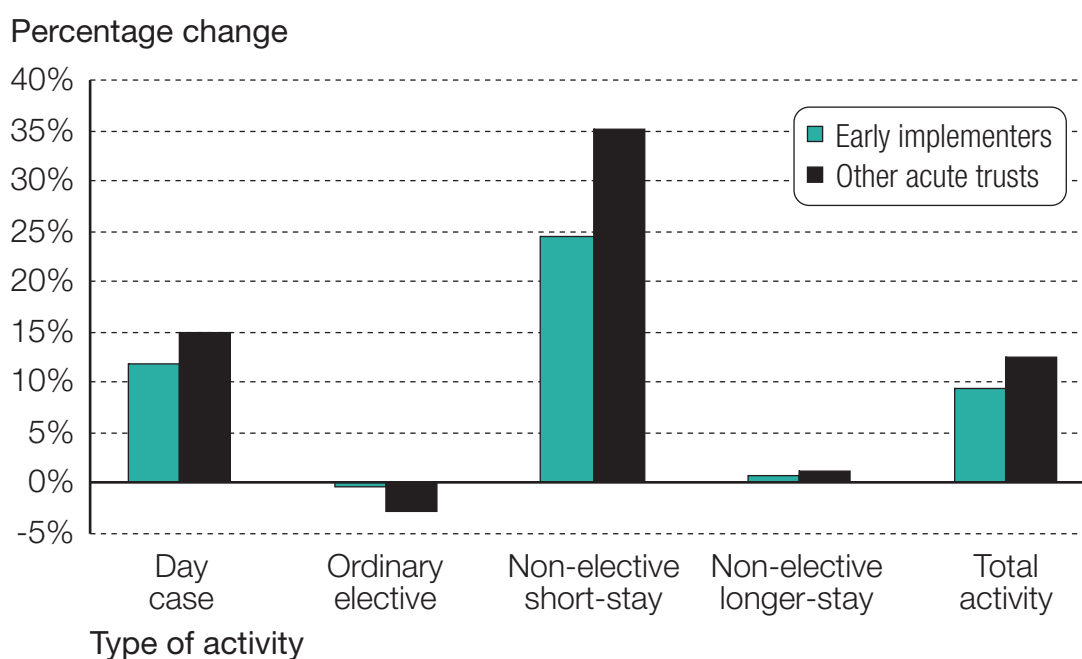
the types of activity we would expect PbR to encourage, as they offer providers the greatest potential for increasing throughput and profit. The increase in day cases can be regarded as positive in terms of efficiency, particularly where they replace longer inpatient stays. The increase in non-elective short-stay admissions may also be positive, as long as they are necessary and appropriate, and also perhaps substitute for longer-stay admissions, but is not necessarily consistent with the move to provide more care outside hospital, particularly for long-term conditions.

Figure 2
NHS hospital activity 2003/04 – 2006/07



Source: Audit Commission (data from Hospital Episode Statistics – HES)

- 21 The increase in total activity has been noticeably lower for the early implementers of PbR (**Figure 3, overleaf**) than for other acute trusts, reflecting a lower rate of increase in short-stay emergency admissions and day cases.

Figure 3**Comparative growth in activity for early implementers compared with other acute trusts 2003/04 – 2006/07**

Source: Audit Commission (data from HES)

- 22 There has been a slight increase year-on-year in the proportion of admissions with complications. This suggests either that casemix¹ is becoming more complex or that trusts are recording complications more systematically. Although there is little difference in trends by provider type to indicate whether this was driven by PbR, it is well recognised the PbR has led to improved counting and recording of data locally, as discussed further in **Chapter 3**. We can expect this to be a factor behind the increasing casemix complexity, and that PbR will further increase coding depth as recording of activity continues to improve. While there are examples of PCTs identifying irrelevant coding of co-morbidities for payment purposes, as demonstrated in **Case study 7**, evidence from the Audit Commission's PbR data assurance audits in early 2007/08 shows that, overall, providers are more likely to be undercoding relevant co-morbidities.

¹ The range and types of patients treated by a healthcare provider.

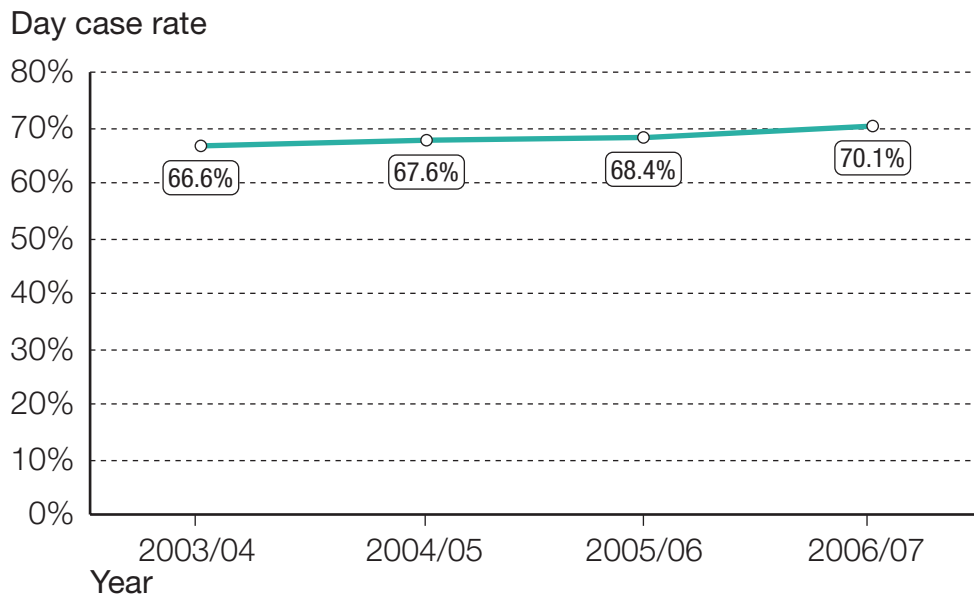
23 Outpatient contacts were included in the scope of PbR from 2004/05 for the early implementers and from 2006/07 for other acute trusts. However, outpatient contacts increased at half the rate for early implementers compared with other trusts between 2003/04 and 2005/06, at 5 per cent and 10 per cent respectively.¹ The ratio of new to follow-up consultations was higher for other trusts during this period, despite the incentives for early implementers to minimise unnecessary follow-up appointments in response to a lower reimbursement rate under PbR.

Elective activity

- 24 As shown in **Figure 2**, overall, elective activity rose over the period between 2003/04 and 2006/07, although it declined as a proportion of total hospital activity. The increases mainly occurred in 2005/06 and 2006/07, with increases of 6 and 3 per cent respectively.
- 25 The increase has been driven by day cases, which have increased from 67 per cent to 70 per cent as a proportion of elective activity (**Figure 4, overleaf**), although they remained constant as a proportion of total activity. PbR encourages procedures to be undertaken as day cases because the tariff is the same, regardless of whether the procedure is undertaken as an inpatient or a day case. Providers can therefore increase throughput, and thereby their income, by undertaking more elective procedures as day cases. The largest increase was in 2005/06, when there was a step change in day case activity. There was also a slight increase in ordinary elective activity in this year, after which it reverted to a downward trend. This was the first year that PbR applied to elective activity for all acute trusts, and it is almost certain that PbR has contributed to the increase.
- 26 Although the step change in day cases was most evident for other acute trusts, there was also a noticeable change for the early implementers, which had been using PbR for elective care since 2004/05. This may indicate a delayed response to incentives, or that, in addition to PbR, trusts were reacting to other factors, such as a renewed central drive to increase day case rates.

¹ As data is only currently available up to 2005/06, outpatient activity in 2006/07 has not been analysed in any detail.

Figure 4
Trend in day case rates 2003/04 – 2006/07



Source: Audit Commission (data from HES)

- 27 There are two further points that are significant in this increase. Firstly, endoscopic procedures accounted for 31 per cent of the increase in day case activity between 2003/04 and 2006/07. This may reflect changes in coding practice, with trusts increasingly undertaking endoscopies as day case rather than outpatient procedures, thereby attracting a higher payment under PbR. Secondly, between 2003/04 and 2006/07, the number of day cases rose by 15 per cent for trusts that were not early implementers. Further analysis shows that the increase is most prominent for those that previously had relatively low day case rates, and therefore the most room for improvement. In fact, 18 trusts that were all relatively higher cost as measured by reference cost index (RCI),¹ accounted for 50 per cent of the increase in day case rates. Through undertaking more elective day cases, these trusts can better use their resources, such as operating theatre and staff time and bed usage, and become more efficient by reducing costs in line with the tariff. This is exactly the response that PbR is intended to elicit.

¹ The RCI is a measure of relative cost attributed to each trust, and is often used as a proxy for efficiency among NHS providers.

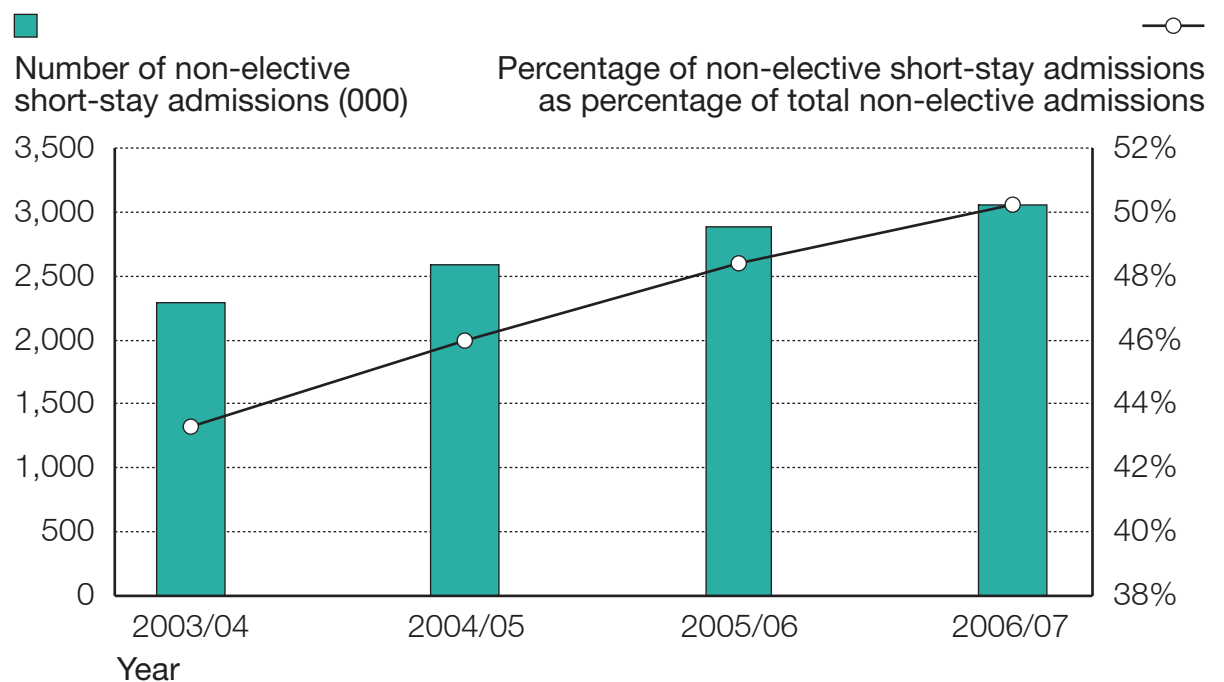
28 We conclude that the introduction of the elective tariff has helped to stimulate day cases and thereby drive an increase in elective activity overall.

Non-elective activity

- 29 Between 2003/04 and 2005/06, prior to the introduction of PbR for non-elective care in 2006/07 for all trusts, non-elective activity increased steadily at a rate of around 6 per cent per year. It rose at a slower rate for the early implementers, despite the fact that they had been operating PbR for non-elective activity since 2004/05. Once the non-elective tariff was introduced for all trusts in 2006/07, the rate of increase of non-elective activity decreased.
- 30 The growth in short-stay admissions over this period has been marked. It now accounts for 50 per cent of total non-elective activity (up from 43 per cent in 2003/04), as shown in Figure 5.

Figure 5

Trends in non-elective short-stay admissions for all acute trusts 2003/04 – 2006/07



Source: Audit Commission (data from HES)

- 31 The primary driver of the increase in short-stay admissions is most likely the four-hour waiting time target for Accident and Emergency (A&E) departments combined with a growth in medical admissions units. Analysis by clinical specialty shows that around 40 per cent of the increase is accounted for by A&E. However, there does not appear to be a relationship between A&E waiting time performance and the increase in short-stay emergency admissions.
- 32 It is unlikely that PbR has been the primary driver of the increases. Growth between 2003/04 and 2006/07 in non-elective activity overall, and in short-stay emergency admissions in particular, has been lower for the early implementers, which have been operating PbR for non-elective activity since 2004/05. Furthermore, growth rates for other acute trusts slowed in 2006/07, when PbR was introduced.
- 33 In summary, PbR was expected to stimulate activity in the NHS. Our analysis of national data shows that it has encouraged an increase in day cases, particularly among trusts that had performed relatively poorly in this area before the introduction of PbR, but has had little impact on non-elective activity. We can expect that at least part of this effect is due to improvements in counting and coding activity, rather than real increases in activity. This has certainly been a factor in the increasing complexity of casemix as noted earlier.

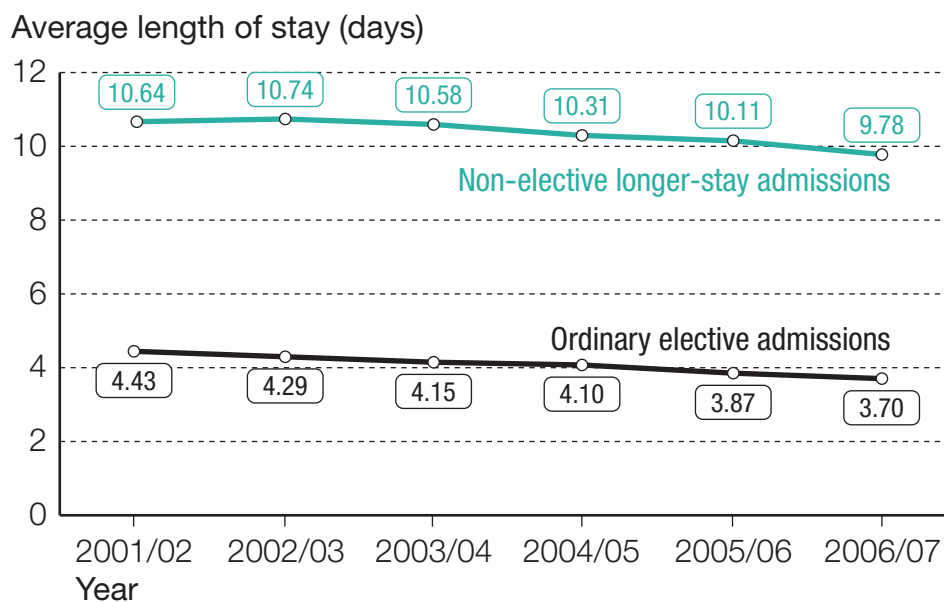
Aim 2: Driving efficiency

- 34 Arguably the most important aim of PbR is to drive improvements in efficiency by encouraging acute providers to keep their costs below the tariff. PbR rewards trusts that are low cost and penalises those that are high cost relative to the tariff. The incentives are likely to be strongest for FTs as they have had greater freedom in how they use any revenue surplus, for example, to develop services or borrow capital. We would therefore expect to see improvements in efficiency over this transition period, particularly for the trusts that implemented PbR earliest.
- 35 Improvements in day case rates and lengths of stay, and changes in the RCI can all be indicators of greater efficiency. The evidence, as noted earlier, is that PbR has led to an increase in day case rates, which has positive implications for efficiency. However, a wider analysis of length of stay and reference costs suggests that the impact of PbR on overall efficiency is questionable.

