Reforming NHS Financial Flows

Introducing payment by results

October 2002
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Executive Summary

Introduction

1. This document sets out plans for fundamental changes to the way that funds flow through the NHS. The proposals include moves towards a nationally agreed set of prices, commissioning at specialty level based on volumes adjusted for casemix using Healthcare Resource Groups and a shortlist of those Healthcare Resource Groups which should be commissioned and monitored individually. The short term focus is on the commissioning of elective care between PCTs and NHS Trusts but as new arrangements in primary care develop, it will encapsulate all commissioning arrangements within the NHS.

Context

2. Delivering the NHS Plan set out the next steps of the programme of reforms to the NHS that will deliver the NHS Plan's vision of prompt, convenient, high quality services which treat patients as partners. These reforms take place within a context of a firm financial commitment to the NHS with an annual average increase of funding for the NHS in England of 7.4% in real terms over 5 years from 2003/4. This funding offers the NHS the opportunity to grow and to deliver improved services but brings with it the responsibility to deliver demonstrable results for patients and the public.

3. As the NHS develops its financial framework and funding flows need to change. The new financial system must help maximise the benefit to patients from the substantial growth in NHS funding. Increasingly, a financial system will be needed that:

- Pays NHS Trusts and other providers fairly and transparently for services delivered, while managing demand and risk
- Supports the introduction of patient choice by ensuring that diverse providers can be funded according to where patients choose to be treated
- Rewards efficiency and quality in providing services
- Helps match capacity to demand
- Refocuses discussion from disputes over price to the volume and mix of services that meet population need and the pathway of care for patients.

4. The move to a national tariff will be phased in over the next 5 years and our proposal is to do this in the following way:
2003/04

5. In the transition to using a national tariff for each HRG, we propose three key changes for 2003/04:

a. For at least 6 surgical specialties, SLAs should be set at specialty level. For these there will be a move away from block contracts, and Service Level Agreements (SLAs) should include explicit links between funding and the volume of services provided. There will be no ‘block’ agreements where funding is fixed regardless of the activity provided and SLAs should set out clearly how risk will be handled. Rather than being based purely on FCEs, HRGs will be used to reflect the intensity of casemix so that providers who work through a more complex workload this year than last are rewarded fairly. For now, prices in these SLAs will be determined locally rather than by the national tariff. However, we propose that the weights used to adjust for casemix will be based on national averages using national Reference Costs as a guide. The six specialties are:

- Ophthalmology
- Cardiothoracic surgery
- ENT
- Trauma & orthopaedics
- General surgery
- Urology.

b. Some procedures are so important to the delivery of national targets that they should be the subject of specific agreements. For 15 HRGs we propose that commissioning and monitoring be at the level of the individual HRG. For instance, for cataract extraction, a commissioner will work with its providers to determine how many extra procedures it would need for its population in order to meet waiting time targets. It would then monitor through the year and where it became clear that the required activity would not be provided by the end of the year, it would be able to move funding equivalent to the shortfall to a provider with capacity. Locally set prices would apply to activity up to the level of 2002/03 planned activity. The national tariff would apply to the extra activity commissioned to meet increases in demand and reduce waiting times. It would also apply to activity that was moved by commissioners as a result of under-delivery during the year. The list of HRGs encompassed within the scheme in 2003/4 is attached in annex 3.

c. Although greater clarity and fairness in rewarding work done are necessary conditions for increasing activity and improving waiting times, they may not be sufficient. International and previous domestic experience suggests that increasing activity alone may not be enough to improve access and reduce waiting times. PCTs and Trusts will need to manage referral and admission thresholds and the priorities for admitting patients.

2004/05

6. In addition to the above

- the number of individual HRGs included in the scheme will be extended
- health communities will be asked to use HRGs to casemix adjust their cost- and-volume SLAs for all surgical specialties;
health communities will be invited to act as pilots in applying the national tariff to commissioning agreements in some or all specialties.

2005/06

7. The national tariff will be applied to all activity for which HRGs or other appropriate casemix measures are available. This means that almost all NHS Trust activity will be commissioned using Service Level Agreements that:

- At specialty level, link funding to the planned volume of services to be provided and the national tariff for HRGs, adjusted for regional differences in costs;
- Make clear how funding will be changed where the activity actually delivered, adjusted for casemix, differs from what was agreed;
- Manage and share volume risk so as to encourage volume growth only where it is desirable for clinical and access reasons.

Progress to full national tariff

8. In order to manage the impact on both providers and commissioners of moving to a uniform national price tariff, it is intended that the move from a provider’s current price to the national tariff will be staged, probably over three years from 2005/6. Detailed analytical work is underway to assess possible financial impact on PCTs and NHS Trusts and to inform policy on the transition path.

Support/development and information

9. Service Level Agreements will be the vehicles that ensure financial flows work, that activity requirements are understood and that arrangements for risk sharing and monitoring activity are understood and agreed. To make sure that we get this vital element right, a working group of senior NHS managers is developing standardised documents including worked examples by January 2003.

10. The OSCAR system currently being delivered to commissioners is an integral part of extending the knowledge base and making information available. In addition, we will offer support where it is needed. A framework of commissioning competencies specific to the transition of financial flows is being developed to enable STHAs to carry out a baseline assessment of readiness and to focus support where it is most needed.

Feedback and consultation

11. Views are invited on a number of specific issues raised in the document. These should be sent to: Financial-Flow@doh.gsi.gov.uk
1. Introduction and context

1.1 The changing NHS

The NHS Plan shaped the strategic direction and vision for the NHS for the next 10 years. Following the budget in April 2002, *Delivering the NHS Plan* set out the next steps of the modernisation programme: a programme of reforms to the systems of the NHS that will deliver the NHS Plan’s vision of prompt, convenient, high quality services which treat patients as partners.

