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Summary

1 Payment by results is now a reality for the National Health Service (NHS). The new payment system represents a major change in the NHS financing regime and is a key component of the government’s modernisation programme for the NHS. By introducing a national tariff (or price) and paying providers for the volume and type of work that they do, payment by results aims to stimulate activity (and reduce waiting lists), reward efficiency and facilitate patient choice and plurality of provision by allowing the money to follow the patient. This replaces the previous system of block contracts and locally agreed prices, where providers were often paid a set amount regardless of the work they carried out.

2 Payment by results presents both opportunities and challenges for the NHS. It creates an unprecedented level of financial risk for primary care trusts (PCTs) and trusts and greater potential for financial instability across the system as a whole. In July 2004, the Audit Commission published Introducing Payment by Results: Getting the Balance Right for the NHS and Taxpayers, which set out the objectives, expected benefits and key risks of the new system. We concluded that although the system had considerable potential to drive improvement in efficiency and offered greater fairness and transparency in funding, it posed some critical financial management questions. As commissioners, PCTs face major risks since they are committed to pay for work at a nationally set price, but have limited control over volumes. Providers face greater financial exposure from changes in activity levels and those that are relatively high cost (compared to the average) face a rigorous cost improvement process to be financially viable. The Department of Health (DH) has set a challenging pace of implementation and we urged them to assess the risks throughout the transition and refine the system accordingly. A number of changes were subsequently made to the policy framework in 2004/05 and further refinements are expected in future years.
3 NHS foundation trusts and the PCTs that contract with them started to operate under payment by results from April 2004 for acute inpatient (elective and non-elective) activity. On 1 April 2005, payment by results was introduced for elective activity in all other NHS trusts. Coverage of non-elective and outpatient care was deferred until April 2006 due to concerns about the reliability of the tariff in the face of unstable activity levels.

4 This report reviews the experiences of foundation trusts and commissioning PCTs, as early implementers of payment by results, looking at how they have responded to the new incentives and identifying important lessons for other NHS bodies.

5 Four key findings have emerged:

- First, the early implementers of payment by results are, on balance, positive about the change (foundation trusts slightly more so than PCTs). The new system offers a clearer framework for planning and managing their business. The greater level of financial risk inherent in payment by results has provided the impetus to strengthen planning, financial management arrangements, information systems and overall performance management. In addition to this, payment by results has encouraged commissioners to focus on demand management and improving clinical pathways. Both PCTs and foundation trusts report greater clarity of roles and responsibilities; a positive change in culture and accountability and improved understanding of their business and local health economy. However, there are still concerns about certain aspects of the policy framework, the speed of transition and the readiness of the rest of the NHS to implement the system. Even foundation trusts that are relatively efficient, with high bed occupancy and a low cost base are pursuing cost improvements and structural change in order to be financially viable under payment by results. This raises questions about the ability of less efficient trusts to make the much larger gains required.

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For example, the fairness of the Market Forces Factor (MFF), the adequate reflection of the costs of specialist services and the usefulness of a tariff for accident and emergency contacts.
Secondly, in the first year, payment by results proved to be a more complex, time-consuming and challenging process for the early implementers than they anticipated. It requires investment of time and resources – the organisations in our sample spent approximately £100,000 each, equivalent to £50 million nationally. It also requires clinical engagement, better planning and reporting arrangements, careful negotiation and close attention to detail. All this has meant that time and energy has been devoted to the system and its mechanics, and has not yet broadened into the expected concentration on quality of care and performance improvement. The majority of NHS bodies are only just beginning to use payment by results as a lever for change.

Three factors have influenced the relative ease or difficulty of introducing payment by results:

- the underlying financial stability;
- the complexity of the commissioning environment; and
- the degree of preparation.

Those economies with an underlying historic deficit have found that payment by results tended to increase pressure and polarise organisational interests, leading to disputes. This is likely to increase going forward, given that the number of health bodies in financial deficit increased in 2004/05 in comparison to the previous year. Commissioners in complex economies have also found implementation more challenging. In particular, some London PCTs struggled to manage payment by results when commissioning from the larger hospitals. They felt they lacked sufficient clout as commissioners to manage in the new environment and needed stronger strategic leadership, planning and joint working within and across health economies. And while the early implementers have a good understanding of payment by results and its impact, those that shadowed the system in previous years and put the necessary capacity and systems in place in advance found it easier to harness payment by results to achieve their objectives.