36 Excluding day cases and non-elective short-stay admissions, the total average length of stay across all trusts has fallen steadily by 1.3 days between 2003/04 and 2006/07 in total, with a proportionately larger reduction for elective activity, as shown in **Figure 6**. This generally reflects the longer-term downward trend for length of stay, apart from a slight increase for non-elective longer-stay activity in 2002/03. Other acute trusts made more progress on length of stay in both elective and non-elective activity than the early implementers since the introduction of PbR in 2003/04, despite the early implementers having greater exposure to PbR incentives. This is possibly because the acute trusts had more room for improvement.

Figure 6

Average length of stay is decreasing for both ordinary elective and longer-stay non-elective activity



Source: Audit Commission (data from HES)

37 Between 2004/05 and 2005/06, the decrease in length of stay for elective activity was 3.7 per cent greater than for non-elective activity. There was a slightly sharper fall in length of stay in 2005/06 for ordinary elective activity, which coincided with the introduction of the elective tariff for other acute trusts. It is possible that this reduction could be attributed to PbR. However, this change is also evident for early implementers, which had already

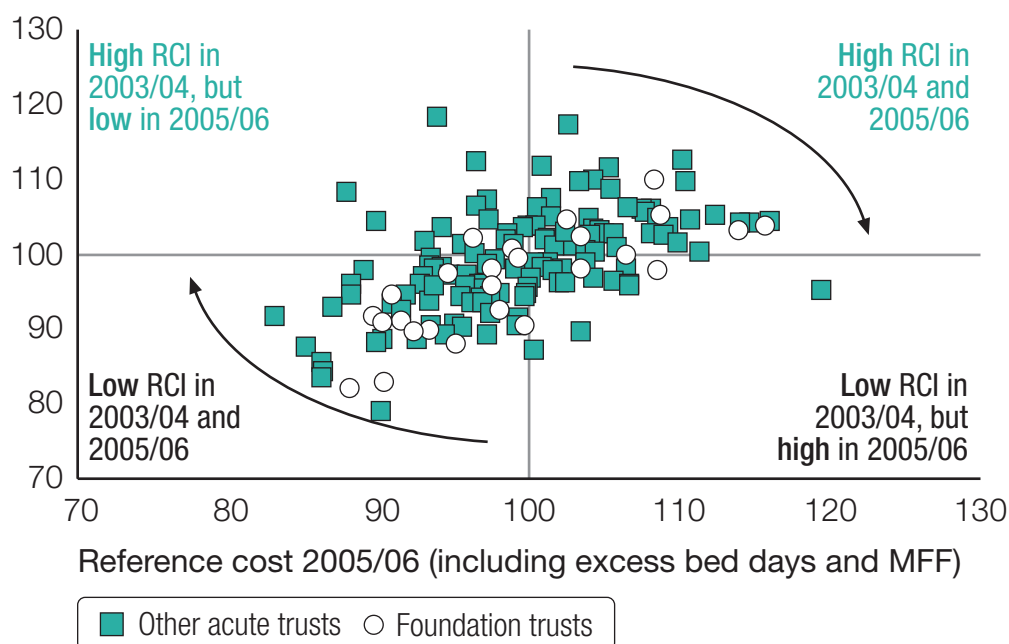
been operating the PbR tariff for a year, and is consistent with longer-term trends. Other factors may have been at play, such as waiting time targets and the need to use resources more efficiently in order to meet them. In addition, we did not find a link between improvements in lengths of stay and high cost trusts, which arguably had the greatest incentive to improve.

- 38 The RCI is a measure of a provider's relative cost, including services not covered by PbR. However, it is often used as a proxy for efficiency and can be used to gain insight into the relative efficiency of NHS providers, despite a number of known weaknesses.¹ A low RCI indicates a relatively low cost (and potentially more efficient) trust and vice versa.
- 39 PbR should encourage generally high cost trusts to reduce their costs towards the average, either through improving efficiency or reducing quality. As illustrated in **Figure 7**, for the most part those trusts that were relatively low cost and those that were relatively high cost in 2003/04 remained so in 2005/06. At the extremes, there has been a tendency for those providers with the highest and lowest RCIs to move towards the average. Trusts with a RCI of 107 and over have all reduced their costs, and the majority of trusts with a RCI of 91 and below have increased their costs. FTs have continued to be lower cost providers over this period, and their relative cost position has been less subject to change than other trusts. Interestingly, all but four of the early implementer trusts increased their RCI over this period, which is consistent with the significant income gain they have made (see **Chapter 3**) and may indicate a reduction in their relative efficiency.
- 40 Overall, while there have been changes in the relative cost of some trusts, decreases have been largely offset by corresponding increases in other trusts, and the distribution of trusts' RCIs remains quite wide. In 2005/06 there were still 12 trusts with an RCI of over 110 and 14 trusts with an RCI below 90. The lowest RCI was 83 as compared to 79 in 2003/04, the highest RCI 119 as compared to 118. It is therefore difficult to argue that PbR has led to systematic cost and efficiency improvements, which supports our findings on length of stay. In addition, given that the transition to PbR for acute trusts is almost complete, it is not clear how high cost trusts will remain financially viable under PbR.

¹ The most prominent concerns with the RCI are about the quality of reference cost data which is used to calculate the index, and the fact that it is based on Finished Consultant Episodes (FCEs) rather than spells. There have been reports of trusts 'gaming' the RCI by deliberately inflating their FCE to spell ratio. Indeed, we found a slight correlation between those trusts that have a lower RCI and those that have a higher number of FCEs per spell, which indicates that this may indeed be an issue.

Figure 7**Movement of trust RCIs from 2003/04 to 2005/06**

Reference cost 2003/04 (including excess bed days and Market Forces Factor – MFF)

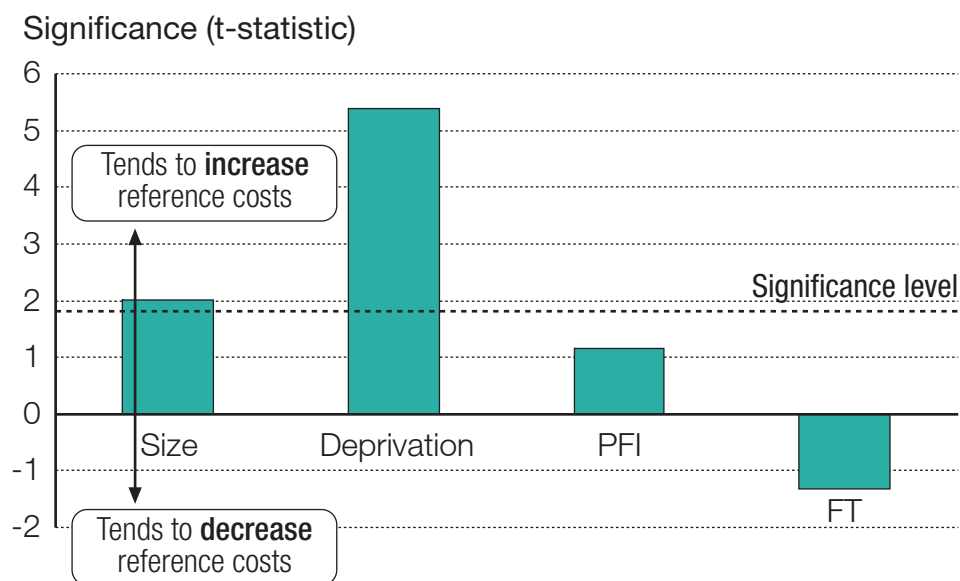


Source: Audit Commission (data from RCI)

- 41 In order to understand what is driving changes in relative cost, we examined some of the factors affecting RCI. FTs are associated with lower reference costs, having been authorised partly on the basis of their efficiency, and the majority are still relatively more efficient than the average trust.
- 42 We found that trusts in more deprived areas tend to have higher reference costs (**Figure 8, overleaf**). This may be because patients from deprived areas are more acutely ill. However the RCI already takes account of casemix. Our analysis of length of stay and mortality within individual HRGs found that patients in deprived areas do not tend to be more acutely ill than elsewhere. Although there is a tendency for patients to stay in hospital longer for a select number of HRGs, primarily involving abdominal surgery, this is not generally the case. The simplest explanation for the higher cost may be that, as PCT allocations are heavily driven by deprivation (around 80 per cent) the greater availability of

funding at PCT level in deprived areas has led to historically higher payments to providers, which is reflected in higher reference costs, and may disguise inefficiencies.

Figure 8
Factors influencing the RCI



Source: Audit Commission (data from Trust Account Returns, FT accounts, Reference Cost Index, Index of Multiple Deprivation)

43 We also found a link between non-PbR income and RCI.¹ In both 2005/06 and 2006/07, approximately one-fifth of FT income was derived from non-PbR activity, such as critical care. Trusts that receive relatively more non-PbR income tend to have a higher RCI (**Figure 9**). Early implementers have a higher percentage of non-PbR income than later FTs. Most trusts that have a high income from non-PbR sources provide specialist services or are teaching hospitals, which may explain the level of non-PbR income. This may also be consistent with the fact that larger trusts, which may have more specialist services, have higher reference costs, although this may also reflect diseconomies of scale. However, it may also indicate that non-tariff income is being used as a mechanism to shift costs into non-PbR activity, where payment is subject to local negotiation and not

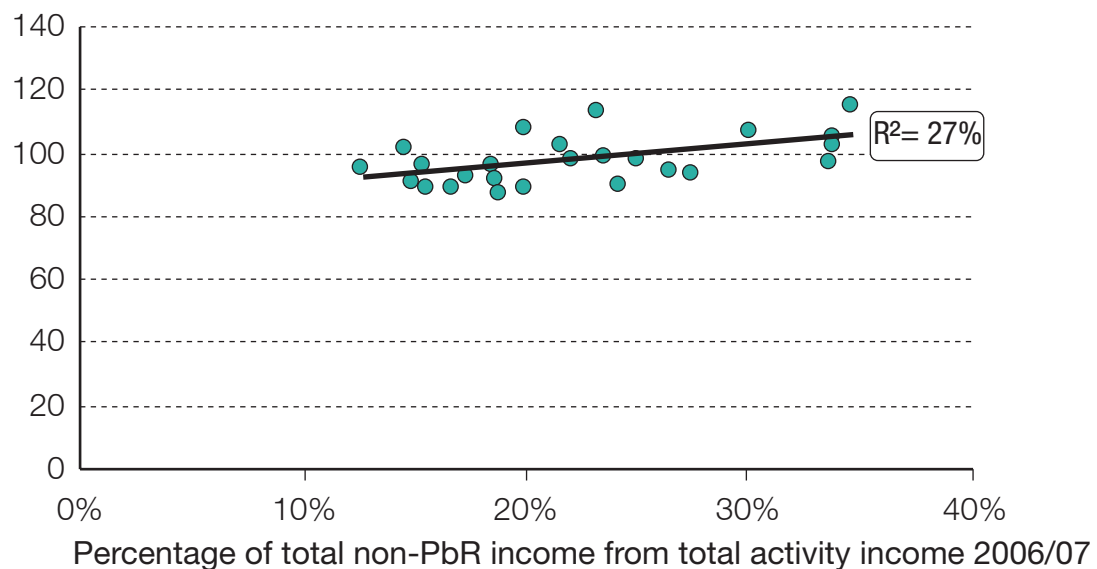
¹ This analysis was based on FT accounts only, as NHS trust accounts do not specify income derived from non-PbR activities.

the national tariff, perhaps to ensure that trusts breakeven, with or without PCT complicity. This has been an issue in some areas, as documented in *Early Lessons from Payment by Results*. Although as the scope of PbR is expanded, the opportunity for this will be reduced,¹ it is important for PCTs to monitor non-PbR activity and payments to ensure these are appropriate, and as transparent as possible.

Figure 9

Non-tariff income partially explains the variation in RCI*

Reference cost 2005/06 (including excess bed days and MFF)



***Note:** Excludes one FT due to inexplicably low figures.

Source: Audit Commission (data from RCI and FT accounts)

- 44 Although we expected PbR to drive improvements in the efficiency of acute providers, particularly for FTs, our analysis of national data provides mixed messages as to whether PbR is responsible for the trends explained. PbR has, at most, contributed to an increase in day cases and a fall in the length of stay for elective inpatients. In addition, despite the change in position of trusts' RCI between 2003/04 and 2005/06, trusts were just as likely to remain relatively efficient as inefficient over this period.

¹ PCTs are less likely to be concerned about FTs breaking even.

Aim 3: Focusing on quality of care

- 45 The introduction of the national tariff was intended to remove the need for local price negotiation and allow PCTs and trusts to focus on the nature and quality of patient care. After an initial focus on quantity and type of activity, and how it should be counted, some commissioners and providers are beginning to focus on quality of care. However, it is difficult to find concrete examples of any improved service outcomes being achieved. At present the financial incentives do not reward outcomes or the quality of service provided. As discussed in **Chapter 4**, rewarding quality is likely to be a focus of policy development in the future, building on local initiatives such as the NHS North West Advancing Quality initiative (**Case study 1**).

Case study 1

NHS North West Advancing Quality (AQ) initiative

The NHS in the North West is planning to make PbR work for patients by using financial payments to incentivise improvement in the quality of care. The Advancing Quality initiative is based on their review of the Centers for Medicare and Medicaid Services (CMS)/Premier scheme in the US which defines quality as consistency, or reliability, of care. NHS North West is developing a voluntary incentive-based system across the SHA in order to align commissioners and providers on the quality agenda and promote sharing of data on quality of care.

AQ is seen as a method to help understand and complement various system reforms such as PbR and the tariff, PBC, contracting and patient-focused care. It was decided to introduce payment for quality in addition, and parallel to, the tariff and PbR, as PbR currently does not provide the levers to incentivise improved quality and has no direct link with quality of service or outcomes.

The scheme is funded from 0.1 per cent of PCT recurrent baseline allocations. Financial incentive (or bonus) payments account for a proportion of this amount, working alongside reputational incentives (ultimately through public reporting of outcomes) and alignment with organisational and professional values. It is anticipated that providers will see efficiency gains, such as reductions in lengths of stay, bed days and readmission rates, from improvements in the quality of care.

The initial focus will be on five high-volume clinical conditions: acute myocardial infarction; coronary artery bypass graft; heart failure; community acquired pneumonia; and hip and knee replacement surgery, where 35 agreed process and

outcome quality measures have already been developed by CMS/Premier. The quality measures comprise what are considered basic elements of a care pathway. For example, those for heart failure include the provision of detailed discharge instructions and smoking cessation advice. The NHS in the North West has undertaken further development work to align these quality measures with National Institute of Health and Clinical Excellence (NICE) guidelines. The AQ Programme will also attempt to align clinical outcomes with patient reported outcome measures and more general patient experience metrics.

As well as obvious benefits for patients and providers, there are benefits for PCTs and practice based commissioners. These include helping them to become world class commissioners that include specifications in their provider contracts around quality, better measure provider performance and value for money outcomes. It will also assist them in developing patient choice and reducing local health inequalities.

Wave One of this programme includes seven trusts, eight PCTs and the North West Ambulance Service, spread across the North West. Data pilots started to collect indicator information from October 2007 and other hospitals are expected to start collecting data in early 2008, with the system planned to go live in October 2008 and first incentive payments to be made in October 2009.