The NHS will move, over the next few years, from a monopoly provider of health services, run from Whitehall, to offer a greater diversity and plurality of services for NHS patients, inspected and regulated against transparent, common standards by an independent body. The Government’s commitment to a national health service requires a diversity of locally appropriate, patient responsive services delivered within the context of national standards.

The vast majority of patients are seen in a primary and community care setting. The new primary care contracts will drive greater local flexibility and diversity in provision to expand patient choice. Patients needing elective surgery will be offered choice of provider at the point of referral from 2005.

PCTs and NHS Trusts will be given greater freedom to enable them to focus on the best way to deliver services for their local populations and, underpinning this, there will be a national framework of standards and accountability. High performing organisations will have even greater freedoms.

The levers available to PCTs as commissioners are powerful drivers of change. Delivering results locally will need the application of a full range of levers and strategies. These include effective, long term commissioning relationships that are open and co-operative, and clinician engagement across primary and secondary care.

National standards will continue to be set through NSFs and NICE, there will be more information and greater accountability for patients and the public, a larger and more flexible workforce and more power devolved to frontline organisations through the 3 year planning and allocation framework.

These reforms take place within a context of a firm financial commitment to the NHS. The Budget in 2002 set out an annual average increase of funding for the NHS in England of 7.4% in real terms over the 5 years 2003/4 to 2007/8. This funding offers the NHS the opportunity to grow and to deliver improved services for patients and the public. This increased funding must deliver demonstrable results for patients and the public.
1.2 The NHS financial framework – the need for national change

As the NHS develops its financial framework and funding flows need to change. The new NHS needs a financial framework, which is responsive to patients’ choices, in which there is plurality and diversity of services and where NHS organisations have greater freedom. A new financial system must also help maximise the benefit to patients from the substantial growth in NHS funding.

From 2005-06:

- Patients will be able to see a GP within 2 working days and a primary care professional within 1 working day
- the maximum inpatient wait will be 6 months and outpatient wait 3 months;
- there will be full integrated emergency care network across primary, community and secondary care, ensuring that patients are seen in the right place and that no patient will spend more than 4 hours in A&E from arrival to admission, discharge or transfer;
- choice of provider will routinely be offered at the point of booking (by December 2005)
- the choice of provider offered may include DTC facilities, NHS Foundation Hospitals, the UK independent sector and overseas providers, as well as mainstream NHS Trust providers and GPs with a special interest working in large practices.

(See Improvement, Expansion and Reform: the next 3 years, Priorities and Planning Framework 2003-2006).

So, increasingly, a financial system will be needed that:

- Facilitates achievement of national and local strategic objectives, including the national objective of sustained reductions in waiting times, together with local objectives for service improvement agreed among PCTs and providers
- Delivers these objectives in a decentralised way: moving beyond reliance on central budgets for short-term initiatives
- Pays NHS Trusts and other providers on a fair and transparent basis for services delivered, while managing demand and risk
- Supports patient choice by ensuring that diverse providers can be funded according to where patients choose to be treated
- Rewards efficiency and quality in providing services
- Helps match capacity to demand
- Reduces transaction costs and negotiating disputes over price between PCTs and acute Trusts – focusing the role of PCTs on the volume and mix of services that meet population need, and on the pathway of care for patients and facilitating partnership working.
2. Introducing new financial flows

*Delivering the NHS Plan* outlined the system reforms to support delivery of access targets, patient choice, devolution of power to the frontline, diversity of service provision, and value for money. It included the government’s proposals for reforms to the financial system to support delivery: It initially concentrates on the commissioning arrangements around elective care between PCTs and NHS Trusts. Over time, and as new arrangements in primary care develop, we hope it will encapsulate all financial transactions within the NHS. Our current focus:

- instead of being commissioned through block agreements, hospitals (and other providers) will be paid for the activity that they undertake; so
- PCTs will commission:
  - the volume of activity required to deliver service priorities
  - from a plurality of providers
  - on the basis of a standard national price tariff,
  - adjusted for case mix; and
  - for regional variation in wages and other costs of service delivery
- funding will flow to the providers of patients’ choices;
- where PCTs or other providers undertake daycase or outpatient activity, the new payment system will facilitate the flow of funds to these providers.

In the context of shifting of resources and commissioning power to the PCTs the commissioning agreements between PCTs and providers – the Service Level Agreements (SLAs) – will now be the key driver of linking resources to service delivery. It will become critical to conclude SLAs if possible by the start of the financial year, and to give a medium term focus to the SLA. Under *Improvement, Expansion and Reform: the next 3 years, Priorities and Planning Framework 2003-2006* local delivery plans will be agreed by April 2003.

2.1 Context

This document sets out the changes that commissioners will need to implement to deliver the new system of financial flows. There are, of course, other important dimensions to commissioning. Payment by results is just one tool among many available to PCTs (see annex 5) and can only be fully effective as part of the broader cycle of commissioning activities. This cycle needs to be grounded in health needs assessment and driven by patient-responsive whole systems planning, within a context of effective, open and co-operative, long-term relationships between PCTs and providers. In particular, improving quality remains a very important objective. There are a number of other important mechanisms for delivering the quality agenda, including NSFs, NICE, CHI (and CHAI) and the role of commissioners and clinical networks in securing appropriate services for the community is also crucial.
2.2 Scope

By 2005-06 the new system is expected to cover most inpatient, daypatient and outpatient activity, including both elective and non-elective services in surgical and medical specialties. We recognise that, in some areas, particularly services for patients with chronic illness and services that have a strong community service component, such as mental health and learning disabilities, suitable measures of service are particularly challenging to develop. A lot of development work is needed on the tools underpinning commissioning in these areas. In the meantime we will start next year on a pilot scale in the areas where tools are already best developed: some acute surgical services, together with other services that form part of the patient care pathway for acute care (such as outpatient services and rehabilitation). The planned timetable for implementation allows the Service the time to build up capacity to use financial flows effectively, and to learn lessons from the initial phase before full implementation. Figure 1 below shows how the scope of the new financial flows system will develop.