Finally, payment by results is exposing existing weaknesses in the NHS, in health economies and in individual institutions – underlying financial difficulties, inadequate financial management arrangements and problems with data quality. It has created instability and increased tensions between organisations. Changes to the policy framework, late or unclear guidance and lack of attention to organisational development at the national level, particularly for PCTs, have exacerbated this. Overall, the potential risks that we identified in our earlier report have been confirmed by many organisations in the first year and will likely remain an issue throughout the transition period.
Analysis of provisional hospital activity data for 2004/05 shows little difference in activity growth or efficiency between foundation trusts and other acute trusts, although foundation trusts may have marginally improved their efficiency as measured by average length of stay. This suggests that the reported growth in activity across the NHS has been driven by initiatives other than payment by results (for example, national targets) and that expected efficiency gains have not yet been realised by the early implementers. While it is too early to draw any definitive conclusions, there is little evidence at the system level that the new incentives have generated the positive behaviours intended.

However, the potential for payment by results to destabilise finances locally (either due to weaknesses in local arrangements or volatile activity levels) has certainly been felt. Payment by results is intended to increase risk in order to spur financial discipline and improvement. But there are valid concerns that the level of risk inherent in the current policy design, particularly given the pace of implementation and the size of the change agenda, is too great. While national policy clearly states that all activity should be funded at tariff, a number of local variations were negotiated in 2004/05 to reduce financial instability, including the use of caps and floors on activity volumes. While this dilutes incentives for improved productivity and stronger commissioning, the organisations involved maintain that there is little point in introducing payment by results in full if it is going to destabilise the local health economy and undermine patient services. This is especially true during the transition, while organisations are still strengthening arrangements.

There is an ongoing need to review the policy in light of the experience of the early implementers and, in particular, the approach to funding non-elective care. While there may not be a strong argument for caps on elective activity in an era of patient choice, if policy objectives are to be realised then the DH should consider alternative payment models for non-elective activity that provide incentives to control growth and enable individual bodies to better manage their risks, for example, funding capacity and paying for activity at marginal cost.

Not all of the concerns about payment by results can or should be addressed through changes to the policy framework – there are other mechanisms. The required improvements in data quality (particularly clinical coding) and the potential for ‘gaming’ or manipulation of the system for financial gain necessitate a robust framework to provide assurance on payments and behaviour and promote stability across the system. We are currently working with the DH and other stakeholders to develop such a framework.
Further, payment by results is being applied to organisations that are still developing and a clear mechanism needs to be in place to identify and deal with potential failure of either a service – for example, under payment by results a service becomes unviable and the trust wishes to close it, but the service is vital for emergency patients – or the entire organisation, where this will impact on access to and quality of patient care.

Meanwhile, the DH’s decision to defer full implementation of payment by results for non-foundation trusts until April 2006 has given trusts and PCTs more time to prepare during the current financial year, with the prospect of better risk management. These potential advantages will be lost, however, unless trusts, and PCTs in particular, give a high priority to adequate preparation. Payment by results is as much about a change in culture as it is about incentives and payments. It requires a holistic organisational response. Clinical engagement is particularly important and this takes time and effort. NHS bodies should actively seek to learn from the early implementers of payment by results and others that have relevant knowledge and expertise – the findings and case studies included in this report are intended to support this. NHS bodies should explore opportunities for collaboration (particularly across PCTs) in order to strengthen their capacity to manage in the new environment. There also needs to be greater stability in the policy framework, with clear and balanced guidance communicated early. Although the tariff and overall policy design will inevitably be refined continually over the next few years, the instability of the national framework during 2004/05 and into 2005/06 created additional difficulties for foundation trusts and PCTs. Further large-scale changes will undermine planning and management in the new environment. The impact of these changes on NHS bodies needs to be assessed fully and likely changes should be communicated early.

Our key recommendations for NHS bodies and the DH are set out below. Additional recommendations are made throughout the report and a set of questions for boards to assess the readiness of their organisations for payment by results can be found in Appendix 1.

1 The recent changes to commissioning structures set out in Commissioning a Patient-Led NHS should support improved collaboration.
Recommendations

PCTs and trusts should:

- Review their arrangements in the areas of: organisational development, planning and analysis, data quality, partnerships, demand management and service redesign, contracting and monitoring in light of our findings and detailed recommendations (Chapter 3). Boards should use the questions in Appendix 1.