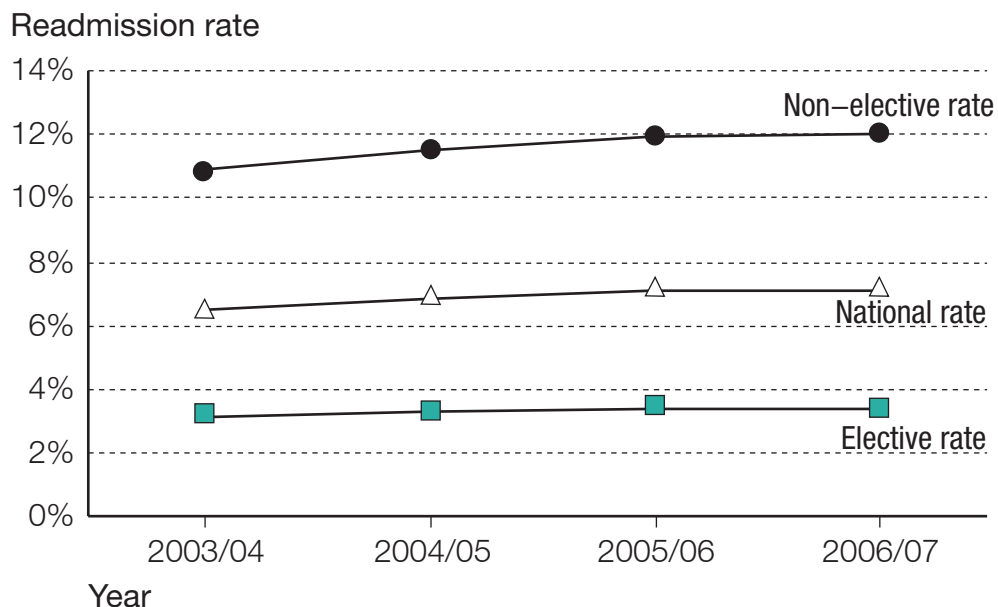
Source: Audit Commission

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- 46 One of the major concerns about PbR has been that trusts would compromise quality in their drive to achieve efficiencies and remain financially viable. The British Medical Association (BMA) found that 53 per cent of doctors who responded to their 2007 survey think PbR will worsen, or considerably worsen, patient care (**Ref. 8**). However, there is no evidence to date that providers are sacrificing quality of care in response to the incentives under PbR.
- 47 It has been argued that PbR may encourage providers to discharge their patients prematurely, and in some cases inappropriately, in order to increase throughput and activity, resulting in patients needing to be readmitted later as an emergency. *Early Lessons from Payment by Results* (**Ref. 2**) highlighted the need for PCTs to ‘maintain and strengthen their focus on quality of care, putting arrangements in place to counter premature discharge (for example, establishing readmission targets)’. While none of the trusts we spoke to felt there had been any change in their emergency readmissions, **Figure 10, overleaf**, shows that readmission rates are increasing, and 83 per cent of PCTs

show an increase in hospital readmission rates between 2003/04 and 2006/07. This could indicate that providers are discharging patients early to reduce costs or to maintain throughput to deliver on waiting times, or that PCTs are trying to reduce excess bed day payments. However, we cannot attribute this to PbR. The readmission rates for the PbR early implementers have stabilised. The ten trusts with the highest increases over the period are all, with one exception, NHS trusts, and are therefore later implementers of PbR. This may reflect the fact that PCTs with more experience of PbR have been able to address this issue more effectively, for example, through monitoring and enforcing readmission targets. In theory, trusts should not be paid for an emergency readmission within 28 days of original discharge, which should counteract incentives for early discharge. However, we have found that, in practice, this provision has often been negotiated out of contracts and most providers continue to be reimbursed for them. This is discussed further in **Chapter 4**.

Figure 10

Rates of readmission to hospital are increasing, particularly for emergency patients



Source: Audit Commission (data from HES)

- 48 There is also likely to be a positive impact on quality at the local level where patients, who are increasingly offered day case instead of inpatient procedures, have a lower probability of contracting healthcare associated infections. However, HERU found no evidence, either positive or negative, of the impact of PbR on quality at trust level. We conclude that PbR has not had a measurable impact on quality of care nationally.

Aim 4: Ensuring fairness and transparency of funding hospital care

- 49 The final aim of PbR is to improve the fairness and transparency of funding flows through the NHS, creating a clear link between activity, income and expenditure and removing much of the need for local price negotiation. This has largely been realised, and is seen as a positive and valuable outcome from the policy. Despite the inevitable winners and losers locally and the concerns mentioned above, NHS bodies consider the principles of the policy to be right. The playing field may not be completely level, but it is fairer.
- 50 Local concerns continue to be voiced about specific details of the policy and transitional arrangements that add complexity and undermine fairness and transparency. While international experience shows that there will always be commissioners and providers that have concerns about specific aspects of funding, what is important is that the systematic issues that impact universally on fairness and transparency, such as fair reward for specialised services, quality and regional cost variation, are addressed. The DH has been exploring options for achieving this through its recent consultation on the future of PbR (**Ref. 3**). This is discussed further in **Chapter 4**.

3

Benefits and barriers at the local level

- 51 Our two previous reports on PbR identified the positive developments that were expected and those that were realised in the first year. Since then, the early implementers, and indeed the rest of the NHS, have had an additional two years to familiarise themselves with the system and take advantage of the opportunities and incentives it offers. Despite our finding in the previous chapter that PbR has not had the expected impact at a national, aggregate level, it has certainly affected behaviour and culture at the local level, where it is easier to identify the drivers of change. This chapter discusses the positive changes that PbR has engendered in the NHS, and some of the obstacles that need to be overcome to achieve further progress.

Payment by Results as the way of doing business

- 52 PbR has been largely mainstreamed by the NHS. It is now seen as the way of doing business – the way hospitals are paid and the basis for contracting – rather than a separate initiative. The terminology is now embedded in discussions of planning, finance, performance and business strategies by both managers and clinicians. The large-scale changes to systems and processes associated with the implementation of PbR have mostly been completed, although significant developments are still required in costing and information systems at providers and in the wider commissioning environment. While there are still exceptions, trusts and PCTs are increasingly focused on using PbR as a tool to change behaviour on the ground to identify and resolve inefficiencies, redesign pathways, manage demand and drive improvement.
- 53 The relative stability of the tariff since 2005/06 has allowed PbR to become more embedded. The commitment to extensive testing of the tariff before issuing the final version and earlier publication of the tariff and guidance in response to the Lawlor Review¹ have all made a difference to local planning. However, it was the decision not to update the tariff in 2007/08, other than to take account of inflation, which has had the greatest

¹ *Report on the Tariff Setting Process for 2006/07*, DH 2006. This was an independent review that followed the withdrawal and re-issuing of the 2006/07 tariff due to errors in the tariff calculation. The review examined the 2006/07 tariff setting process and what did and did not go well, and made recommendations for improvement.

impact on stability. Although this has resulted in a greater divergence between prices, the costs of individual services and the pattern of service delivery, most NHS bodies believe this is outweighed by the much-needed continuity that a stable tariff has provided. Anticipating future volatility has meant that organisations are wary about changes to their business strategies, and investing or disinvesting in services.

- 54 PbR, along with the introduction of FTs, has undoubtedly encouraged a more business-like approach from many providers and, to a lesser degree, commissioners. This has included tighter planning, financial management and performance management, based on a better understanding of their business and local environment. The earlier FTs are more commercially aware than other trusts and are best able to use PbR to their advantage. However, while FT status has been an advantage, there are examples of NHS trusts that have used PbR to achieve the same business culture without FT status. **South West Essex PCT**, which commissions services from an NHS trust, a Wave One FT, a later wave FT and a mental health FT that does not use PbR, believes that PbR, of all the recent reforms, has had the biggest impact on provider behaviour.
- 55 These positive changes have been achieved at a relatively low cost. We estimated in our previous report (**Ref. 2**) that the direct costs of PbR implementation, excluding additional hours worked and time diverted, ranged from £70-150,000 per organisation. Similar figures of £100-180,000 for trusts and £90-190,000 for PCTs have also been suggested by the Centre for Health Economics, The University of York (**Ref. 9**). Although organisations find it difficult to estimate the ongoing costs of PbR, particularly as it is no longer seen as a separate initiative, our recent research indicated ongoing costs in the range of £50-100,000 per year for an average PCT and up to £200,000 for a trust. This includes information systems and software licenses, additional staff and management time, audits and training. However, it does not reflect the costs incurred through, for example, dispute resolution or activity validation, or indeed the benefits or costs saved as result of PbR improving monitoring or less time spent negotiating local prices. It can be argued that investment in improving information systems and wider commissioning functions has a purpose wider than PbR, and therefore the cost of such investments should not be attributed solely to PbR implementation. However, the requirements necessary to function under PbR have certainly hastened the introduction of these system improvements.
- 56 Nevertheless, there is still further to go before all NHS bodies are able to make the most of PbR. Although the policy has stabilised and the systems are largely in place, this does not

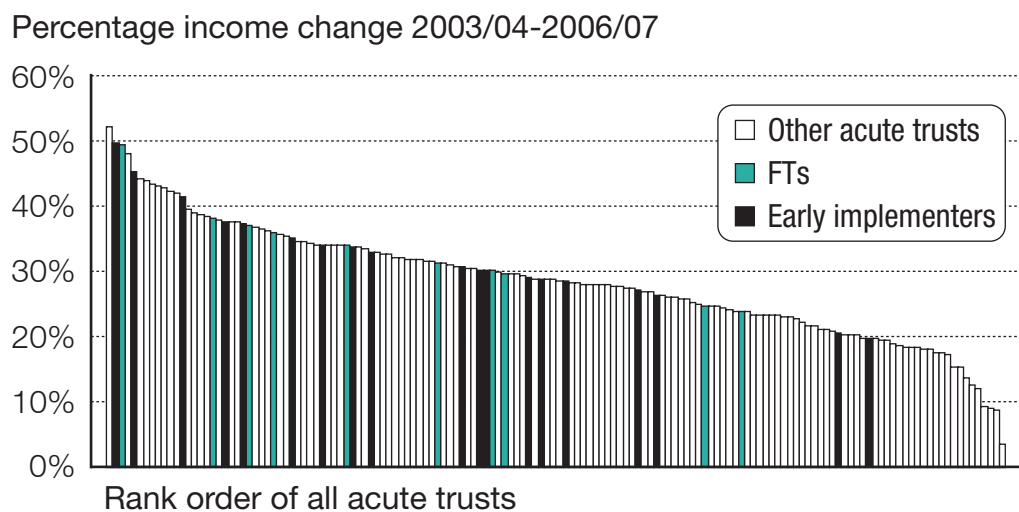
mean that the process and outputs are being well-managed. The much-needed business focus engendered among providers requires an equivalent response from commissioners, who currently lack the experience and skills required to work in a more business-like NHS. PCTs need to develop their commissioning, business and legal acumen to match the capability and capacity of provider trusts, particularly early FTs. Many PCTs have yet to take advantage of the tools and levers that have more recently been offered by PbR, and progress has been disrupted by the recent NHS reorganisation. On the provider side, many trusts do not have the robust costing systems in place that are required to enable PbR to be used to full effect. The following sections on strengthening financial management, commissioning and contracting address this in further detail.

Improving financial standing

- 57** The financial position for the NHS in 2006/07, the first year that PbR applied to elective, non-elective and outpatient activity for all trusts, shows a positive picture. Despite concerns that PbR would destabilise the NHS, the NHS made a net surplus of £514 million (**Ref. 10**), excluding FTs, improving on a deficit of £547 million the previous year. This was made possible by the £1,144 million top-sliced from 128 PCTs by SHAs during 2006/07, £319 million of which was returned to PCTs by the end of the year. Indeed, the forecast position for 2007/08 is £1.8 billion surplus. Although the better understanding of costs that PbR has encouraged is still in its infancy in parts of the NHS, the overall improvement in financial management arrangements encouraged by PbR will no doubt have played a role in generating this positive financial position.
- 58** Income grew faster for FTs than for other trusts between 2003/04 and 2006/07 (**Figure 11**), a difference that is statistically significant. This is even more pronounced for those trusts that were early implementers. As historically relatively low cost trusts, they stood to gain income under PbR through a higher national tariff than local price and they were also on a faster transition path towards the national tariff. In addition, early implementers and first wave FTs were not subject to the 2 per cent cap set to smooth the financial impact of transition and therefore would have been able to retain any gains made as a result of price changes. However, of the 13 trusts that made over 40 per cent income gain over this period, fewer than half were FTs.

59 As mentioned in our previous reports, trusts should invest any additional income under PbR as a result of higher prices paid, or increases in activity, in increased service provision or higher service quality, in order to maintain or improve value for money. Analysis of the 13 trusts that made over 40 per cent income gain shows no significantly greater increase in activity than other acute trusts over the same period, except for ordinary elective and non-elective longer-stay admissions. They are also not any more efficient than other trusts when comparing RCI positions, although the majority of these trusts did make average or above average reductions in length of stay. However, it is not clear that quality of service provision has improved.

Figure 11
Percentage change in income gain for trusts 2003/04 – 2006/07



Source: Audit Commission (data from Trust account returns and FT accounts)

60 These overall income gains will have contributed to the FT net surplus before exceptional items,^I which in 2006/07 amounted to £134.4 million, and their cash surplus,^{II} which amounted to £995 million. The incentive to maintain surpluses in order to perform well on Monitor’s financial risk rating has no doubt encouraged this.

^I This includes the effect of impairments and profits on disposals of fixed assets.

^{II} Net surplus is the excess of income over expenditure. Cash surplus is the cash at the bank and in hand, as reported on the balance sheet, minus any bank overdrafts.

- 61 There has been concern that income growth, of FTs in particular, would bankrupt PCTs. However these fears are largely unfounded to date. We found that PCTs that commissioned over 50 per cent of their work from FTs were no more likely to be in deficit than other PCTs. There has also been no adverse effect on the financial standing of the host PCTs that commission from the 13 trusts with the highest income gain, over two-thirds of which reported a surplus in 2006/07. This may be because PCTs have been effective at managing demand and their finances. Growing acute expenditure has not crowded out primary care expenditure either. Spending on primary care increased by 42 per cent, as compared to 16 per cent for acute expenditure between 2003/04 and 2006/07. However, while this may seem significant, a large proportion of this growth in primary care expenditure includes the higher costs associated with the new general medical services contract.

Strengthening financial management arrangements

- 62 The financial position for the NHS in 2006/07 reflects overall improvements in financial management. NHS bodies have also continued to strengthen their financial management arrangements in response to PbR. This is particularly true of NHS trusts. The relative transparency of the tariff-based system offers clearer insight into the links between income, expenditure and activity, and into comparative costs between providers, which in turn has provided a better basis for planning, reporting and decision making.
- 63 During the first two years of PbR there were a number of changes to core financial management processes and systems, more staff, and various training initiatives. These have now stabilised. Trusts report that income and activity planning, costing, business cases and overall decision making have all improved. The Auditors' Local Evaluation (ALE) assessments¹ also showed evidence of improvement in these areas. For example, the number of NHS trusts failing to meet the minimum ALE standards decreased by 15 per cent for medium-term financial planning and strategic decision making between 2005/06 and 2006/07.

¹ The Audit Commission's ALE, undertaken for the second time in 2006/07, assesses how well NHS trusts and PCTs manage and use their financial resources and is used to inform the Healthcare Commission's annual assessment of NHS bodies.