The development programme for service classification tools over the next two years will see the tariff refined and extended to provide tools for commissioning packages of care, encompassing diagnostics, outpatient care, and community health services, as well as hospital services.

We would like to invite the participation of any health communities that have a particular interest in helping to develop the service classification tools for community health and other currently less developed areas. Please express interest in this piloting and development work through the following mailbox address: Financial-Flow@doh.gsi.gov.uk

Figure 1: How the scope of financial flows will develop

The initial focus on elective surgery represents only a small amount of total NHS spend on patient activity. But ultimately we want to cover as much of patient activity as possible.

The above uses 2000-1 HCHS figures to illustrate the scope of NHS activity accounting for almost £25bn NHS expenditure (excludes general practitioners, dental, pharmacy, drugs).

It is intended that enhanced/additional GP services will also eventually be covered by the scope of the scheme.
2.3 How will this work?

In the medium term, we envisage that PCTs will commission most acute care on the basis of cost-and-volume agreements at specialty level, using Healthcare Resource Groups (HRGs) to adjust funding to reflect the complexity of the mix of patients treated. The commissioning agreements between PCTs and providers (Service Level Agreements – SLAs) should be sufficiently flexible to include appropriate provision for sharing the risk of change in the number and mix of patients needing treatment. The changes to financial flows do not mean that we envisage paying providers on a demand driven basis for each patient they treat. There will continue to be caps on the level of activity PCTs commission. Capacity and the level and mix of activity will continue to be planned by health communities.

Providers will generally only receive funding for the activity they actually deliver. Providers who underperform compared to the commissioning agreement will have funding reduced in-year. Where there are unforeseen increases in demand, such as higher emergency admissions or referrals from primary care, providers and commissioners will need to agree in their SLAs on how to respond. This may or may not involve funding to cover extra activity: there should be sufficient risk sharing to discourage growth in activity that is not a local or national priority. The Strategic Health Authorities will play a role in arbitrating where there are disputes.

Where particular services, conditions or treatments are strategically important, SLAs will be at a more detailed and specific level – for example, for specific HRGs or specific packages of care built up from combinations of HRGs and other standard service classification measures.

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1 Healthcare Resource Groups (HRGs) are a tool for classifying patients into a manageable number of groups of cases that are clinically similar and that require similar levels of healthcare resources for diagnosis, treatment and care. HRGs have been developed in the UK by the NHS Information Authority, with input from UK clinicians, to reflect our clinical practice and our patterns of service delivery. Other countries have developed similar tools, often called Diagnostic Related Groups (DRGs).
3. Why make these changes?

3.1 How will this benefit patients?

This mechanism will ensure that patient demand is better met by capacity. Providers will be paid for the activity that they undertake and failure to deliver will mean that the funding can be reallocated so that patients can be treated elsewhere.

In the future, patients will be able to choose between alternative providers knowing that funding will not be an obstacle. In conjunction with their GPs and supported by more information, patients will be able to take more responsibility for their own health and choice of health services.

Patients can also have confidence that new funding arrangements will sustain improving quality. National Service Frameworks, NICE and CHAI will ensure standards for patients are met nationally.

3.2 How will this benefit PCTs?

With the shift of power and resources to PCTs, the commissioning role and the SLAs that encapsulate commissioning agreements will become more important levers for PCTs to use to achieve service improvement, and leverage to resist pressures to compensate Trusts for inefficiency or unwarranted cost inflation. Through the development of commissioning, PCTs will have better information on the activity, including the casemix, that providers are delivering for them and their patients. Providers should be more responsive to PCTs and patients as they will gain funding by being able to do more planned activity and risk losing funding if they do not deliver the services agreed. The clearer arrangements on risk sharing between PCTs and providers will give PCTs an incentive to manage demand for services effectively. Clear rules on price can help to support partnership working.

PCTs will also be able to choose the best way and place to deliver services for their patients, knowing that funding can follow. PCTs will be able to look at new models for service delivery rather than committing resources on a historical basis to traditional providers through block agreements. The development of casemix tools and the tariff will provide a basis for shifting resources when activity shifts from acute hospitals to primary and community care settings.

3.3 How will this benefit service providers?

This will provide a rules based approach to the commissioning of services across all commissioners. Providers will have a clearer picture of the volume of activity that is required and the funding that goes with achieving this. There will be direct incentives for managing the supply of activity in return for direct funding rather than a block agreement or central funds.

Greater transparency will give greater planning certainty for providers. High performing providers will have the flexibility to plan expansion knowing that it will be funded.

Clearer arrangements for risk sharing between PCTs and providers will incentivise PCTs to manage demand effectively.
3.4 How does this affect clinicians and clinical networks?

Clinical networks are an important mechanism for organisations to improve work in key clinical areas across institutional boundaries. Clinical Networks can develop:

- Integrated care
- Improved clinical outcomes
- Cost-effective services
- Improved patient experience
- Equity of service provision

PCTs and Trusts should continue to work together through clinical networks and PCTs should continue to commission collaboratively across the network to ensure streamlining of care and consistency of services.

The use of casemix adjustment in budgeting means that the casemix of providers’ actual clinical activity below specialty level will be better reflected in budgets and better understood by commissioners. Improving the quality of data and information available also has clinical benefits.