- Ensure that there is a common set of expectations across the health economy locally, based on joint planning, agreement on high-level clinical pathways and a clear understanding of business arrangements (for example, reporting, monitoring and dispute resolution).

- PCTs should prioritise the development of robust local monitoring arrangements, recognising that the introduction of the Secondary User Service (SUS) and other developments under Connecting for Health (formerly the National Programme for IT) will not remove the need to have local arrangements in place for reporting and analysis.

Strategic health authorities should:

- Continue to review the financial impact of payment by results on each organisation and on the health economy as a whole and assess the preparedness of individual organisations in light of this report.

- Facilitate joint planning, skills transfer and organisation development across the health economy and support health economy-wide demand management and service redesign initiatives.

The DH should:

- Continue to refine the policy framework in light of early experiences, avoiding increases in complexity, keeping large-scale changes in the policy framework to a minimum and communicating intentions well in advance, to enable the system to bed in.

- Focus on organisational development to support the implementation of payment by results over the period to 2008/09, particularly to strengthen commissioning, and commit to the timely release and communication of balanced guidance and tools to NHS bodies.
● Clarify its stance on the use of local risk management strategies that are not in line with national policy, but have been negotiated locally in order to promote stability, and review the design of payment by results for non-elective care.

● Develop a comprehensive and robust strategy and framework, which meets the needs of local and national stakeholders, to provide assurance on payments and behaviour under payment by results.

● Work with Connecting for Health to review arrangements for the education and training of clinical coders and prioritise the development of coding tools that are up to date and that support the provision of good-quality data.

● Develop a strategy to identify and address potential failure of services or organisations if they become unviable in the new environment, in order to safeguard access and patient care.
Introduction

12 On 1 April 2005, payment by results, the new financial regime that will cover the majority of hospital and community services in the NHS, became a reality.

13 By now the principles of payment by results are well known. Instead of relying on historic budgets and locally negotiated contracts, providers of NHS services will be funded through a single rules-based system, where payments are directly related to the work that they do. Hospital activity, classified according to healthcare resource groups (HRGs), will be paid for at a national tariff. The tariff is currently based on the average cost of providing care or treatment in the NHS, uplifted for inflation, changes in technology and clinical practice and assumptions about local efficiency gains. While the national tariff will determine the price, commissioners and providers will negotiate on volumes, agreeing cost and volume contracts within the national framework and focusing attention on quality rather than price. Payment by results is a key component of the government’s overall modernisation programme for the NHS, aiming to stimulate activity (to reduce waiting lists) and productivity and facilitate patient choice and plurality of provision.

14 England is not the first country to introduce a funding mechanism like payment by results, where providers are paid prospectively for the work that they do – although payment by results is somewhat unique in its scope and strength of incentives. Similar systems are in place elsewhere, some of which have been in use for over a decade. While the policy objectives of these systems vary, a common theme has been to improve productivity in the hospital sector.\(^1\)

15 Payment by results presents both opportunities and challenges for the NHS. By design, it creates an unprecedented level of financial risk for both commissioners and providers and greater potential for financial instability across the system as a whole. Our report, Introducing Payment by Results: Getting the Balance Right for the NHS and Taxpayers (July 2004), explored some of the expected benefits and risks associated with the new system. We concluded that although the system had considerable potential to drive

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\(^1\) Policy objectives associated with prospective payment systems like payment by results range from increasing activity to improve access (reduce waiting lists), improving provider efficiency and reducing hospital expenditure on hospital care, through to structural reform, for example, to reduce hospital capacity.
improvement in services and efficiency, and offered greater fairness and transparency in funding, it posed some critical financial management questions. As commissioners, PCTs face major risks, since they are committed to pay for work at a nationally set price, but have limited influence over volumes. Providers face greater financial exposure as a result of changes in demand and activity levels. They need to be much more aware of their costs in relation to the national price. Those that are relatively high cost face a rigorous cost improvement agenda in order to be financially viable in the new environment.

We also highlighted the challenging pace of implementation and our report urged the DH to continue to assess the risks and refine the system accordingly. A number of changes were subsequently made to the policy framework in 2004/05 (Box A), the most significant being the change in the implementation timetable. While payment by results was rolled out to all acute trusts from 1 April 2005, an important step change in the transition to payment by results over the period to 2008/09, it applies to elective care only. Inclusion of non-elective and outpatient care services has now been deferred to 2006/07 for all non-foundation trusts.