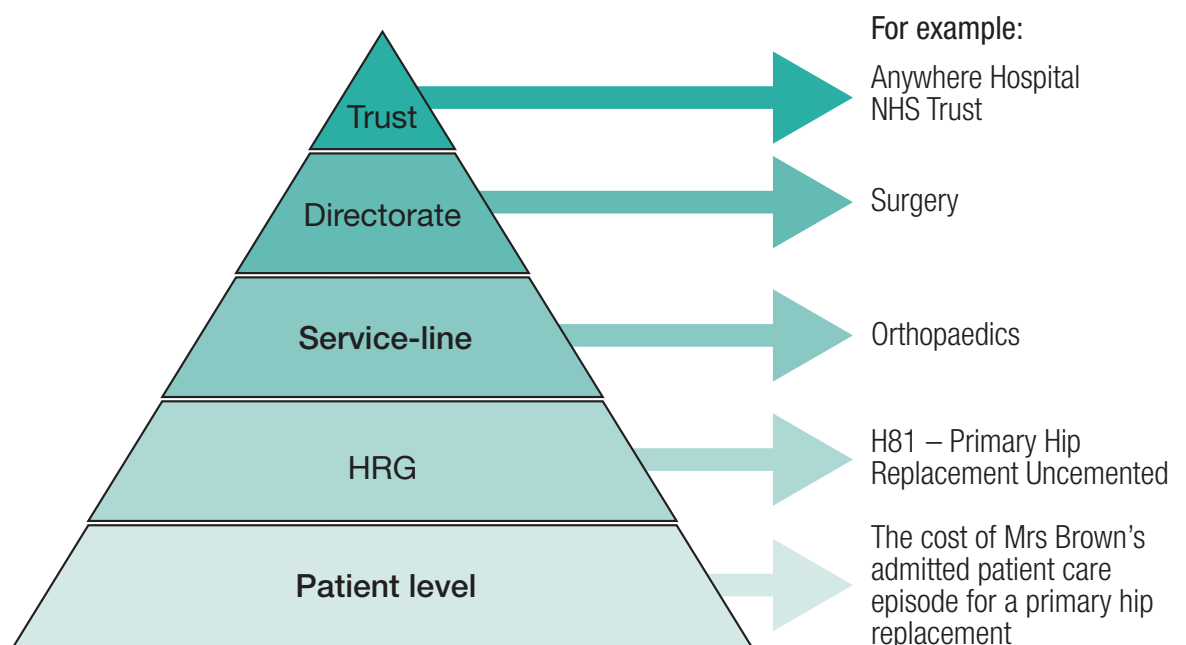
- 64 However, medium-term planning remains a challenge.¹ NHS trusts report that, due to previous significant changes in the tariff in the early years of implementation, and expected future swings, planning horizons tend to remain short term. Providers in particular are hesitant about making decisions to invest or disinvest on the basis of a tariff that may change significantly over a short period. Large scale changes to the tariff structure have not been made for 2008/09, although major changes are expected in 2009/10.

Improving reporting and costing systems

- 65 Acute trusts continue to focus on developing service-line management and patient level costing. Both are important tools for trusts to gain the maximum possible benefit from PbR, and trusts, particularly FTs, are keen to take these forward. **Figure 12** shows how these different levels of understanding information are related within a trust.

Figure 12

Reporting and costing: levels of analysis



Source: Audit Commission, adapted from Monitor

¹ This will be discussed further in an Audit Commission briefing on improving PCT medium-term financial planning, to be published in 2008.

Service-line management

- 66 Service-line economics provides a framework that helps an organisation to understand the combined view of resources, costs and income, and hence profit and loss, by service-line or specialty rather than at directorate or trust level. Service-line management applies these principles by devolving the management of finances to specific business units. While trusts have always managed their services, they have not always understood profitability at the service level. Managing at this level allows managers and clinicians to make more effective decisions about, for example, growing or reducing services on the basis of efficiency and profitability, where cross-subsidisation is required or where services might be better provided in the community. Service-line reporting enables managers and clinicians to identify the financial effects of their actions more clearly. Although some trusts have been using service-line reporting for years, PbR has encouraged more trusts to adopt a more comprehensive and thorough approach. Monitor, a keen proponent and supporter of various service-line management pilots in NHS, is considering bringing it into the requirements for achieving FT status.
- 67 Service-line management is not without its challenges. It can be a resource intensive and organisationally challenging task that involves considerable cultural and behavioural change. To realise its full potential, service-line management has to be deeply embedded within management processes and promoted throughout a trust. Board members, managers and clinicians must all understand the implications of service-line data and be able and willing to use the information, for example, for investment decisions. Monitor suggests an implementation time of three to six months for service-line reporting, although some trusts expect it to take up to two years for the benefits to be realised. There are also technical challenges in defining service-lines on a consistent basis and making available reliable data to support the allocation of costs (particularly non-PbR income) to service-lines. More fundamentally, unless the tariff is stable and provides a viable basis for decisions about starting or stopping services, trusts will continue to be wary of making substantial changes to services based on tariff prices, regardless of improved data, thereby making it hard to realise the full benefits of service-line management.
- 68 Despite these challenges, all the trusts that we visited could identify the benefits of service-line management and were either working with or planning to implement it. They have found that the principles of service-line management have been very helpful, but each trust requires its own approach. The more advanced trusts have already identified

loss-making specialties and specific business drivers, and acted to address the situation. Although there are other methods that trusts may use to understand profitability and identify loss-making specialties, service-line reporting offers a more systematic approach. It provides a more detailed picture and enables a stronger basis for decision making and clinician engagement.

- 69 The following case study from *A Prescription for Partnership* (Ref. 5) describes how one trust has approached service-line management and dealt with some of the challenges.

Case study 2

Newcastle upon Tyne Hospitals NHS Foundation Trust

Newcastle upon Tyne Hospitals Foundation Trust (NuTH FT) is a large teaching trust, operating from three (soon to be two) main hospital sites in Newcastle upon Tyne. Its annual budgeted income is £616 million (2007/08) and it employs over 9,000 staff.

The NuTH FT has recently taken on the challenge of implementing service-line reporting, with the principal aim of improving decision making at directorate level.

The finance department believed it would gain sufficient clinical engagement on service-line reporting, but was initially sceptical about the technical feasibility. In common with other organisations attempting to take up service-line reporting for the first time, NuTH FT encountered a range of problems, some of which seemed insurmountable to the finance staff who were familiar with them of old. The income accountant told the Audit Commission team at the end of its work, 'It was helpful to take a fresh look at the overall information system, without getting bogged down in the detail'.

Key issues and ways in which they were addressed are set out below:

Lack of clarity over what constituted a service-line

The Trust's various organisational frameworks (financial, clinical and administrative) were not entirely consistent, so defining service-lines for the purposes of financial reporting was not straightforward. The first-stage model includes 29 service-lines, covering the Trust's 22 clinical directorates and selected other service-lines that management wanted separately analysed.

Lack of reliable activity data to enable costs of support services, for example, theatres, labs, radiology, etc, to be allocated to service-lines

In the first stage, the project team concentrated on developing a workable solution in one area (radiology), constructing a standard cost based on historical data and

assembling useable activity data from the specialty's information system. A key objective of the second stage of the project is to tackle other identified data gaps, including the allocation of clinical staff resources between service-lines.

Difficulty associating income with service-lines

A large part of the Trust's income comes through PbR, and can easily be allocated to a service-line. However, a significant minority of the Trust's income is for non-PbR services, including teaching. Historical funding agreements and unclear contracts with commissioners meant that considerable work had to be undertaken to understand how this income relates to activity. The Trust is seeking a better shared understanding with its commissioners of the contents of its commissioning contracts to aid this process in the future.

Since having a workable model available, the Trust has now produced full service-line reports for Quarter 1 and embarked on a programme of information areas that can be improved in the medium term and engaging all clinical directors and general managers. Participants in a finance workshop were briefed on the principles of service-line reporting, discussed the key messages emerging from the first-cut model, the limitations of the currently available data, and the proposed next steps.

Source: Audit Commission

Patient level information and costing

- 70 As noted in the above case study, one of the difficulties that trusts have experienced with implementing service-line management is the quality of data available to support accurate costing. Robust activity and cost information is the most fundamental building block of PbR; without this, the system does not have a credible foundation. Historically, most providers have used a top-down approach to costing, apportioning hospital costs to activity at HRG level, following the national reference cost methodology. However, this approach lacks credibility for a number of reasons. Reference cost calculations are often seen as a bureaucratic exercise by trusts and are generally not given the necessary priority, resources and rigour. More fundamentally, this approach does not give an insight into costs of individual patients and hence the variation of costs within a given HRG.
- 71 There is a growing impetus, both nationally and locally, for trusts to introduce patient level information and costing systems (PLICs). They allow for a deeper understanding of service profitability and opportunities for improving efficiency within a trust. This is particularly important for an organisation that is seeking to maximise its profitability or undertake major

service change. It involves a bottom-up approach to costing, using information about individual patients' resource consumption. The costs of individual patients can be aggregated to generate costs for different groupings, for example by HRG, by procedure or by consultant. This not only provides a much better understanding of cost drivers, but also allows for a greater level of transparency and accuracy. In addition, it is a powerful vehicle for engaging clinicians in the financial implications of their practice, as highlighted in *A Prescription for Partnership* (Ref. 5) as it allows costs to be presented in ways that are meaningful to them and that generate informed debate about future action.

- 72 According to the DH, there are 13 patient level costing sites in the NHS at present, and, in total, 59 sites are planning to implement patient level costing in some form over the next few years.¹ The following case study from *A Prescription for Partnership* (Ref. 5) describes the approach taken by **Cambridge University Hospitals NHS Foundation Trust**, which is one of the leaders in the implementation of patient level costing in the NHS.

Case study 3

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust, one of the largest in the country, launched its ambitious costing project in August 2005. The project's purpose has been to establish the methodology, structure and data the Trust needs to produce sound costings. Its success will be measured by improvements in performance in areas such as length of stay, day surgery ratio and excess bed days.

The project has had a material effect on clinician engagement, assisted by its linkage to a broader initiative on efficient patient care which is reviewing the efficiency, quality and safety of patient care within the Trust. It is working at patient level, with an objective of producing a 'hotel bill' for individual patient episodes. The patient therefore becomes the 'building block' for costing. The Trust sees patient level costing as vital to underpinning service-line reporting and the trading account approach to financial management.

The Trust has now produced patient level income and expenditure reports for a number of specialties. This has involved:

- preparing an itemised expenditure analysis;
- splitting up all income – non-tariff as well as tariff; and

¹ Although there is a question over consistency of definition and what hospitals mean by patient level costing.

- working with directorate management on identifying the cause of variations to link the analysis directly with service-line reporting, giving assurance that patient level costs and income are reliable.

Accountability for the project lies not with finance but with corporate management, and the project board has been clinically led.

Although the direct financial impact of the costing project has not been measured, it is estimated to have cost in total over £100,000. The Trust sees it, along with the budget-setting process, as an essential step prior to integrating revised and more accurate costing information. This is likely to be the project's next step.

Source: Audit Commission

- 73 Patient level costing can undoubtedly have benefits for trusts. It can also be important for developing and maintaining a robust and accurate classification and tariff. Although the costs of introducing patient level costing have been prohibitive in the past, particularly if hospitals invest in complex feeder systems to routinely collect additional individual patient data on, for example, operating theatre minutes, these are reducing. The costs of software and technical support for undertaking work on developing costing standards and supplier criteria are much lower than even a year ago, with current estimates ranging from £35,000 to £250,000.
- 74 However, patient level costing is not a panacea. Many of the limitations that have plagued reference costs still need to be addressed. There need to be robust information systems and accurate cost modelling and allocation data. This needs to be a priority for providers, properly resourced, and with clinicians engaged in validating and using the information.
- 75 While there is no doubt that patient level costing will improve an organisation's understanding of its economic and financial drivers, investing in patient level information and costing will not make sense for all trusts. The ability to derive benefits may be limited for some organisations, for example, a small, rural hospital that is unlikely radically to change its pattern of services. Similarly, not all hospitals will have the capacity to maintain a patient level costing system.
- 76 For many organisations, it is the cultural shift and the investment in good information systems, rather than the costing methodology and software that are most important. Individual hospitals need to determine the level of precision that they require for their

operational management. For some, a good understanding of costs by HRG, supported by targeted reviews of HRGs that are identified as loss-making, for example, through asking clinicians to review clinical pathways and identify variation, is likely to be sufficient. There is considerable scope to improve costing without moving to a systematic patient level approach. The Foundation Trust Network's benchmarking project (**Case study 4**) is a good example of this.

- 77 Individual trusts should evaluate the merits of investing in patient level costing, based on their own circumstances, as they would do for other investment decisions. We do not support suggestions that patient level costing should be mandated for all trusts. Providers should instead ensure they have enough detailed information to support optimum service delivery and as required by their PCT. The DH should aim to collect patient level costing data from a representative sample to support the classification system and the tariff. Regardless of the approach that individual trusts take, there is no doubt that PbR has created a positive appetite for better cost information.

Case study 4

Foundation Trust Network Benchmarking Project

In 2006, the Foundation Trust Network undertook a cost benchmarking exercise with volunteers from its membership to gain a detailed understanding of cost drivers.

Seven FTs began by investigating three high-volume HRGs in orthopaedics: primary hip, primary knee and arthroscopy. The participants developed a cost-driver tree and a standardised methodology for apportioning indirect costs.

The major cost drivers were found to be: theatre utilisation, length of stay and prosthetic costs. Although casemix was relatively standard across all seven FTs, costs per HRG varied substantially. All participants identified potential cost savings by improving their performance to the benchmark for a particular cost driver/pathway step. No one organisation was the most efficient across the whole pathway.

Twelve FTs repeated the cost benchmarking in orthopaedics and a third group of 22 applied the approach to maternity, focusing on three delivery HRGs: N07, N09 and N11.

Cost drivers were found to be more complex than for orthopaedics: midwife costs per birth; average length of stay costs per birth; medical costs per birth; the Clinical Negligence Scheme for Trusts (CNST); and theatre costs. For N07 CNST costs alone accounted for between 31 per cent and 47 per cent of total costs. The majority of FTs

were found to be operating above tariff and this finding has, in part, led to amendments to the 2008/09 maternity tariffs.

The FTN is developing an ongoing programme of benchmarking activities to help trusts increase their understanding of HRG-level costs and identify further efficiency improvements.

Source: Audit Commission

- 78 While this section has been heavily provider-focused, PCTs are also taking a greater interest in provider efficiency and cost drivers, and are monitoring these more closely, seeking to influence them where appropriate. The ability of PCTs to monitor and challenge providers' performance is a critical part of managing in the PbR environment and of the new World Class Commissioning framework. Commissioners should learn from trusts' use of service-line management and PLICs in order both to make sustainable commissioning decisions and improve the performance of their provider arms.

Engaging clinicians in business matters

- 79 The Audit Commission has frequently stressed the importance of engaging clinicians in financial issues if best use is to be made of the resources available. Our report, *A Prescription for Partnership* (**Ref. 5**), explores clinical engagement in more detail. PbR, as noted in our previous reports, provides an important platform for this engagement.
- 80 Clinical engagement in financial management within trusts continues to grow. It has been further encouraged by service-line reporting and the information this provides, an approach we recommended in *Early Lessons from Payment by Results* (**Ref. 2**). Clinicians are increasingly interested in PbR, using the language and taking an interest in the financial implications of their clinical decision making.
- 81 At PCT level, PBC is the primary lever for engaging primary care clinicians in financial matters. Both PBC and PbR provide an incentive for GPs to monitor and validate hospital activity, consider alternatives to hospital care, and develop business cases for pathway redesign, using the tariff to identify whether providing care in a primary setting is likely to be a more cost-effective approach. Under PbR, practices can more easily identify the cost of procedures and services for which they refer their patients, which helps them understand the financial impact of the clinical decisions that they make. GP

understanding of PbR remains highly variable and, on average, quite limited. Although it is improving, there has been faster engagement from clinicians in the acute sector.

- 82** There is still a lot of work to do before clinicians are fully engaged in financial management and there are several obstacles to overcome. The credibility of the tariff is an issue for primary and secondary care clinicians alike. Reference costs are considered to be flawed as the basis for tariff calculation and service management. The use of spells, rather than FCEs, lacks meaning for clinicians, and the HRG classification is thought to be unsophisticated, although the release of version 4 (HRG4) should address this.¹ In general, confidence in the quality and timeliness of data is low. Clinicians are also suspicious of any apportionments or adjustments made by their finance departments that are not fully transparent. Such issues, particularly around the allocation of support function and overhead costs, have yet to be overcome.
- 83** There are also issues specific to service-line management that affect clinical engagement, such as the treatment of surpluses that clinicians achieve for their service-line. Retaining surpluses centrally to subsidise other specialties or requiring business cases for release of the money can lead to disengagement and needs to be handled carefully, with a fair and justified approach. However, this must not compromise the ability of the director of finance to manage a trust's finances and meet its statutory duties; financial strategies both need to retain clinical motivation and ensure that financial duties are met.
- 84** Any large scale changes in the tariff structure which may alter the position of service-lines may also result in disengagement. It is therefore positive that the DH has chosen not to make such amendments in 2008/09, ahead of major changes due in 2009/10.