HRGs should reflect clinically meaningful groupings of activity and we are currently planning to develop HRGs to represent packages of care. The aim is that HRGs will be able to be used as building blocks to commission along the care pathway. Clinicians will continue to be involved in the development of HRGs. These changes should not result in decreased co-operation between primary and secondary care or between secondary care providers. Innovative commissioners will wish to change care pathways, and commission some components of the pathway from alternative providers (Annex 5 discusses an example). Some providers might wish to take responsibility for coordinating and managing the risk of an integrated package, combining a number of HRGs and other elements of the pathway.

3.5 Why develop cost and volume commissioning?

Though some commissioning agreements (SLAs) in the NHS clearly specify the volume and cost of services to be provided, many continue to rely on less sophisticated block agreements – mainly based on historic funding patterns and locally negotiated annual increases. This approach is not supported by international experience. The SLAs for the new cost and volume agreements will set out explicit arrangements for risk sharing between commissioner and provider (see appendix to annex 5 on a model SLA). The new approach will:

- be sufficiently flexible to expand the capacity of the NHS efficiently
- pay all Trusts on a reasonable, consistent and transparent basis for the services they provide
- create direct incentives for increasing the volume of services where growth is needed in order to improve access
- bear down on national variations in cost and efficiency
- make it easier to allow funds to flow to new and alternative providers or forms of provision
- give providers greater certainty about prices to assist medium term planning; and
• make it easier for the NHS to account to the public for where money has been spent and to answer questions about value for money.

Cost and volume are only two of many dimensions of commissioning. Being clear about these dimensions need not detract from the need for commissioning to focus also on service redesign and quality.

3.6 Why introduce casemix adjusted payment?

In the past decade, there has been a growing trend internationally towards the use of casemix adjusted payment for healthcare. Many health systems use this approach to fund hospital activity, including other tax-financed and social insurance-financed health systems with public hospitals such as Australia, Sweden, Norway, and Austria. The use of DRGs was pioneered in the US and adopted for the publicly financed Medicare programme in the USA in the 1980’s. Many other countries in Europe and elsewhere are in the process of adopting some form of casemix payment. Some countries have now extended the casemix approach to ambulatory care, rehabilitation and a range of community health services.

Case-based payment has led to increased use of day surgery and reduction in lengths of stay in hospital. (Annex 2 includes a summary of international experience with casemix payment.)

The new system of financial flows will also build on successful experience in some areas of the NHS in England that have used cost-and-volume agreements as the basis for their SLAs for many years, and have used HRGs as a basis for adjusting their agreements for casemix.

3.7 Why introduce a standard price tariff?

A standard price tariff will be introduced in the medium term to:

• enable PCT commissioners to focus on the quality and volume of services provided, minimising the transaction costs and conflict involved in local price negotiation,
• incentivise NHS Trusts to manage costs efficiently and ensure NHS Trusts are on a level playing field when dealing with different PCTs and vice versa,
• create greater transparency and planning certainty in the system.

In adopting a standard price tariff, we are recognising that price competition is generally ineffective for hospital services. Emergency patients have no choice but to use the nearest acute care hospital; most patients prefer to use their local hospital for non-emergency services too. We want to increase choice for patients and to ensure that local services are high quality, responsive and convenient as the evidence suggests that most patients will choose these.

There is a theoretical case for basing the price tariff on standard costing of optimal practice for the desired treatment. Over time, we would expect to review the tariff moving towards this ideal using progressively more sophisticated benchmarking methods to support and sustain further quality improvement. We wish to explore the scope to institute a programme of selective use of standard costing (for example to take account of changes in practice recommended by NICE guidance).
The initial tariff will be announced later this year, along with allocations. This initial set of tariff rates will be derived from 2001/02 NHS reference costs. A benchmark level around the average NHS reference costs will form the basis for the relative values for casemix adjustment. The prices based on this benchmark will be adjusted upwards for inflation in health service wages and prices, and downwards for expected efficiency gains. A system will be adopted to allow for unavoidable regional variation in costs using the same Market Forces Factor that is used to adjust PCT funding allocations. (Annex 3 sets out more information about the basis for setting the tariff.)

3.8 Transition issues in moving to a standard tariff

The key issue of concern to the NHS in using a standard tariff is the risk of financial instability for NHS Trusts and PCTs. Some NHS Trusts have costs per HRG significantly higher or significantly lower than average. Some of this variation in costs we would expect to be reduced by improvements in reference cost data, and refinement of HRGs over time. Provisional analysis of the 2001/2 reference cost data from Trusts already suggests a reduction in the range of reference costs across Trusts compared to 2000/1 reference cost data. We expect future years’ reference cost data to improve in quality further. But some variation in costs is likely to remain.

We see a need to give Trusts and PCTs a period of time to bring higher costs down in line with the standard price tariff. We also recognise that it is only possible to use a standard tariff to influence Trust efficiency when the tariff is applied to all or nearly all of services Trusts deliver – otherwise there is scope for cross-subsidisation. This will not therefore be an objective in 2003-04 or 2004-05.

From 2005/6 HRGs and similar standard service measures will be applied to nearly all of Trust services. Beginning in 2005/6 there will be a transition process, expected to last three years, during the introduction of full HRG tariff scheme; to give time for higher cost providers to adjust to the new tariff, and to manage risks to NHS financial stability. There are several options for the type of transition process that other countries have used, and options about the speed of transition. We will be carrying out simulation studies to quantify the potential impact of these options and will consult the service over the transition process and the pace of transition.