**Box A**

**Changes to the payment by results framework during 2004/05**

- Limited to elective care only in 2005/06, with non-elective and outpatient care deferred to 2006/07 (except for foundation trusts).
- Introduction of a separate tariff for short-stay patients.
- Compensation for unavoidable local cost variations (using the MMF) paid directly to providers to ensure a single tariff.
- Exclusion of specialist work from the tariff.
- Arrangements for tariff sharing between providers (for example, between acute and community providers) to facilitate service redesign and innovation until ‘unbundling’ the tariff (splitting it into its component parts) can be supported.

Source: Audit Commission
17 Foundation trusts and PCTs that contract with them were early implementers of payment by results, introducing the system a year earlier than the rest of the NHS. In 2004/05, the early implementers used payment by results as the basis for funding elective and non-elective inpatient care. The scope was extended to cover outpatient and accident and emergency contacts from 1 April 2005, despite the slowing in transition for non-foundation trusts.

18 The experience of the early implementers offers an important opportunity to observe payment by results in practice, prior to full implementation by the rest of the NHS from 1 April 2006. This report reviews this experience, assessing its impact nationally and locally and drawing out practical recommendations for NHS bodies and policymakers. The report deliberately focuses on acute care, as payment by results will not be introduced for mental health and community services until 2008 and the policy framework is not yet developed. We will consider some of the particular financial management challenges facing mental health services and the implications of introducing payment by results in a separate study, to be published in 2006.

19 In preparing this report we have primarily drawn on interviews with a sample of 10 foundation trusts and 15 PCTs that implemented payment by results in 2004/05. We also used findings from risk-based local audit work undertaken to assess the preparedness of NHS bodies for payment by results towards the end of 2004/05.\(^1\)

20 In the following chapter, we consider how payment by results is working in practice and whether the benefits and risks that we identified in our earlier report need updating in the light of experience gleaned in the first year. Chapter 3 discusses the practical approaches to managing payment by results taken by the early implementers. We identify case studies and highlight lessons and key success factors to assist other NHS bodies as they prepare for full implementation of payment by results.

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\(^1\) Audits on preparedness for the introduction of payment by results were undertaken at NHS bodies where auditors deemed this issue to be a significant risk to the organisation or health economy.
Payment by results in practice: revisiting the benefits and risks

21 Our review of the experiences of the early implementers of payment by results explored whether the benefits and risks identified in our first report were emerging. We also assessed whether new or different benefits and risks were coming into play and looked at how successfully trusts and PCTs were managing them.

22 We note that it is too early to make definitive judgements about the impact of payment by results on the NHS. It is also difficult to disentangle responses to payment by results from other reforms, such as foundation trust status and its associated financial regime. Practice-based commissioning and the roll-out of patient choice will bring further changes to the landscape and impact on payment by results. The review of contract management and administration and consideration of a centralised payment mechanism will also impact on local arrangements and risks. In many ways, this is a movable feast.

23 This means that the findings from the first year require careful interpretation. Nevertheless, the early implementation of payment by results by foundation trusts, while other NHS trusts continued under the old regime, provides an important opportunity to learn from early findings, revisit the risks and benefits associated with payment by results and inform refinement of the policy.

The benefits

24 Payment by results brings a number of potential benefits. As well as facilitating patient choice and encouraging plurality of provision, it aims to encourage quicker and more appropriate care, giving trusts and PCTs incentives to increase efficiency and improve their performance (Box B).
Box B
Incentives under payment by results

Providers have an incentive to:
- increase activity in areas where the tariff is greater than marginal cost; and
- reduce costs per case, for example, through reducing length of stay.

Commissioners have an incentive to:
- manage demand for acute services in order to reduce unnecessary admissions; and
- develop community-based alternatives to hospital care, where it is appropriate and cost-effective to do so.

Source: Audit Commission

Quicker, more appropriate care

Payment by results deliberately provides powerful incentives for trusts to increase their activity. International experience with similar systems indicates that this will translate into practice. While increased activity may be desirable in the case of outpatient appointments or for elective surgery (to reduce waiting lists), it is less appropriate for non-elective inpatient care, where the policy direction is to provide more care for patients outside a hospital setting (particularly for those patients with long-term conditions).