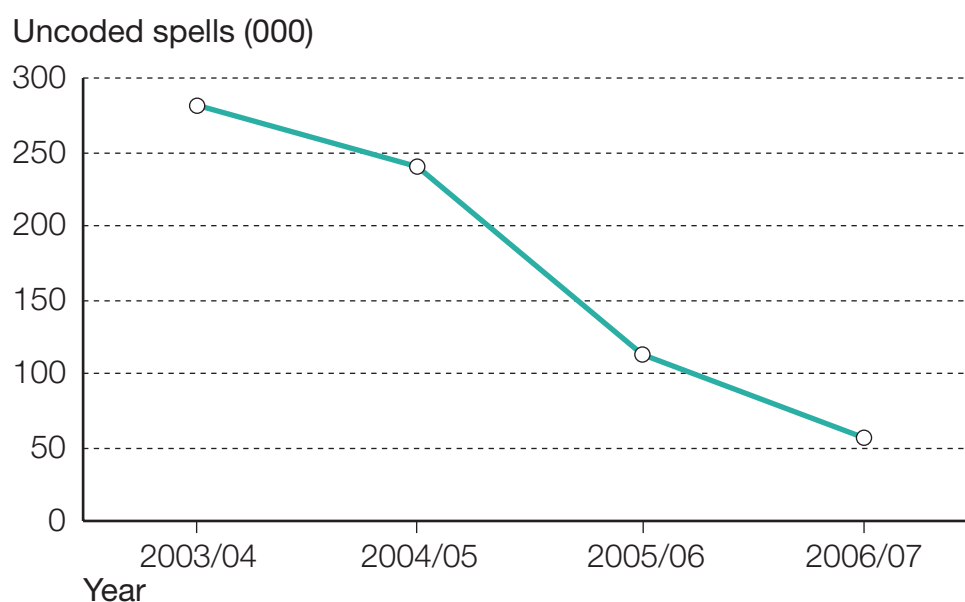
Improving information

- 85** Discussion of financial management, costing and engaging clinicians has already highlighted the importance of robust information for the effective operation of PbR. It has also been a central theme of our two previous reports and the key rationale behind the PbR data assurance framework. Both commissioners and providers report an increased interest in information and data quality and the importance of timely and accurate data for billing and payments, all driven by PbR. Trusts reported they were becoming more

¹ Increased granularity and accommodation of recent developments in healthcare provision and new technologies in HRG4 is intended to improve clinician buy-in and fairness.

rigorous in counting and coding activity and most believe that data quality has improved, although there are examples of where PCTs believe it has deteriorated. Demonstrating that coding completeness has improved, the number of uncoded spells decreased from 2003/04 to 2006/07 (**Figure 13**).

Figure 13
The number of uncoded spells in NHS trusts is decreasing



Source: Audit Commission (data from HES)

- 86 Better counting and coding is an inevitable side effect of introducing PbR and has resulted in much discussion of ‘found’ versus ‘real’ activity over the last two years. It is possible that increases in activity, as reported in **Chapter 2**, may simply be the result of better recording, rather than any real change in activity. The implication of ‘found’ activity is that PCTs have to pay more for essentially the same level of activity as undertaken in previous years, which they tend to resent. This is limited by the PbR *Code of Conduct* (**Ref. 11**), which states that, although trusts may make changes to clinical coding and counting practices in order to improve data quality and the accuracy of PbR transactions, these should not lead to claims for additional payment or loss of income for commissioners under PbR until the next financial year. Over time, improvements in the recording of information will stabilise and annual changes in the tariff can be used to offset

the effects of an upward drift in activity. This should therefore be a short-term phenomenon.

- 87 The potential for fraud or ‘gaming’, through deliberately manipulating coding to increase payments under PbR, for example, by overstating the complexity of a diagnosis (‘upcoding’), was highlighted as a risk in our previous report (**Ref. 2**) based on international experience with similar systems. Such concerns were also highlighted in a survey of PCTs and GPs in 2006 (**Ref. 12**). The perception now among PCTs and trusts is that fears of ‘gaming’ have receded. Moreover, the Audit Commission’s audits of clinical coding have not found any concrete examples of fraudulent behaviour or ‘gaming’ to date. However, the need to improve the quality of the data is still widely recognised.
- 88 The first quarter of clinical coding audits conducted in 2007/08 under the Audit Commission PbR data assurance framework shows error rates in recorded HRGs, ranging from 2 to 25 per cent, due to incorrect clinical coding. The underlying coding error rates are often much higher, but as under- and over-payments tend to cancel each other out, this suggests that their cause is systematic error rather than deliberate ‘gaming’. However, if the balance of under- and over-payments were to change for any reason, this could present a serious financial risk to providers or commissioners. The interim findings show a number of emerging trends in the causes of inaccurate coding, including: coding from incomplete or poor source documentation; lack of access to information and additional systems; omission of relevant co-morbidities; inclusion of irrelevant ones; limited clinician involvement in the coding process; and limited training and internal audit. The inadequacies in existing systems, processes and training that trusts need to overcome are a priority, but the audits have also identified examples of good practice from which the NHS can learn. Acting on the findings from the audits will be an important step for NHS bodies in improving information quality.
- 89 PCTs have continued to concentrate on improving the availability and use of information to monitor contracts and provider performance and to ensure that payments are correct. However, practice is variable. **Case study 5, overleaf**, shows how **Salford PCT** has created a Contracting Unit to undertake routine checks on their acute trusts’ data and monitor clauses within these contracts, resulting in both financial and non-financial benefits.

Case study 5

Salford PCT

Salford PCT serves a population of 216,000 local people in the North West of England. It works closely with Salford Royal NHS Foundation Trust. Together they recently won an HSJ Award for clinical service redesign.

In response to the demands of ALE, World Class Commissioning, its fitness for purpose review, PBC and PbR, Salford PCT has created a Contracting Unit that focuses on contract validations and claims management. It has worked hard to align the PCT's management accounts, information and commissioning functions.

The Unit comprises ten WTE staff and the project has so far cost the PCT £300,000, although approximately £250,000 of this was from existing staffing within the organisation. It categorises its validations work into three main areas, ensuring that:

- contract monitoring checks are routinely undertaken and data quality is validated;
- specific clauses that were negotiated into the FT contract are monitored; and
- validations are undertaken at GP practice level, as part of the PBC incentive scheme and to underpin the PCT's 30 best value programmes.

In 2006/07, systems were developed to ensure the alignment of trust and SUS data, the monitoring of duplicate records, the correct application of PbR rules and locally agreed rules and prices, and that the PCT is charged for its patients only. These routine checks reduced the Quarter 1 FT invoice from £470,000 to £75,000. The PCT has undertaken variance analysis of activity and financial performance, reviewed admission methods down to HRG level and monitored changes in coding practice. The Quarter 3 A&E invoice was subsequently negotiated down from £200,000 to £100,000.

Additionally in 2007/08 the Unit is focusing on trends and coding issues, for example A&E short-stay admission increases, the move from outpatient to day case, HRGs with or without complications, very short-stay admissions and minor conditions that do not require an admission. This will be undertaken alongside the Audit Commission's PbR data assurance framework audit and benchmarking work. Data validations in 2007/08 Quarter 1 have resulted in a total saving of £123,000.

Specific clauses, penalties and incentives have been negotiated into the FT contract for 2007/08. These cover emergency readmissions (within 14 days) and planned procedures not carried out (S22) and will be monitored alongside a quality incentive scheme. The Unit is currently working with practice managers to help GPs check

some FT contract clauses, for example, the timeliness and quality of FT letters and outpatient attendances where test results were not available. One successful challenge per practice per week should save approximately £200,000.

There have also been some non-financial benefits. All contracts, including the additional clauses, were signed by 31 March 2007, there is better information and reporting at PCT and practice/GP levels and ALE scores have improved. The PCT has also experienced the benefits of using practice based commissioners in contracting and claims management.

Source: Audit Commission

- 90 GP practices that are actively participating in PBC are increasingly engaged in validating hospital activity data against discharge letters and referrals, to ensure data accuracy for billing and payments. PbR, alongside incentives provided as part of the Directed Enhanced Service,^I encourages such validation. However, practices are constrained by PCTs' ability to provide timely and accurate information. The Audit Commission's reports on PBC (**Ref. 13, Ref. 4**) have found that GPs' confidence in the quality of activity data is low, and there is frustration about the time spent on data validation rather than service redesign. Providers report a significant increase in patient validation queries from GPs in some areas. Providers are concerned that some of the queries are immaterial or based on preconceived notions of clinical pathways that are not realistic. It is therefore important that PCTs explore the use of peer challenge forums between primary and secondary care clinicians, so that GPs can not only challenge acute colleagues about the way in which treatment has been provided in hospital, but also understand why their original referral may have been inappropriate. Misallocation of patients between practices has also been a big concern. This is not solely a financial issue, however, as accurate GP details are necessary for effective communication between secondary and primary care.

Data provision

- 91 The SUS^{II} provides information about provider activity (as submitted by trusts and verified by PCTs) and casemix, grouped by HRG, and applies the national tariff in accordance with national guidance. While it supports a range of business activities, it is intended to be

^I The incentive scheme offered to practices by PCTs in 2006/07 to participate and deliver PBC.

^{II} SUS is part of the National Programme for IT (NPfIT). It aims to provide a single, consistent source of patient level data and support additional analysis for management and clinical purposes, other than direct clinical care.

the definitive source of activity data for payment under PbR^I and should ensure that commissioners have the relevant data when they need it. However, since its implementation in 2005/06, NHS bodies have heavily criticised SUS for delays in obtaining data, unworkable deadlines and untimely guidance, causing difficulty with changes to local systems. There has also been a perceived lack of national accountability.

- 92 SUS should enable providers to submit data on a continual basis for commissioners to access and use at any time. Without timely access to accurate data, the NHS will not be able to account for activity performed, ensure provider payments are accurate, or indeed commission the right services. However, providers and commissioners report that the poor performance of SUS has been an obstacle to timely and accurate data provision. Our PBC study (**Ref. 4**) found that PCTs and practices had regularly experienced significant delays in obtaining data from SUS. In addition, the online reporting service that SUS had intended to provide to help commissioners monitor and challenge providers' activity data has not yet been delivered.
- 93 The timetable for the provision of activity data, set by the DH, has also been problematic. SUS supports quarterly provision of final datasets in line with the DH Flex and Freeze timetable,^{II} which is not necessarily in line with the PbR payment cycle. This means there is a considerable lag in the receipt of data required to monitor and reconcile payments,^{III} thereby increasing the likelihood of inaccurate payments. There is an expectation that changes will be made in 2008/09, so that by 2009/10, activity data will be frozen and available to commissioners no later than one month in arrears of the month-end, with final payment adjustment against plan within a further 30 days. This may present challenges for trusts that currently operate within a more relaxed timetable, but is necessary and will help to address issues of timeliness.

I *The Operating Framework for the NHS in England 2008/09*, DH 2007 states that from April 2009, the NHS will use SUS as the standard repository for activity for the purpose of performance monitoring, reconciliation and payments.

II Trusts currently send their activity data to SUS on a continual basis and at the 'flex' date a snapshot position is taken, at which point PCTs and trusts enter a dialogue regarding any activity queries and suggested payment adjustments. No payment adjustments may be made after the final ('freeze') date, approximately six weeks later.

III From 2008/09, payment reconciliations for activity within the scope of PbR will be as per the standard NHS contract.

- 94 Local systems have been developed to compensate for the perceived shortcomings of SUS and the timetable for data provision. The Information Centre for Health and Social Care (IC) always envisaged that local arrangements would be required during the transition, and for any locally agreed payment rules. However, the scale of local systems we identified as still in place was not predicted by the IC. It argues that timeliness of data and its processing is the responsibility of providers and that criticism is being inappropriately attributed to SUS. It also argues that NHS bodies' criticism of the inability of SUS to provide the support PCTs require for contract monitoring and payment under PbR is unfounded. While SUS reflects the standard contract and the required data flows, local systems are and should still be used for contract management and billing. SUS is not able to take into account every provider/commissioner partnership in the NHS or locally agreed prices.
- 95 In reality, achieving timely and accurate data provision requires action both from individual providers and national bodies to address existing concerns about SUS. Regardless of where the limitations lie, there is a lack of clarity among NHS bodies about the accountability of NHS data provision, including data definitions, standards and the collection and ownership of SUS, and the respective roles and responsibilities of NHS Connecting for Health (formerly NPfIT), the IC and the DH. While these bodies argue that the dichotomy between PbR policy and the technical aspects of SUS is not understood at the local level, the perception of NHS bodies at the frontline is that such failings are attributable to SUS and accountability needs to be taken somewhere to improve the system. To address this, the DH must set clear expectations about what and when SUS will deliver and by whom, and ensure that these expectations are met.

Data definitions

- 96 A number of grey areas and inconsistencies in data definitions have fuelled disputes between providers and commissioners, and remain unaddressed. The definition of admissions has been the most problematic, leading to inconsistent coding of outpatient and day case patients, followed by recording of rehabilitation and intermediate care. In the absence of clear national guidance, local approaches to achieving consistency and avoiding disputes have developed, such as the use of an approval panel to adjudicate definitions and prevent disputes, and locally led initiatives to research and standardise definitions across an area or region. However, there is still a strong desire for more explicit guidance to clarify areas that are open to interpretation. The DH plans to address this through publishing interim guidance to clarify ambiguity on definitions, while NHS Connecting for Health works

to improve data definitions on an ongoing basis. PbR guidance for 2008/09 includes new advice on how to count and pay for HRG N12 'antenatal admissions not related to a delivery', which has been the cause of several disputes between providers and commissioners. Early indications from the draft PbR guidance, issued for roadtesting^I in October 2007, were that this clarity has been well received.

Strengthening commissioning

- 97 PbR gives PCTs a clear financial incentive to strengthen their commissioning function. There are large gaps in PCT capacity and capability, evidenced most recently by the PCT Fitness for Purpose audits conducted in 2006. Under PbR, weak management skills result in difficulties in achieving commissioning objectives; challenges in negotiating and enforcing balanced contracts; ensuring accurate payments; agreeing demand management strategies; and moving care out of hospitals where it is in the best interests of patients. The limitations of PCT commissioning capacity are now well-recognised and are starting to be addressed both locally and nationally through the DH's World Class Commissioning initiative. PbR has provided the impetus for this agenda.
- 98 PCT reconfiguration undertaken in 2006, which reduced the number of PCTs from 303 to 152, has brought both benefits and further challenges. Collaboration across PCTs, as advocated in the 2008/09 standard NHS contract for acute services (**Ref. 14**), has been a good way to share expertise and strengthen commissioning capacity and power, and was being realised even before reconfiguration. One example is the **West Midlands Commissioning Business Support Agency** (CBSA), which is providing transactional contract management support for 17 PCTs in the West Midlands and is now working through an informatics development programme, including, for example, detailed algorithmic tests for data quality and a new set of clinical quality metrics. However, the benefits of pooled expertise and greater bargaining power are often offset by setbacks in contract management, which is a key area for PCTs in managing PbR, and a short-term loss of organisational memory through PCT re-organisation.
- 99 World Class Commissioning will provide an important vision and framework for strengthening commissioning. As recommended in our previous report (**Ref. 2**), PCTs

^I The DH undertook a period of 'roadtesting' with the NHS prior to the implementation of the guidance as part of a programme of quality assurance to support early service and financial planning, verify the accuracy of the tariff and invite any comments.

should carry out regular assessments of staff capacity and capability at practice and PCT level. They should also undertake such assessments even where they are not the host in shared commissioning arrangements. Shared services arrangements, for example in commissioning informatics, which are increasingly used by PCTs, support further streamlining and are a good opportunity to source additional expertise. However, they do not prevent the need for in-house accountability and the development of core expertise.