Other aspects of the transition process that we see a need to consider include:

- the need to strike a balance between allowing PCTs as commissioners to benefit where their local Trust has lower costs than the tariff, and allowing the Trust to benefit from their efficiency by retaining surpluses for use in developing their services;
- the potential impact of the standard tariff on PCT “purchasing power” and their distance from resource allocation targets; it may be prudent to carry out a re-basing process as part of the transition arrangements to address this concern;
- the need to have a credible, certain transition path to create incentives for efficiency and financial control and to support medium term planning;
- the need for a coordinated approach to revision and recosting of training levies and other non-patient income, and the revision and updating of reference costs.
In view of the transition path issues, and the need to refine HRGs and reference costs, we plan to take a cautious approach to introduction of the tariff in 2003/04 and 2004/5. The tariff will be used at the margin for a limited range of elective treatment cases next year, as set out in section 4 below. The key objective for the next two years is to create incentives for additional activity and capacity for these high priority cases, by ensuring that Trusts are assured of receiving adequate funding for the activity they need to deliver to meet waiting time targets.

*Views are invited on the pace of transition and specific transition issues facing particular health communities or services.*

### 3.9 Risk: learning the lessons

The new financial flows system builds on lessons we have learned from abroad (see Annex 2) and previous UK experience. We are aiming to keep transaction costs down since there will be a fixed tariff and therefore no competition on price between providers. Instead PCTs and providers will focus on the quality and volume of services. There will be explicit rules about the commissioning process and we will encourage a standardised approach to Service Level Agreements. We have given a lot of attention to getting the incentives right so that efficient providers and PCTs will be rewarded by keeping any surplus to plough back into service expansion. Implementation of the new financial flows system will be gradual giving time to improve the quality of HRGs and information on both cost and quality before the transition period to full implementation begins in 2005-06.

We also envisage that STHAs will take the lead in setting up clear arbitration arrangements to underpin the SLAs, and in ensuring timely agreement of SLAs.

### 3.10 Implications for the Trust Financial Regime

These changes have important implications for the current Trust Financial Regime. In particular, the intention is to move to a system in which Trusts are able to retain surpluses they earn if they are able to provide services at lower costs than the tariff rate, while meeting quality standards. The regime is currently being reviewed to ensure that it is consistent with the new financial flows arrangements.

### 3.11 Changes to Financial Flows in the context of 3 year planning and allocations

For the first time in 2003/4 the NHS will receive three-year allocations to enable longer term planning (see *Improvement, Expansion and Reform: the next 3 years, Priorities and Planning Framework 2003-2006*). The introduction of new financial flows will also facilitate better planning. It will provide better information for commissioners on activity casemix and activity at procedure level in some key areas and a more transparent basis for funding providers for the activity that they carry out.

PCTs and NHS Trusts will need to ensure that local service level agreements and three year plans reflect the introduction of the new system of financial flows from 2005/6 and the objective of convergence to a national price tariff. Sections 4 and 5 of this document set out what commissioners will need to do to plan for this system over the next three years. This should give commissioners and providers sufficient basis on which to formulate plans and agreements.
Funding providers according to activity is not inconsistent with longer term planning, providing that activity plans are sufficiently robust and realistic, and providing that SLAs are sufficiently flexible to respond to variations from plan.

The introduction of this scheme should not prevent providers and commissioners from committing to long term investment decisions, underpinned by multi-year agreements on key dimensions in SLAs and contracts. Securing sufficient capacity to deliver is critical and should not be impeded by these changes. Indeed, the move to a standard tariff and to cost-and-volume agreements provides greater certainty for evaluation of investment plans. Because the tariff will be used only at the margin in the next two years, and because there will be a transition path from 2005/06 for full introduction of the tariff, NHS organisations are able to plan with considerable confidence for the next three years, although the tariff will be updated annually to incorporate refinement of HRGs and reference cost information. Once the tariff is fully implemented, it should be possible to update the tariff less frequently (apart from general uplifts for pay and price movements).
4. First phase of implementation: 2003-04

2003/4 will be the first year of a stable and managed process to introduce payment by results from 2005-06 and Figure 2 below sets out the phased approach.

The principal objectives for 2003-04 and 2004-05 are:

- To support national strategic goals of increasing elective activity and achieving waiting times targets, including by use of a plurality of providers (increased day case rates, innovative service delivery models and whole systems working will be important in achieving this)
- To provide tools for leading edge health communities to use to advance local strategic priorities in other areas of service, including moves to provide daycase and outpatient services in primary care settings, and moves to commission along agreed care pathways
- To begin a managed transition to phase in both use of HRGs as the commissioning currency/activity measure and a standard price tariff
### Figure 2: Phasing Implementation

| Phase 1: High priority specialties use HRGs; high priority HRGs use tariff for growth |
|---|---|---|---|
| **2003/2004** | 15 HRGs commissioned on the basis of specific output targets; volume growth above 2002/03 SLA/plan level should be funded at the national tariff. Leading edge commissioners and Trusts encouraged to use HRGs/costed pathways of care for commissioning for other conditions, based on local service priorities. | 6 surgical specialties to be commissioned on a cost-and-volume basis, using HRGs to adjust for casemix. Leading edge health communities are encouraged to extend this approach to a wider range of specialties. | Almost all remaining activity will be commissioned as currently. A small proportion of activity in areas such as mental health and some highly specialised services that will require a slower implementation timetable will be commissioned on the same basis as present. |

| Phase 2: Surgical specialties use HRGs, high priority HRGs use tariff for growth |
|---|---|---|---|
| **2004/2005** | 30-45 HRGs commissioned on the basis of specific output targets; volume growth funded at the national tariff. Leading edge commissioners encouraged to use HRGs/costed pathways of care for commissioning for other conditions, based on local service priorities | Most or all activity in the remaining Trust surgical specialties to be commissioned on a cost-and-volume basis, using HRGs to adjust for casemix. | Activity in most remaining specialties will be commissioned on a cost/volume basis. A small proportion of activity in areas such as mental health and some highly specialised services that will require a slower implementation timetable will be commissioned on the same basis as present. |