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1 Australia, Italy, Portugal, Sweden and Norway all point to increases in hospital activity as a result of introducing systems like payment by results.
Non-elective activity levels at foundation trusts increased in 2004/05. However, the increase is only marginal and it is difficult to attribute it to payment by results. As illustrated in Figure 1, our analysis of preliminary hospital activity data for 2003/04 and 2004/05 (which excludes activity not funded under payment by results) shows that growth in non-elective activity was actually higher at non-foundation trusts (5 per cent as compared to 1 per cent for foundation trusts). The growth in non-elective activity is largely offset by a small but consistent reduction in elective care across all trusts, the area where payment by results was intended to stimulate activity. Total inpatient activity at foundation trusts for services covered by payment by results may have marginally fallen, while increasing slightly at other trusts. Case mix complexity (as measured by complex HRGs as a proportion of all HRGs) increased fairly consistently across the two groups.

**Figure 1**
Change in the number of total admissions at acute trusts 2003/04-2004/05

Source: HES dataset (provisional data for 2004/05)
Concerns about payment by results leading to increased short-stay emergency admissions are not reflected in the data. Short-stay admissions are increasing at a faster rate across other trusts than for foundation trusts, at 12 per cent and 7 per cent respectively (Figure 2). There is also little difference between the ratio of accident and emergency (A&E) admissions to attendances for foundation trusts and other trusts (Figure 3). This finding is consistent with the Healthcare Commission’s review of NHS foundation trusts, which found that ‘if anything…foundation trusts as a group may be admitting a smaller proportion of those attending A&E than the national average…’.

While there are some outlier foundation trusts where the proportion of attendances to admissions is as high as 30 per cent, compared to an average of just under 18 per cent, these ratios have been consistent across the two years.

Based on the above analysis, it is difficult to attribute changes in activity in 2004/05 to payment by results. Non-elective activity increased at a significantly higher rate for NHS trusts that were not operating under payment by results over this period than for foundation trusts. While the lower growth in activity at foundation trusts could be attributed to successful demand management by PCTs, evidence on the effectiveness of early implementer PCTs in managing demand (see para 134-138) does not necessarily support this. It is generally accepted that the target for A&E waiting times (and probably changes in out-of-hours service provision) has been the key driver of increases in short-stay admissions across the NHS. The reduction in elective activity at foundation trusts may be explained by the explicit or implicit volume caps that were almost universally in place at local level. This may also partially explain the reduction at other trusts.

This is the national picture. At the local level, most PCTs in our sample reported higher than planned levels of activity, particularly A&E admissions, which could be due to unexpected increases in activity (or recording of activity) or poor planning. Certainly some had concerns about whether the additional activity was clinically appropriate. The reported increases were relatively small, but if effective risk management arrangements were not in place they could still destabilise a smaller PCT under payment by results.

Although the picture following the first year of payment by results is that it has had little impact on activity, we can expect to see increases in hospital activity over time due to the incentives inherent in the system. However, improved access is not a foregone conclusion - this also depends on the type and appropriateness of the activity. Trusts are already considering cutting services where their costs are well above tariff. This could adversely affect access and patient care unless effective planning and management is in place across the health economy, to ensure that capacity is available to meet health needs.

Source: HES dataset (provisional data for 2004/05)
Finally, payment by results will not, on its own, encourage the provision of care in a more appropriate setting. This will only be achieved through strong commissioning and a commitment to service redesign at the local level. PCTs have incentives to offset expected increases in hospital admission rates through managing referrals, strengthening primary care and providing alternative services in the community. However, the current absence of an adequate mechanism for unbundling the tariff, where a part of the care paid for through the tariff is provided outside of the acute hospital setting (for example, diagnostics or rehabilitation), impedes the provision of care in the community in some cases. This needs to be addressed as a matter of urgency – at present, the intention is that the next version of the HRG classification, to be released in 2008, will facilitate this.

Source: DH, hospital activity statistics
Stimulating efficiency

33 Payment by results is expected to help stimulate improvements in the productivity of NHS providers. In other countries, payment by results has almost universally resulted in efficiency gains in the hospital sector, as measured by average length of stay – although reductions in length of stay may have been accompanied by a corresponding increase in cost intensity (that is, higher costs per day).¹

34 In the NHS, we expect payment by results to encourage similar efficiency gains, producing higher activity (outputs) using the same or lower inputs. Preliminary data for 2004/05 shows a slight reduction in average length of stay across foundation trusts operating under payment by results (a slight drop in emergency length of stay, and with elective length of stay remaining constant) and an increase in average length of stay for other acute trusts (Figure 4). Foundation trusts appear to have marginally improved their efficiency, as measured by length of stay, relative to other trusts.