- 100 Weaknesses in commissioning capacity make balanced guidance and support on the operation of PbR for both commissioners and providers particularly important, yet PCTs continue to raise this as a concern. While guidance has improved, PCTs feel that the support they receive from SHAs to operate under PbR is limited, particularly given that they lack commercial experience and technical expertise. This should be addressed through the World Class Commissioning initiative, which includes a support and development framework. Examples include sharing good practice, help to develop existing staff or buying in external expertise through the Framework for procuring External Support for Commissioners.
- 101 Although our interviewees reported fewer disputes since the tariff has stabilised, PCTs report frustration at SHAs' lack of expertise to deal with disputes of a technical nature. It is important that SHAs further develop the skills and expertise required to carry out their role of supporting PCTs in this more commercial environment.

Demand management

- 102 Although PCTs have been engaged in initiatives to manage demand for hospital activity (also referred to as care and resource utilisation) for many years, the introduction of PbR has increased their number and importance. Demand management is a key strategy for managing the financial risks associated with increasing hospital admissions that are borne by commissioners. PbR gives PCTs an incentive to move care out of hospital into a community setting, where it is appropriate and more cost-effective to do so. In some cases it can be more expensive and so PCTs and practice based commissioners need to evaluate this carefully. The national tariff enables them more easily to move funds where they can achieve a reduction in hospital activity.
- 103 Some PCTs report that the differential tariff for emergency admissions introduced in 2006/07 has diluted incentives to reduce unnecessary emergency admissions, as the benefit of reducing activity below planned levels in-year is much less, achieving only a 50

per cent reduction in cost. However, this is a short-term view, which does not take into account the longer-term cost savings, as planned activity levels and payments adjust the following year at 100 per cent of tariff, or indeed the benefits to patients.

- 104 Universally, there is now much greater emphasis on monitoring demand, understanding its drivers, and developing cost-effective alternatives to hospital care. The DH is actively encouraging PCTs to work with providers on demand management and pathway redesign (**Ref. 15**). PCTs were able to give more examples of demand management initiatives, and in more wide-ranging areas, than when we researched this issue in 2005. In addition to referral management schemes and redesign of pathways for services in specialties like dermatology and orthopaedics, we found criteria being developed and payment negotiated for telephone consultations by **Derby Hospitals NHS Foundation Trust** and their PCT to replace follow-up consultations, and an agreement in one local health community that, as initiatives shift care into the community, secondary care capacity will not be backfilled with other activity. Trusts often consider that, when such moves take place, they will be left treating more complex cases, but will only receive payment at the average cost through the tariff. This could be addressed by setting the secondary care tariff at a higher rate to account for any changes in casemix complexity, or indeed by setting the indicative tariff at a lower rate for less complex work that is moved out of secondary care. PCTs have also begun to address other areas, such as controlling internal consultant to consultant referrals, a point covered in the 2008/09 standard contract (**Ref. 14**). **Case study 6** sets out the approach of **Wirral PCT**, winner of the HSJ Primary Care Organisation of the Year Award 2007, and the achievements they have made through service redesign.

Case study 6

Wirral PCT

Wirral PCT was established in October 2006, covering a population of approximately 335,000 people with a budget of £504 million for 2007/08.

The PCT is keen to take a modernised approach to commissioning and has undertaken initiatives in innovative service redesign in 14 areas across secondary, primary and community care. One such area is diabetes where, before 2004, approximately 70 per cent of services were provided in secondary care, and the remaining in primary care.

In order to move more diabetes care provision into the primary and community sectors, where appropriate and cost-effective, the PCT has set up a Diabetes

Enhanced Service. Protocols and transfer arrangements have been agreed with secondary care and now more than 70 per cent of care is provided in a primary care setting. The Wirral Diabetes Register has been set up. Practice nurses and GPs have been accredited and trained in specialised diabetic care and diabetic technicians have been employed and trained. For example, over 80 per cent of diabetic patients now have regular foot checks. Patients who develop complications are referred to hospital where they will be seen immediately by the Specialist Diabetes Team rather than waiting for a consultant's appointment. Patient education is a key aspect of the programme and has been commended by the National Diabetes Audit.

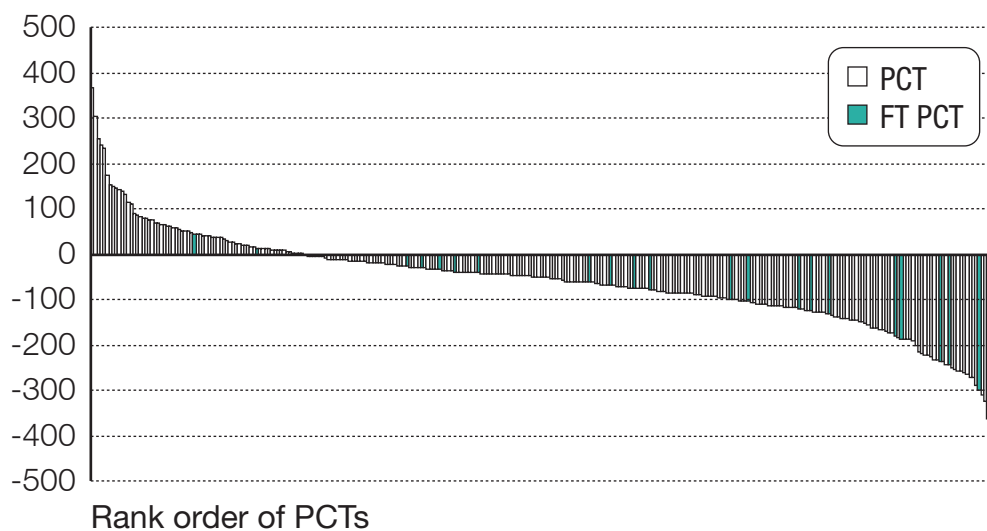
The benefits have been a reduction in waiting times from three-four months to one-three weeks. By providing the service in this way, the PCT have also been able to make significant savings through PbR.

Source: Audit Commission

- 105** The role played by practice based commissioners is growing. They increasingly have demand management objectives in their practice plans, and are receiving and using information more regularly to review care pathways and to discuss alternative ways of providing care with acute clinicians. However, practice based commissioners have yet to realise their full potential in this area and PCTs still need to maximise their involvement. The DH is, in addition to the World Class Commissioning initiative, currently working with PCTs to support this area of work.
- 106** PCTs are making progress on reducing avoidable admissions, that is, preventing people being admitted to hospital with conditions which in theory should never warrant it. Ambulatory Care Sensitive conditions (ACSCs) account for about 15 per cent of all non-elective admissions and cost £7 million per PCT per year, or over £1 billion nationally. As many PCTs increased as decreased their avoidable admissions rates between the last half of 2004/05 and the same period in 2005/06. However, between the first half of 2005/06 and the same period in 2006/07, the picture improved, with three-quarters of PCTs managing to reduce their avoidable admissions (**Figure 14, overleaf**). Those PCTs with an FT in their area have done even better, possibly in reaction to income gains by the FT. PCTs are working hard to prevent over-performance on activity and resultant financial pressures through, for example, demand management and efficiency initiatives, although it is unclear whether PbR is the driver.

Figure 14**The number of PCTs successfully addressing avoidable admissions has significantly improved**

Increase/decrease in avoidable admissions
from 2005/06 Q1,2 to 2006/07 Q1,2



Source: Audit Commission (data from HES)

- 107** Locally, there is evidence of real achievements in some places, but not all PCTs are able to demonstrate reductions in hospital activity or improved outcomes for patients as a result of demand management initiatives. This may be due to the lag between implementation of the initiatives and the realisation of benefits (which may be up to three years for service redesign) or to poorly designed initiatives and difficulties engaging trusts. In order to measure the success of their schemes, PCTs need to focus on evaluating both individual initiatives and their demand management programme as a whole.
- 108** Some PCTs still see demand management as a blunt tool for stopping or constraining hospital activity, rather than taking a strategic approach to service redesign. **Case study 7**, however, sets out how **Birmingham East and North PCT** has approached demand management and the positive impact this has had on shifting the PCT's focus, as well as improving the relationship with its local FT.

Case study 7

Birmingham East and North PCT

Birmingham East and North PCT (BENPCT) serves a population of 437,500 people in some of the most deprived parts of Birmingham. It commissions acute hospital services from Heart of England NHS Foundation Trust.

Since the introduction of PbR, and more specifically since its main provider achieved FT status in 2005, BENPCT has seen acute hospital expenditure increase. This has put significant pressure on PCT budgets and contributed to a projected deficit of £5 million for 2006/07. In response, BENPCT decided to shift the focus of its activities to help control expenditure and manage demand effectively.

Activity for emergency admissions was stable, but the costs of those admissions were increasing. In 2006/07, BENPCT reviewed DH benchmarking data that showed those ACSCs admitted through A&E that could be managed appropriately within a community setting. The figures for cellulitis suggested that one of their pre-merger PCTs had the highest unplanned cellulitis admissions in the country at a yearly cost to the PCT of £1 million.

The PCT finance and information departments drilled down into patient level data, working with clinicians to verify the validity of these admissions and researching how to change processes to avoid the situation continuing. They discovered 'activity attribution', a legitimate coding practice but one that is a significant cost burden to the PCT. For example, a patient admitted with a respiratory problem may also have a pre-existing condition such as cellulitis or diabetes, which is also included when the episode is coded. This had resulted in a higher tariff charged to the PCT that reflected such co-morbidities, although no care was being provided specifically for these pre-existing conditions.

Data verification and pathway redesign has reduced both unnecessary costs for the PCT and demand for the service in a hospital setting. The FT agreed that the PCT should pay only for the treatment given, and not for unrelated pre-existing conditions. A new community service was introduced, to which patients are sent should they attend A&E with a cellulitis complaint, resulting in a saving in excess of £2,500 per avoided admission.

BENPCT's investigation into this case became a catalyst for changing the PCT's focus and functions and how it manages PbR. Not only is the PCT better at proactively managing the acute provider and developing systems to control demand, but it has carried out a total review of PbR charges in areas where the PCT is a significant outlier.

Source: Audit Commission

109 Drawing on the experience of recent years, we have identified a number of key success factors to ensure the success of PCT demand management initiatives. These are set out in **Box 2** below.

Box 2

Key success factors for effective demand management

Engagement of individuals across the local health economy

- Engagement of clinical and non-clinical staff in primary and secondary care across the local health economy, including all those who generate significant referral activity, for example, practice nurses or out of hours staff, approached from a 'right care, right time, right place' perspective.
- Utilisation of GPs' skills, particularly practice based commissioners and GPs with specialist interests in commissioning care and providing services within the community.
- Consultation with service users and other key stakeholders on proposed care pathways and their impact.

Process issues

- Robust planning at both strategic and operational levels.
- Business cases that include robust costings, clarity on what management information is needed, clear and measurable outcomes, targets and patient benefits, and clear responsibility for managing the process.
- Timely and robust information provided to PCTs on activity cost and volume, and effective discharge summaries to GPs.
- Regular monitoring of activity, and identification and control of demand drivers (for example, frequent users of healthcare) by PCTs and practice based commissioners. Close monitoring of new to follow-up outpatient appointment ratios by trusts.
- Validation of activity data by PCTs and GPs. GP peer challenge of referral decisions is a useful tool.
- Real links between PbR and PBC, for example, ensuring that demand management objectives are included in PBC plans.
- Setting clear criteria against which the PCT can monitor the impact and success of demand management initiatives to inform future work programmes, and evaluating the initiative against these criteria.

Infrastructure development

- PCTs, trusts and GPs working in partnership and supportive of plans to manage demand, for example, by ensuring that there are local agreements in place not to backfill released elective activity or for unbundling care.
- Good clinical governance to allow focus/judgements to be made based on clinical outcomes rather than purely on cost.
- Recognition that demand management yields long-term benefits and results will not be immediate.

Source: Audit Commission

- 110** One of the obstacles to service redesign has been difficulties in ‘unbundling’ the tariff into its component parts so that funding can match the new patient pathway. As the tariff includes a component of post-acute care, PCTs that support early discharge from hospital and use community facilities for rehabilitation can currently end up paying twice, once to the acute provider through the national tariff which includes such care, and again to the community hospital for the actual provision of the care. A similar situation applies with diagnostics in the early part of care. In response, the DH introduced the concept of ‘unbundling’ the tariff in 2005/06 and published indicative tariffs for a limited number of diagnostics. Currently, unbundling is allowed for both inpatient and outpatient tariffs, and indicative tariffs are available for rehabilitation and diagnostic imaging. However, this is not mandatory, and the use of indicative tariffs requires local agreement between commissioners and providers, which some areas find challenging. Not all providers are committed to the principle of developing out of hospital services, particularly when it is likely to reduce their income, unless there is an obvious benefit such as assistance in meeting the 18 week referral to treatment target. On the contrary, some trusts are even beginning to think about ‘bundling’ as they are not finding increasing degrees of price specificity helpful.
- 111** Despite these limitations, there have been several positive examples of where PCTs have been able to make progress with unbundling, using either indicative tariffs or locally-agreed prices. These are most frequently found in stroke services and, increasingly, in diagnostics. In the future, HRG4 is intended to support unbundling, making it possible to separately record, cost and reimburse various care pathway components. This is discussed further in **Chapter 4**. In the meantime, PCTs must start work on developing their capabilities in this area now and not wait for HRG4 before they move forward.

Contract negotiation and management

- 112** Contract negotiation and management is a central issue for PCTs. In addition to challenges negotiating unbundling of the tariff, PCTs report continued challenges in agreeing assumptions on activity, what is included and excluded from the tariff and consistent definitions to support them. PCTs often feel they have little choice but to agree to provider demands, perhaps reflecting their limited commissioning capacity. Conversely, there are examples of PCTs deliberately contracting for activity well below the forecast in order to meet demand management targets. In such circumstances it is not surprising that they have difficulty agreeing contracts.
- 113** The acute services contract itself has been a problem in the past. We previously criticised the first model contract for FTs for not reflecting frontline reality. PCTs have found it to be inflexible, heavily in FTs' favour and consequently difficult to negotiate. This contract continues to be in use for some of the early FTs. Subsequent revisions to the standard contract have sought to improve fairness and consistency, providing minimum requirements with scope to negotiate locally around certain additional elements of the contract. The new acute standard contract to be introduced from April 2008 (**Ref. 14**) makes further improvements in this area, such as encouraging the sharing of innovative practice to improve both services and the patient experience.
- 114** In practice, however, the clauses in later versions of the FT contract that would have redressed the balance in favour of PCTs have tended to be negotiated out. These include financial penalty clauses for breaching the 18 week target and emergency readmissions. The former is now subject to a mandatory contract sanction in the 2008/09 standard contract for NHS trusts, whereas the latter is to be locally agreed. Without a stronger negotiating position, PCTs will not be in a position to take advantage of the improved balance of power that the new contract affords them. They also need to ensure that they are appropriately covered for the risks they face.
- 115** The introduction of HRG4, which will more than double the number of prices, will add further complication to contracting, requiring another systematic review of activity levels and assumptions. When working with their trusts, PCTs should ensure they have early insight into the implications for their contracts and any adjustments that they will have to negotiate in response.
- 116** Trusting and mature relationships between commissioners and providers, underpinned by a set of principles to which both parties agree, will go some way to addressing these

difficulties. There are some positive examples of how PCTs are tightening their contract management processes and taking a harder line in negotiations. **Box 3** sets out the principles that **Birmingham East and North PCT (BEN)** has agreed with **Heart of England NHS Foundation Trust (HEFT)** to underpin local negotiations and limit disputes, an approach that other PCTs should seek to replicate. Elsewhere, there are examples of PCTs starting to tighten up on contract exclusions, for example, cosmetic plastic surgery, through the use of an approval panel.