| Phase 3: Almost all activity adjusted for casemix using HRGs, transition path to price tariff for all other activity begins |
|---|---|---|---|
| **2005/2006** | 30-45 HRGs commissioned on the basis of output targets and funded at the national tariff – including both baseline and growth activity. Leading edge commissioners encouraged as above. | Most Trust activity to be commissioned on the basis of cost-and-volume agreements, using HRGs to adjust for casemix, with appropriate agreements about managing and sharing volume risk built into SLAs, to encourage volume growth only where it is desirable for clinical and access reasons. Transition path for moving providers’ costs toward national tariff will be defined and the first step in the transition will apply. It is likely that the transition process will take place over three years. | A small proportion of remaining specialist activity that will require a slower implementation timetable will be commissioned on the same basis as present. |
Table 1: % expenditure to be covered by the national tariff 2003/2006 (with 30 HRGs included in 2004/5)

<table>
<thead>
<tr>
<th></th>
<th>2003-04</th>
<th>2004-05</th>
<th>2005-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>% hospital spend</td>
<td>0.5%</td>
<td>8.4%</td>
<td>90%</td>
</tr>
<tr>
<td>patient care</td>
<td>£20.0bn</td>
<td>2000-01</td>
<td></td>
</tr>
<tr>
<td>% NHS spend</td>
<td>0.2%</td>
<td>4.3%</td>
<td>45%</td>
</tr>
<tr>
<td>£38.9bn 2000-01</td>
<td></td>
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</tbody>
</table>

Table 2: % expenditure to be covered by the national tariff 2003/2006 (with 45 HRGs included in 2004/5)

<table>
<thead>
<tr>
<th></th>
<th>2003-04</th>
<th>2004-05</th>
<th>2005-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>% hospital spend</td>
<td>0.6%</td>
<td>10.6%</td>
<td>90%</td>
</tr>
<tr>
<td>patient care</td>
<td>£20.0bn</td>
<td>2000-01</td>
<td></td>
</tr>
<tr>
<td>% NHS spend</td>
<td>0.3%</td>
<td>5.4%</td>
<td>45%</td>
</tr>
<tr>
<td>£38.9bn 2000-01</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: % expenditure to be covered by casemix adjusted commissioning 2003/2006

<table>
<thead>
<tr>
<th></th>
<th>2003-04</th>
<th>2004-05</th>
<th>2005-06</th>
</tr>
</thead>
<tbody>
<tr>
<td>% hospital spend</td>
<td>21.8%</td>
<td>27.5%</td>
<td>90%</td>
</tr>
<tr>
<td>patient care</td>
<td>£20.0bn</td>
<td>2000-01</td>
<td></td>
</tr>
<tr>
<td>% NHS spend</td>
<td>11.2%</td>
<td>14.1%</td>
<td>45%</td>
</tr>
<tr>
<td>£38.9bn 2000-01</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note that the figures in Tables 1-3 above are based on preliminary analysis regarding the coverage of individual HRGs and specialties from 2004 onwards. These may be subject to change following consultation and further analysis and the figures in Tables 1-3 are therefore illustrative only.

4.1 How far will we go in 2003/4?

There are 2 elements to the proposals for 2003-04 (see top left of Figure 2):

a. For six surgical specialties commissioning agreements will be on a cost and volume basis, adjusted for casemix using HRGs, and PCTs are asked to specify appropriate terms in their SLAs for sharing volume risk so as to encourage activity growth only in areas where this desirable for clinical and access reasons.

We are proposing that the minimum list of specialties for 2003-04 will be:

- ophthalmology
- trauma and orthopaedics
- ENT
cardiac surgery
- general surgery; and
- urology

The approach will apply to both emergency and elective activity in the 6 specialties in order that elective and emergency activity within one specialty do not need to be commissioned separately.

This does not necessarily require commissioning at the level of individual HRG (except for the 15 HRGs – see 4.1b below). Commissioning at aggregate specialty level is likely to be the preferred option, except where there are strategic reasons for commissioning at a more detailed level. Commissioning agreements should include separate provisions for sharing volume risk for elective and other activity so as encourage expansion of elective capacity and activity to meet waiting list targets, while avoiding inappropriate incentives for growth in emergency admissions or in admissions not in line with agreed clinical guidance. (See Annex 5, which discusses in more detail what is meant by cost and volume commissioning, and includes an outline of a model SLA, on which we invite your feedback.)

Some leading edge health communities already use cost-and-volume commissioning more extensively than this. We encourage health communities to extend this approach to a wider range of specialties where they are able to do so. This will be important where PCTs are contracting with new Diagnostic and Treatment Centres and offering choice to patients in other specialties than the six listed above. We also encourage health communities to identify additional HRGs and packages of care that are strategically important locally – either to achievement of waiting targets or to achievement of goals in other areas of services – where commissioning at this level of specificity is justified.

Applying the standard price tariff will be optional in 2003/04 and 2004/05 for these specialties, with health communities free to negotiate price locally. Annex 5 sets out how this might be approached in the context of agreeing SLAs.

b. For 15 high volume/high expenditure HRGs that are critical to waiting times targets and to the CHD strategy, additional activity over the 2002/03 baseline will be commissioned at the level of individual HRGs on a cost and volume basis; the standard HRG price tariff will apply to commissioning of additional elective activity and to retraction of funds for under-delivery.

For the 15 HRGs that are most strategically important to meeting waiting times targets, we are asking PCTs to commission at the level of individual HRGs, based on additional activity calculated to meet waiting times targets. The list of HRGs encompassed within the scheme in 2003/4 is attached in annex 3.

Most of the 15 specified HRGs are primarily elective procedures but both elective and emergency activity will be encompassed in the scheme for these. A different cost weight will however be issued under the tariff for elective and emergency activity for these HRGs, reflecting the additional cost of treating cases as emergencies.

PCTs will be asked to pay for additional elective activity, up to agreed volume caps, at the full tariff price. Where providers do not deliver on commissioned volumes, PCTs will withdraw funds at the full tariff price. The reason for using full tariff price in these cases (rather than marginal cost) is because the NHS needs to expand capacity in these services to meet NHS plan access targets, new capacity cannot be secured at marginal cost. Also, PCTs and alternative providers need to be sure of having funds available to treat waiting list patients in cases where a Trust is unable to expand its capacity rapidly enough to meet access targets.
These arrangements will apply to NHS Trusts for 2003-04 but there will be transitional arrangements for the purchase of spare capacity from the existing UK independent sector or overseas providers. For information relating to Diagnosis and Treatment Centres (DTCs), new International Establishment units and other new provision see section 7 and annex 6 on plurality and diversity of provision.

For some cases, commissioners may be able to commission a package of care that includes not only the acute inpatient stay or daycase procedure included in the HRG but also other elements of the package of care (such as community physiotherapy, follow-up outpatient visits, transport costs for patients in “choice” pilots). Commissioning packages of care, based on agreed care pathways, is an important direction of development. Ideally, we see HRGs and the standard tariff as building blocks that can be combined into packages of care in ways that encourage seamless provision, and provide appropriate incentives for cost-effective prevention and care. It will be up to commissioners and providers to determine how best to combine these elements into care packages. To support this development, we will disseminate information from the “choice” pilots about specification of care packages, to share the lessons from this experience. This is discussed in more detail in Annex 5.

Annex 4 outlines in more detail how the new tariff will be applied in 2003-04 and 2004-05 across a range of providers.
5. What commissioners and Trusts will need to do for April 2003

The changes to financial flows for next year are intended to complement development of commissioning by PCTs. Annex 5 contains information on the tools that will be available to help commissioners with the processes set out below.

5.1 Building on capacity planning

The main tasks for commissioners and Trusts, supported by StHAs, for next year will build on the capacity and delivery planning requirements already disseminated to the Service and being worked through, (see advice on capacity plans for waiting, booking and choice disseminated in August 2002). This guidance suggested that PCTs should work with StHAs in:

- Modelling the number of patients who will need to be seen/treated to hit 6 month and 3 month waiting time targets, to continue to reduce total waits in A&E and waiting times for CHD, and to hit targets of 2 months from urgent referral to first cancer treatment and one month from diagnosis to first cancer treatment;
- Making realistic assumptions about likely medium term trends in demand;
- Where “choice” pilots are planned or proposed, modelling and showing clearly the implications for activity.

5.2 Implementing payment by results

In order to implement the financial flows changes, PCTs will need to undertake the following:

- agreeing the baseline at HRG level for the 15 HRGs to which tariff will apply in 2003/4. Tariff rates will be used to commission activity growth above the baseline of 2003/04 plan/SLA levels.
- planning: calculating the extra activity needed to meet waiting time targets. This will build upon the process already undertaken for capacity planning. Planning for each of the six specialties should be converted to an aggregate quantity adjusted for the complexity of patients treated using HRG cost-weights. Planned activity levels would only need to be disaggregated to individual HRG level in the case of the 15 HRGs on the designated list (annex 3) needed to meet waiting times target. The six specialties and 15 HRGs are targeted at high-volume, long-wait, high-expenditure procedures, which will facilitate activity increases and waiting time decreases.

As funds will be withdrawn from providers who do not deliver levels of elective activity agreed with the PCT, it will be important to have realism in commissioning agreements about the activity growth NHS Trusts are able to deliver. It will also be vital for PCTs to plan in advance commissioning from alternative providers (other Trusts, DTCs, independent sector and international providers) where a local NHS Trust is capacity-constrained. To achieve maximum value for money, it is important that this planning is done early and commissioning additional activity at year-end is avoided.
Reforming NHS Financial Flows: Introducing payments by results

• **agreeing the additional activity** required to meet 2003/04 access targets over and above the baseline of 2002/03 plan/SLA (rather than actual) levels.

• **profiling**: setting (at least) quarterly profiles for how much activity will need to be done through the year and setting thresholds to identify when activity targets are likely to be missed and funds are likely to be withdrawn to enable commissioning from an alternative provider

• **monitoring**: PCTs will need to monitor and measure activity against aggregate HRG profile for the specialty, and against individual HRG profile for the designated short list of 15 HRGs and move funding with patients to where there is capacity when activity is below the trigger threshold

PCTs should monitor providers against agreed activity as set out above. STHAS will also have a role in overseeing the performance of the whole health community and ensuring that robust plans are in place to deliver the necessary activity.

• **payment by results**: PCTs will need to **withdraw funding** from providers where those providers are unable to deliver agreed plans, on a quarterly basis. Where Trusts in-year find they are able to deliver higher than planned activity, they will be able to earn additional revenue from funds released where provider under-perform. There is also a case for patients PCTs to consider creating mechanisms for reward NHS Trusts for making available this additional capacity and for achieving beyond target levels, for example through a bonus scheme, or through linking the allocation of development funds to performance.

The tariff will be based on the average reference cost for the relevant HRG. The HRG tariff will be published in November along with final allocations for 2003-2006. The tariff has been adjusted to reflect differences in costs of provision in different parts of the country, using the same Market Forces Factor that is used to adjust PCT allocations. (See annex 3).

### 5.3 Risk management

The introduction of a new system of financial flows offers an opportunity to introduce arrangements for risk sharing that are more transparent, provide greater certainty for both providers and commissioners and encourage more effective risk management. Risk should be held by the body best able to manage it, but some risks are more difficult to plan for and manage or can only be managed effectively by co-operation between providers and commissioners.