Box 3

Principles underpinning local negotiations between Birmingham East and North PCT and the Heart of England NHS Foundation Trust

- HEFT will support reductions in consultant to consultant referrals, outpatient department follow-up visits and issues of prior approval where agreed specialty based protocol is in place for 2007/08.
- HEFT accepts circumstances where BEN wishes to commission lower activity levels and will work with BEN to achieve these through reduction in capacity and/or drawing in new business from outside the economy. Where patients are sent by BEN GPs or present as self referrals, then BEN will recognise the activity and both parties will work together to improve the pathway and compliance.
- Where tariff guidance is clear or unequivocal, HEFT and BEN will abide by it.
- BEN and HEFT recognise that a charge should reflect the clinical activity undertaken, within the tariff framework.
- HEFT and BEN will seek transparency in data management; HEFT agree to undertake up to two data quality audits per quarter in areas defined by BEN without advanced warning, and BEN will seek to ensure individual queries are kept to a reasonable minimum.
- HEFT and BEN will seek early regular resolution of any disagreements arising in-year, through a quarterly escalation process, enabling sound finance and activity forecasting in year.

Source: [Birmingham East and North PCT and the Heart of England NHS Foundation Trust](#)

- 117 The use of local flexibilities, such as the development of local prices for services excluded from the tariff or where the tariff does not adequately reflect local circumstances, is also growing. The DH has provided guidance on when it is appropriate to use local flexibilities. As with unbundling, this requires agreement by all the parties involved. Despite the difficulties this can present, there is less reliance on national guidance, and more willingness to negotiate a locally appropriate approach. For example, **Basildon and Thurrock University Hospitals NHS Foundation Trust** followed PbR guidance and negotiated a local tariff with **South West Essex PCT** for its specialist pain management service which is currently excluded from the tariff. As the FT specialises in implementation of spinal cord stimulators for pain relief, the tariff (at £180) does not cover the actual cost of the device (at £6,000). However, there are still areas where commissioners struggle to reach agreement. The DH has stressed the expectation that commissioners and providers will reach agreement on their local approach to local tariffs and unbundling for their 2008/09 contracts, with dispute resolution available if agreement cannot be reached.
- 118 Finally, there are still examples of local agreements for activity within the scope of PbR that appear to go against PbR national guidance and principles. One PCT negotiated a year-end deal for a fixed value contract, when they found they did not have enough money for the original agreement with their local provider. We found another example of local tariffs being used for emergency admissions and A&E attendances, instead of the national tariff. Although DH can grant exemption from central guidance on PbR through special circumstances, no such exemptions have been agreed to date. An effective national monitoring system has yet to be put in place, which has probably been of benefit to trusts. SHAs should ensure they have a comprehensive view of local arrangements and payment rules in place, and their consistency with national policy. PbR must be operated transparently, and according to the rules to ensure its future credibility and success as a policy.

4

The future

- 119** As the previous chapters have shown, the NHS and the DH have made considerable headway with the implementation of PbR. However neither the policy nor its practice is fully developed. In addition to the practical implementation issues and substantial local agenda discussed in **Chapter 3**, the infrastructure that underpins PbR needs improvement and the policy itself needs further refinement so that the system can deliver the intended results. This was recognised in the DH's consultation in March 2007 on the options for developing PbR over the next two years (**Ref. 3**). The DH has published a summary of responses to this consultation, although a detailed work programme is not expected to be available until mid-2008 (**Ref. 16**), to take account of Lord Darzi's report. In this chapter we set out what we believe are the priorities for future development of the policy and the further practical implementation issues that need to be addressed at a national level if PbR is to deliver ongoing results and support further reform.
- 120** In our view, the first priority is to strengthen the information infrastructure. While further refinements to the policy will need to proceed in parallel, they will lack credibility without robust data to underpin them. The sequencing of the tasks is important and needs to be approached with care. There are several key issues that need to be addressed:
- **The quality and timeliness of data.** As set out in **Chapter 3**, trusts need to strengthen their systems and processes for recording information about patient care. PCTs should also be focusing on this agenda, supported by the Audit Commission's PbR data assurance audits. In parallel, data definitions need to be refined, and SUS needs to be developed to meet the requirements of PCTs in particular. The DH needs to move to a tighter timetable for data submission by providers. This is being considered for 2008/09, with data available to commissioners no later than one month after month-end. Once this has been achieved, further progress to a shorter timeframe needs to be considered in line with business requirements.
 - **Diagnosis and procedure classifications.** The DH consultation recognises the need to update the ICD10¹ and OPCS coding classification systems that support diagnosis and procedure coding and underpin the HRG classification. Despite recent updates, the existing procedure classification in particular is archaic and lacks credibility. A more sophisticated diagnosis and procedure classification would have gone a long way to

¹ International classification of diseases, World Health Organisation.

improving the ability to distinguish routine and complex care, which has been a problem in the current HRG classification and will be important for supporting the more granular^I HRG4. Given the time required to develop and implement new classifications, we support DH proposals to explore approaches borne from international experience with a view to eventual adoption. The revised OPCS-4.4 classification was released for use from April 2007. However, early work from the data assurance 2007/08 audits suggests that not all trusts have this most recent classification in place. Indeed, some trusts are still using the earlier OPCS-4.2 and 4.3 versions. This will add further challenges to the implementation of HRG4 which requires use of OPCS-4.4 to ensure the wider range of procedures is coded accurately.

- **The quality of costing data.** The inadequacies of reference cost data, which is currently used to calculate the tariff and is usually the only costing data available for internal management purposes, are universally recognised. Use of poor quality costing data is NHS bodies' main concern with the tariff calculation.^{II} Improving this data is essential to the credibility of the tariff as well as for robust financial management arrangements in individual organisations. As discussed in the previous chapter, this may be achieved through patient level costing, or through a more rigorously applied methodology for calculating reference costs, reinforced by service-line reporting. Local ownership, balanced with a nationally consistent methodology, will be critical. The DH should move to a sample approach as the basis for tariff calculation, using cost data from accredited providers, supported by clear clinical costing standards and stronger quality assurance processes.
- **HRG4.** A clinically sound casemix classification is central to PbR. The HRG classification has had its limitations, but the introduction of HRG4 seeks to address many of these. The new version will improve differentiation between routine and complex care, extend the areas covered by the classification and lend itself to funding of the services provided out of the hospital setting. It is also expected to improve clinical engagement, as well as the accuracy and fairness of payments. However, there are concerns about the timetable for implementation of HRG4. HRG4 will require greater sophistication in the underpinning data, price-setting, and financial and contract management. There are doubts about whether the quality of costing and activity data is sufficient to support the additional granularity and, more generally,

^I Granularity allows for greater differentiation between routine and complex work.

^{II} Other concerns raised during our research include the crudeness of the outpatient tariff, and instability in the trim point methodology.

whether the NHS has the capacity to handle the added complexity. Early messages from the 2006/07 reference cost data collection, which used HRG4, suggests that the core HRGs are comparable in quality to 2005/06. However, there are questions about the unbundled data and it is too early to say whether they are sufficiently robust to support calculation of a more detailed tariff for 2008/09.^I And while HRG4 may be clinically sound, there is a fundamental question as to whether HRG4, which will increase the number of prices from 650 to 1400, can be used successfully as the basis for payment. The additional complexity risks undermining transparency and incentives for efficiency. International approaches vary. However, although it does not support unbundling or cover the same scope, the Australian equivalent, Australian Refined Diagnosis Related Groups (AR-DRGs), achieves excellent differentiation between routine and complex care, using a more sophisticated diagnosis classification, with only 665 DRGs. In the USA, the Centers for Medicare and Medicaid Services (CMS) use 745 severity-adjusted DRGs. The strategy for implementing and further refining HRG4 needs to be considered carefully in the light of 2006/07 reference cost data and the proposed strategy for updating the diagnosis and procedure classifications. It will be important to monitor early experience with the new payment classification and be prepared to simplify it if necessary.

121 Beyond strengthening the information infrastructure, the policy itself needs to evolve. In a survey of PCT managers and professional executive committee chairs in 2006 (**Ref. 12**),^{II} 93 per cent of respondents said the PbR structure needed amending to make it fit for purpose, particularly for commissioning. This view undoubtedly reflects concerns about the calculation of the tariff and fears about unintended consequences and perverse incentives resulting from PbR. These include better counting of activity leading to a one-off increase in costs to the NHS, and incentives to admit patients unnecessarily and discharge them earlier. It is important to recognise that even the most sophisticated payment system has unintended consequences and perverse incentives, and they are often best managed through other mechanisms, such as contract management at the local level, rather than by modifying the policy nationally. Nevertheless, NHS bodies have raised substantial concerns, such as those relating to fairness and quality of care, which will need to be addressed.

^I The 2008/09 tariff has been calculated using updated, but only from 2005/06, cost and activity data.

^{II} 109 responses were received across 28 SHA areas from PCT managers, PEC members, other clinicians and practice managers. Two-thirds of the PCTs represented commissioned services using PbR for all their contracts.

- 122 There are additional reasons for refining the PbR policy. The NHS Next Stage Review,¹ led by Professor Lord Darzi, will provide a new vision for the NHS, based around fair, personalised, effective and safe care. PbR already provides an important foundation for this vision by enabling money to follow the patient, supporting patient centred care and patient choice, and encouraging commissioners to invest in alternatives to hospital care. However, PbR was designed to stimulate activity and efficiency in the hospital sector rather than incentivise quality and care in alternative settings, and there are elements of the policy that work against this vision.
- 123 The DH has recognised in its recent consultation on the future of PbR (**Ref. 3**) that substantial changes are required if PbR is to support fully the wider reform agenda, and the concerns of the NHS itself are to be addressed. PbR would struggle to help drive quality, innovation and responsiveness in its current form. There are three priority areas which we believe the DH needs to address:
- rewarding quality and innovation;
 - supporting care closer to home; and
 - ensuring fairness and efficiency.
- 124 These priorities are reflected in the revised objectives that the DH has set for the next phase of PbR, as shown in **Box 4**, which align it with other service policies.

Box 4

Objectives of PbR to 2010/11

- to incentivise better health and healthcare;
- to drive innovation, productivity and responsiveness; and
- to help maintain a clinically sound, transparent and sustainable transactional framework for commissioning NHS services.

Source: DH, 2007

- 125 Using the tariff in a more sophisticated way as a price lever to drive behaviour locally, rather than simply reflecting the national average cost, will be critical. The tariff will need to

¹ Building on *Our NHS Our Future; NHS Next Stage Review Interim Report*, DH, October 2007.

be more flexible so that it can support different pathways as well as specific interventions, while avoiding a wholesale return to local cost and volume pricing.

- 126 The remainder of this chapter discusses the three priority areas we have identified in more depth, the challenges they present and how they might be addressed. We also briefly mention the extension of PbR beyond acute care.

Rewarding quality and innovation

- 127 Rewarding quality and innovation is a high priority locally for commissioners and providers, as well as being central to the NHS reform programme. Currently, PbR rewards efficiency and volume. The overall principle is that it reimburses average cost, and by implication average care. The tariff is modified to cover the costs of new technologies and clinical practice recommended by the National Institute for Health and Clinical Excellence (NICE). However, there are limitations to the extent to which such adjustments cover quality and innovation. In some cases, specific price adjustments are made to take account of NICE guidance. For all other cases, the costs are covered by a general tariff uplift that applies to all services in all hospitals. This approach rewards hospitals that do not adhere to NICE guidance and penalises those that apply NICE guidance more than the average. There are also advancements in medicine and better ways of working that NICE guidance does not cover. While innovative drugs and technology are often more expensive when first introduced, and best practice can be more resource intensive, it is also true that the most effective treatment is often the most efficient, and more cost-effective in the long term.
- 128 Coordination and integration of care are also core components of quality. The present tariff structure is institution-focused and does not encourage coordination across organisational boundaries, that is, partnership working across primary and secondary care.
- 129 The introduction of HRG4 could go some way towards supporting quality, through a fairer tariff for more complex care, and providing the flexibility to unbundle the tariff, if the data is there to support it. However, a more sophisticated HRG classification will not be sufficient. The DH consultation covered the development of prices to reflect quality. We believe the overarching approach needs to include a number of factors, such as:
- The possible use of **normative tariffs** linked to specified quality standards.

- **Separate quality payments** which directly recognise and reward quality, drawing on the emerging lessons from North West SHA's Advancing Quality initiative (see **Case study 1**) and approaches in other countries, such as the USA.
- Flexibility to set **local prices and currencies** that take account of significant innovations in the delivery of care that are not currently supported by the tariff, while offering fair reimbursement for high quality care. This must be mutually agreed by commissioners and providers and should be underpinned by clear national principles.
- A **flexible tariff structure**, which allows both unbundling of the tariff into separate components and payment for packages of care, based on patient pathways. This should include exploring single payments for a package of care, such as the 'year of care' approach^I being explored for diabetes, or another measure of need.

130 A combination of approaches is necessary. Normative tariffs could drive improvements in the quality of a service or pathway, for example, to support a new clinical strategy. Indeed, the DH's approach to normative pricing is likely to focus on where improvements in the quality of patient care can be supported by the tariff (**Ref. 16**). However, we consider that normative tariffs might be used more easily and appropriately to drive efficiency (see paragraph 141). Separate payments should be made more generally for achieving specific quality goals in order to reward an overarching commitment to quality and support investment in better ways of working. In addition to the national framework, the ability to negotiate local prices and currencies that reflect high quality or innovative local practice is essential, particularly as the nature of innovation is such that it is difficult for national policy to be adequately responsive. Local flexibilities are already in use in some areas to support technical innovation and improve access, as discussed in **Chapter 3**, but this could be more systematic. Finally, the flexibility to unbundle the tariff or to set a price for a pathway of care, rather than a single episode or spell would support personalisation and coordination of care, to be used where an institution-based tariff hinders an integrated approach to commissioning.

131 Such an approach requires the DH to be more flexible, to use the tariff as a policy lever to drive desired behaviours rather than as a reflection of average costs, and to permit the

^I 'Year of care' pathways describe the weekly or monthly 'care activities' that patients and service providers (in primary, community and acute care settings) will undertake in the period of a year for each stage of a disease's progression. Advantages include being able to prospectively cost the pathway in question and specify quality and outcome indicators.

greater use of separate payments over and above the tariff. It will require greater sophistication and confidence in policy making. Most importantly, it will require the engagement of strong and inclusive clinical networks to ensure that any tariffs, regardless of how they are calculated, are clinically sound and drive appropriate behaviour.

- 132** A more sophisticated approach to rewarding quality at the local level should ensure a payment structure informed by the best, evidence-based care, as identified, specified and commissioned by PCTs. Commissioners must carefully monitor the achievement of quality standards and the appropriateness of higher payments in response. Where local prices are in use, commissioners and providers should ensure that these support the adherence to NICE guidance or best practice advocated by the professional regulatory bodies that play a key role in the delivery of high-quality and equitable patient care.¹ Finally, a needs-based funding approach to long-term conditions would work best if the funding for a specific set of patients is held by a particular group with responsibility for coordinating care for these patients, such as community matrons or specialist nurses. This may be achieved through the extension of PBC, in the case of community matrons, or an alternative mechanism. Whatever the approach, it must be locally appropriate.

Supporting care closer to home

- 133** Since the publication of *Our Health, Our Care, Our Say* (**Ref. 17**), in which the government set out a new direction for community services, the momentum for providing care closer to home has been increasing. The recommendations resulting from the NHS Next Stage Review are expected to reinforce this.

Unbundling the tariff

- 134** Without the ability to unbundle the tariff into its component parts, there is only a financial incentive for PCTs to move care out of hospital when they can move the whole service, rather than just part of it. As discussed in **Chapter 3**, indicative tariffs are currently available for rehabilitation and diagnostic imaging, but making use of these tariffs can be challenging, as they are not mandated and require local agreement between commissioners and providers. This is problematic in areas where relationships or PCT negotiation skills are not strong.

¹ In line with *Managing the Financial Implications of NICE Guidance*, Audit Commission, 2005.

- 135** HRG4 supports unbundling for nine services, including critical care, rehabilitation, chemotherapy, radiotherapy, renal dialysis and specialist care. Once this is introduced as the basis for the national tariff, there will no longer be a requirement to agree the use of unbundled tariffs locally. However, this will not be the case until 2009/10 at the earliest. In the meantime, providers and commissioners will need to continue agreeing unbundling arrangements locally, with PCTs taking a harder line in some instances and resorting to dispute resolution where necessary. In addition, recording data on unbundled services separately within a single hospital episode is already proving a challenge for many trusts. NHS trusts therefore need to prioritise adjustments to their systems to support the necessary information requirements.
- 136** While unbundling can offer flexibility in moving care out of the hospital setting, it also has limitations and can work against the integration of primary and secondary care and supporting care closer to home. This is because it can result in providers focusing only on the bundle of care that they provide rather than the spectrum of care provided throughout the whole patient pathway across care boundaries. In reality, a mix of unbundled and bundled care will be required, and in some cases other alternatives may need to be investigated and pursued. These include a capitation-type funding or a single payment, such as the year of care approach.

Moving to a 'setting independent' tariff

- 137** HRG4 has been designed to support 'setting independence', where the same tariff is applied to services regardless of the setting in which they are delivered; that is, inside or outside a hospital. This is intended further to support moving care closer to home, provide a level playing field and improve transparency of payments to other providers of acute care. However, there are practical limitations to this approach. Firstly, outpatient and community activity and cost data are not of a high enough quality to support the development of a robust tariff or accurate payments. In addition, it would involve a major change to the recording and coding of outpatient and community activity, where the NHS already has difficulty meeting much simpler requirements. Previous work by the Audit Commission suggests that data quality for outpatient clinics is extremely variable. There is little clinical involvement and no specific coding of activity at outpatient clinics, other than that for a few selected procedures. In 2007/08, as part of the data assurance framework, the Audit Commission is running pilot projects in outpatients and critical care to investigate data quality further. Considerable investment needs to be made to the infrastructure for outpatient and community care to ensure that data of a sufficient quality

is available. This will be even greater if coding of activity is required to reach acute inpatient standards.

- 138** Secondly, in many cases it is unlikely to be feasible to define a viable tariff that covers the range of alternative providers. Acute hospital and community providers have widely different configurations and overheads. A single tariff would lead to considerable profit or loss per patient for different providers, so its use would need to be limited to instances where there is a unilateral drive for care to be provided in a specific setting. As with quality and innovation, there is a case for using a ‘setting independent’ tariff to drive behavioural changes in specific cases.

Ensuring efficiency and fairness

- 139** Efficiency and fairness remain two important principles underpinning PbR. More can be done to achieve both.
- 140** Following the recent Comprehensive Spending Review, there is an even greater push for efficiency savings in the NHS. Although in theory PbR is an important tool for achieving this, the tariff has done little so far to drive NHS efficiency. The exception is the increase in day cases, which demonstrates the potential of PbR to encourage positive changes in behaviour. If PbR is going to make a real difference to efficiency, further changes are needed.
- 141** There is scope to set normative tariffs based on efficient practice, where prices are ‘based on judgements about what level of technical efficiency can be eked out’ (**Ref. 3**). The DH has proposed this approach in its consultation, and while it would not be feasible across the board, there are clearly opportunities to make this work for specific services. However, this needs to be approached carefully. Work undertaken by the Foundation Trust Network (**Case study 4**) shows that, in theory, even the most efficient trusts can improve their efficiency in some areas of the care pathway. However, in practice, it may not be possible to achieve full efficiency across all aspects. The impact on different types of providers needs to be carefully considered. Some providers may not be able to reach the levels of efficiency achieved elsewhere because of their circumstances, such as small, remote hospitals, but still need to ensure access for their local population. It will be important that a tariff based on efficiency does not undermine such services and make them unviable. In general, efficiency should be viewed as an ongoing objective rather than as an absolute attainable. It would also be important to ensure that normative tariffs can

support good quality services by identifying providers that already achieve such levels of efficiency and deliver a good quality service.

- 142 In relation to fairness, there are at least three specific aspects of PbR that need to be addressed: capital; specialised services; and the Market Forces Factor (MFF).

Capital

- 143 Affordability of capital investment is a critical issue for the NHS. There have been significant underspends on capital resources. Currently, the PbR tariff includes the revenue costs of capital investment. NHS bodies are concerned about the incentives that this provides. A tariff based on national costs will not always recognise the higher revenue costs incurred by providers with new facilities, which may be financed, for example, through the private finance initiative (PFI). Although it is not targeted at trusts with new facilities, the annual tariff uplift includes any generally anticipated increases in capital charges and revenue and the national impact of operationalising PFI schemes.
- 144 There does not appear to be a statistically significant link between PFI schemes and the relative cost of trusts, as measured by the RCI. Those trusts with the largest PFI schemes in 2005/06 were no more expensive overall than any other trusts. And perhaps most importantly, a well planned capital investment scheme should lead to greater efficiency. New builds should be more efficient and have lower maintenance costs, and these should have been the foundation for the business case for investment.
- 145 The DH is currently reviewing its capital policy, with a view to amending the capital investment regime so that it aligns with the future needs of the NHS. The review, due to be carried out by April 2008, will consider what scale of investment can be supported by the tariff and will influence future PbR policy in this area. There are at least two options: a separate payment stream for capital; or continuing to fund capital through the tariff. A separate payment stream for capital costs would allow capital funding to be more effectively targeted. This could be triggered locally, allowing commissioners to support investment in their local providers. This would not only improve fairness, but would also support quality and innovation and moving care closer to home. However, it would reduce the incentives for efficiency and is currently not an approach favoured by the DH, given that it could create an uneven playing field for the independent sector and NHS providers. Continuing to include capital costs in the tariff gives a stronger incentive to trusts to carefully plan investments and ensure that they deliver savings in the longer term. The

approach depends on the extent to which the current policy is truly a barrier to strategic capital investment, and needs to be explored in more depth.

Paying for specialised services

- 146** The current approach to paying for specialised services involves paying top-ups for certain specialist services regardless of the provider. This is thought not to reflect adequately the true costs of specialised care provided by specialist providers, and to over-compensate other providers. The DH's intention in the long term, following the Carter Review (**Ref. 18**), is formally to designate certain providers to provide specific specialised services, based on a nationally agreed set of criteria, in order to provide safe, high quality specialised care.
- 147** In the meantime, the DH has announced its intention to change the approach from 2008/09 in order to more accurately target funding, to support PbR more specifically. Providers will only receive a specialist top-up, a premium paid in addition to the PbR tariff to ensure full costs are covered, if they are included on a list of eligible providers agreed by Specialist Commissioning Groups in conjunction with SHAs. In addition, we can expect HRG4 and the introduction of a tariff for critical care to address some, but not all, of the concerns about the fairness of payments for specialised services.
- 148** Agreeing the list of providers is likely to prove difficult. As a route for managing exceptions, a new flexibility for SHAs has been introduced to support applications for top-up funding for those organisations not on the published list. Furthermore, any major change in the specialised service top-ups will have an impact on commissioners and providers, particularly where hospitals are deemed no longer eligible for top-ups that they were receiving in the past. A change in 2008/09 allows very little notice for the organisations involved and has the potential to destabilise finances locally. This is a challenging area to get right. Most countries with systems similar to PbR have separate payments for specialist care and there is merit in following the same approach for the NHS, at least until HRG4 has been implemented and other changes to the currency and the tariff have stabilised.

Market Forces Factor

- 149** The MFF performs an important function under PbR, allowing adjustments to payments to providers to account for unavoidable cost differences in delivering services in different parts of the country. The limitations of the MFF for this purpose have been debated in the NHS since the introduction of PbR, and the approach has been under review since 2006.

The review has recently been completed, but the guidance for 2008/09 suggests that the approach will remain unchanged. It is unclear how the DH intends to address this issue in the future, but it is imperative that a more robust approach is found to ensure fairness of payments.

- 150** In summary, the PbR tariff is complex when compared with similar systems in other countries. This is primarily because so much is incorporated in the tariff, rather than having separate funding streams, for example for capital renewal and geographical cost variations. This complexity, which is set to become even greater with the introduction of HRG4, is designed to promote fairness but the perceived impact is often to undermine it. The DH should not be afraid to explore separate payment streams outside the tariff, as it currently does for research and development, to cover specific services and costs, such as capital and specialised services.

Beyond acute care

- 151** PbR has rightly focused on acute care to date. However, changes to the payment mechanism for one part of the health system inevitably impact on other parts. It is important that robust, transparent payment mechanisms for non-acute providers are developed, providing the appropriate incentives and supporting policy objectives. We believe that mental health and community care are the priorities for the future application of PbR beyond the acute sector, where funding currently remains opaque.
- 152** Almost a third of responses to the DH consultation mentioned mental health as a priority for the expansion of PbR. Various approaches have been explored in recent years, but there are many challenges in expanding PbR to mental health. Two-thirds of mental health trusts' services are commissioned solely on a block contract, rather than cost and volume, basis (**Ref. 19**) and care is delivered across a spectrum of settings rather than as discrete short-term interventions, as in acute care. The primary challenge in mental health is the development of an appropriate currency. From October 2007, the DH has decided to pursue a 'care pathways and packages' approach. This will involve classifying people into clusters based on symptoms and needs, rather than a mental health casemix initiative based on diagnosis and interventions, and developing payments on this basis. The care packages project was featured as a case study in the Audit Commission's mental health report in 2006 (**Ref. 19**) and we support this direction in principle, although whether it is feasible in practice remains to be seen.

- 153** Developing a community tariff is likely to present different challenges. Developing a ‘setting independent’ tariff is one approach, but as discussed earlier there are likely to be limitations to this approach. Before this can reasonably be attempted, there needs to be a major investment in improving the availability and quality of community care data.
- 154** In conclusion, the PbR policy requires further development to ensure it can reward quality and innovation, support the provision of care outside the hospital setting and fairly reflect costs. We also believe that there is scope for PbR to have a greater impact on efficiency. However, this is an ambitious agenda and one that will be a challenge for the DH to achieve, at least over the next three years. There is also a question about whether all these issues – quality, care closer to home, capital and specialised services – can be addressed through the tariff alone. It is important that the DH has a realistic perspective of what can be achieved and what the immediate priorities are. In our view, the most important area to focus on is developing the tariff to encourage greater efficiency, while developing the capacity of local bodies to use local flexibilities to support unbundling and move care closer to home. In the meantime, separate payments should be considered for rewarding quality and innovation, and for specialised services and capital funding, removing these from the tariff if concerns about fairness cannot otherwise be addressed.

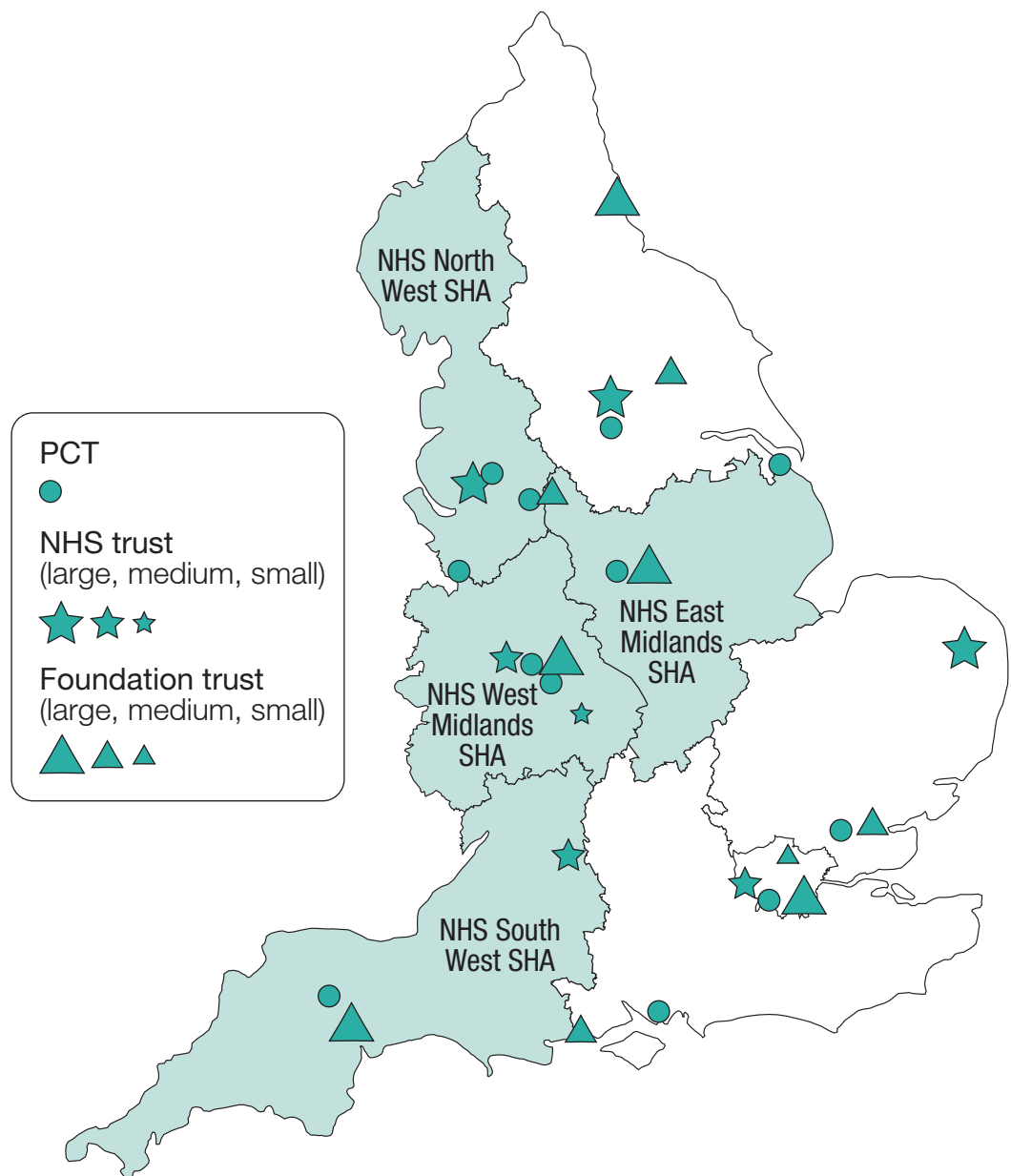
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Conclusion

- 155** PbR is now an established part of the NHS financial regime. The policy and its implementation in the NHS have come a long way since its introduction in 2003/04. It has brought a commercial, business-oriented focus to the NHS, successfully changing the behaviour of decision-makers. There have been corresponding improvements in financial management, performance management and the use of information. Clinicians in both primary and secondary care are beginning to understand and respond to the financial implications of their clinical decision making and to apply this to service planning. PbR has not yet had a significant impact on activity or, more importantly, efficiency, but there are signs that it is changing behaviour locally. In addition, PbR is seen by the NHS as a development with real long-term potential.
- 156** Over the next few years, the NHS and policymakers need to focus on strengthening the infrastructure that supports PbR and refining the policy so that it supports the future objectives and direction of the NHS. Data provision; the HRG classification and the underpinning diagnosis and procedure classifications; reference costs; and the tariff calculation all need attention if PbR is to be a long-term success. Aspects of the policy that are seen as essential to fairness, such as fair payment for specialist activity and capital payments, or which reward quality or support desired models of care, need to be developed. This includes the possibility of making separate payments outside the tariff to address these issues. There is support for the granularity that the next phase of PbR will bring, with the introduction of HRG4, but there are significant questions about the capacity and capability of the service to deliver what a more complex system requires.
- 157** PbR has the potential to support real improvements in the appropriateness and efficiency of NHS care. However, the policy will need continual monitoring, review and updating if it is to achieve that potential.

Appendix 1

The geographical spread of NHS bodies involved in the study



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