The starting principle is that providers should be funded for all the activity adjusted for casemix that they deliver, up to the agreed target set out in the SLA. This would imply that the provider manages the risk that the volume of activity is higher or lower than the target. In addition, after the transition process, providers will be paid for that activity at the national tariff adjusted for regional differences, which suggests that providers will also manage the risk that costs are higher than the price.

It is assumed that, where providers have carried out less elective activity than agreed in the SLA, they should be paid only for that activity that they have carried out and, where providers treat more patients than agreed in the SLA, they should receive extra funding only if the additional volume has been agreed with commissioners. Such agreements to fund additional activity should be made for the cases where there may be an increase in legitimate demand, such as increased referrals from the PCT. The outline model SLA in Annex 5 sets out proposed standard guidance for sharing risk in relation to in-year variations in emergency and elective activity.

The sources of cost and volume risk are complex, so a multi-faceted strategy for monitoring and managing risk is necessary. Clear SLA provisions are only one tool for risk management. The mechanisms for managing risk must be sufficiently sensitive to respond to a range of circumstances, many of which will require action in primary care or in community health services and social services, as well as action in the acute Trust.
6. Other commissioning issues to 2005/6

6.1 Plurality and diversity of provision

It is the Government’s intention that the new financial flows framework will both accommodate and facilitate growing diversity and plurality in the provision of NHS services.

The new financial framework is not just for established NHS Trusts. It is a firm principle that, in the medium term, all providers of services to NHS patients, whether in the public, private or voluntary sectors, should be covered by the same overall financial framework, and meet the same tests of value for money.

The framework establishes the tariff as the “the fixed price for services”. However it also recognises that, particularly in short term while we face capacity constraints in many parts of the NHS, there are some circumstances where it may be necessary to pay prices above tariff levels, and other procedures for ensuring value for money may be more appropriate. In particular, in commissioning a new or expanded service or an expansion of capacity, it may be necessary to use a competitive process in order to establish the best price for the services sought. Nevertheless, even for non-tariff commissioning, an HRG-based measure of activity should normally be used, in order to allow comparison with the tariff. Ultimately providers will only attract business from NHS commissioners and NHS patients at prices that are competitive with the new tariff system.

Exceptions to tariff-based commissioning will be of particular importance in the current environment, in which a substantial expansion in services to NHS patients is being commissioned. Annex 6 sets out the arrangements will apply to different types of providers of services to NHS patients, including Diagnostic and Treatment Centres, International Establishments, and use of spare capacity in the UK independent sector.

6.2 NHS Foundation Trusts

The first NHS Foundation Trusts will be selected this year and established next year.

PCTs should commission services from NHS Foundation Trusts as from NHS Trusts. An important element of the Foundation Trust reform initiative will involve injecting a greater degree of transparency and clearer specification of requirements in the relationships between PCTs and NHS FTs. This will involve developing a binding contractual framework between the two with a focus on outputs, which balances the need for specificity on prices, quality and quantity with ongoing flexibility in commissioning.

We would expect Foundation Trusts to be capable of early adoption of the national HRG tariff, and work under cost and volume agreements for most or all medical and surgical specialties and outpatient activity from the date they are established (2004/05 for the first wave of Foundation Trusts). As Foundation Trusts will be autonomous legal entities, PCTs’ commissioning agreements with FTs will need to clear and well specified. Support for development of commissioning capacity and agreements will be provided to assist PCTs that need to agree contracts with Foundation Trusts.
6.3 Expanding patient choice

Choice will be rolled out in a number of phases:

- Summer 2002 CHD choice pilot starts
- Autumn 2002 London choice pilot starts
- 2003-2005 further choice pilots start
- December 2005 choice routinely available to patient at point of booking

Choice pilots

The financial flows for the London, CHD and other patient choice pilots being developed will follow the same approach to financial flows between commissioners and providers in 2003/04 as is set out in sections 4-7.

In these pilots, choice is offered after a defined period on the waiting list rather than at the point of referral and therefore entails patients moving from an originating Trust to an alternative provider. Where a patient accepts the offer of choice to move to an alternative provider, the new provider will be paid an agreed rate for the additional work, the exact level of payment to be determined. A financial regime will be adopted in the choice pilots which sets out the circumstances and basis on which Choice funding will be withdrawn from originating Trusts, consistent with the requirements of the financial flows scheme set out above.

For international provision, choice pilot funds will be used to meet the difference between the HRG tariff and the tender price. For DTCs, choice pilot funds will be used in appropriate circumstances to contribute to transitional start-up costs where these take the cost above the tariff rate.

PCTs and StHAs will need to ensure that providers from whom patients choose to transfer under the choice pilots due to the length of wait should not thereby become eligible for waiting bonuses as their percentage of long waiters decreases.

Choice from December 2005

The experience of the choice pilots will provide information on the extent to which patients take up choice, and on typical patterns of patient movements. This will help commissioners to plan and commission services to ensure that capacity is in the right places to meet patients’ choices. From 2005 patients should routinely be offered choice at the point of GP referral and booking and therefore commissioners should, in any case, be looking to commission services to take account of overall patient preferences between now and 2005, to ensure that they commission services in line with expected patient choices. From this date, full implementation of casemix tools and the standard tariff will begin for the vast majority of acute health care, including outpatient care. The tariff is expected to provide the basis for funds to flow to the providers patients choose. When the tariff is fully implemented, patients’ choices and the financial impact of their choices on PCTs will not be affected by price – they will be able to choose among providers on the basis of quality, responsiveness, clinical networks – and other non-financial features of provider performance.