35 Payment by results means that trusts with costs above tariff will need to make efficiency gains. Those with costs below tariff will get additional funds. In our last report we estimated that 32 trusts had reference costs over 10 per cent above or below the average (12 of these were above) and that some trusts stood to gain over £10 million, with the highest receiving nearly £30 million, with corresponding losses up to £50 million. This in effect transfers funds from high- to low-cost trusts, creating considerable pressure for cost improvement at high-cost trusts. Value for money for the taxpayer will only be secured if high-cost trusts make savings without reducing the quality of care and if low-cost trusts invest their additional income in higher quality of care. On the basis of the latest reference costs (2004), the difference between high- and low-cost trusts had narrowed (there were 25 trusts with costs over 10 per cent above or below the average, with six trusts having costs over 10 per cent above the tariff). However, this still implies a substantial agenda of cost improvement for the NHS and a large-scale transfer of resources.

¹ Evidence from Victoria, in Australia, suggests that length of stay (excluding same-day cases) has fallen by up to 11 per cent since they introduced case mix funding in 1993, and cost per case has fallen. Public hospitals now surpass private hospitals in efficiency, as measured by cost ratio, and this is largely attributed to the introduction of payment by results and benchmarking performance. Most of the gains were made almost immediately.
For 2004/05, the majority of foundation trusts operating payment by results had reference costs below average (four were above), ranging from a reference cost index of 82 to 105. Most have gained income through the tariff. And although many have looked to improve efficiency for particular services, the required gains are small compared to those that high-cost NHS trusts will need to make once payment by results is introduced in full.

Available data from the audited accounts for 2004/05 shows the average income gain for foundation trusts was higher than that of other NHS trusts, with one foundation trust showing a 20 per cent increase in income compared to 2003/04. A number of foundation trusts reported that the additional income they received enabled them to cope with cost pressures, such as pay reforms and investment in information systems, staffing and equipment, that would otherwise have led to financial difficulty.
Overall, foundation trusts’ awareness about the cost and profitability of their services has increased – a prerequisite in securing future improvements in efficiency. However, even foundation trusts that are relatively efficient (based on the national tariff), with high occupancy and a low cost base are having to look at cost improvement programmes and structural change in order to be financially viable under payment by results in the future.

Focusing on quality of care

The government has stated that one of the objectives of payment by results is to allow providers and commissioners to focus on the quality of care by removing negotiation on price. However, many early implementers found that as they get to grips with the complexity of a new funding system and contracting arrangements, the focus has been on activity volumes, with little attention paid to quality during negotiations.

Other countries have found that systems like payment by results can detract from the quality of hospital care, encouraging hospitals to discharge patients too quickly. One of the concerns about the current design of the system is that, by funding at the average, payment by results does not reward, rather it discourages, higher than average quality of care. The DH is considering options, including the idea of introducing quality premiums, to address this.

Meanwhile, it is important that PCTs maintain and strengthen their focus on quality of care, putting arrangements in place to counter premature discharge (for example, establishing readmission targets) and to monitor clinical practice, such as adherence to National Institute for Health and Clinical Excellence (NICE) guidance and locally established clinical protocols.

The introduction of payment by results provides commissioners and providers with a richer source of information about variations in clinical practice and performance across trusts by facilitating benchmarking of activity and costs. This can be used to improve performance and drive up quality of care. As discussed in Chapter 3, PCTs are beginning to make better use of information to decide whether the reported activity was appropriate. In the first instance this scrutiny has been oriented towards finance, but some of the more advanced PCTs are using it to discuss quality and appropriateness of care.
Fairness and transparency of funding

43 Payment by results aims to improve both transparency and fairness of funding flows in the NHS. Under previous arrangements, where block contracts were negotiated locally, funding was often opaque and fairness relied on the quality and strength of local negotiators, which varied.

44 Foundation trusts and PCTs are already benefiting from the greater transparency that payment by results brings to planning and managing the financial position in-year. Commissioners have a better understanding of what they are buying. Providers can better relate their costs and their income to activity. This enables a more business-like approach, with greater potential to improve efficiency and achieve value for money.

45 Despite being a single rules-based funding mechanism, payment by results is complex in its design. The 2005/06 tariff structure is now more complicated than its predecessor, reflecting an effort to make the system fairer. However, fairness will only be achieved locally if all NHS bodies understand the rules. As the policy framework stabilises and the rules of engagement become clearer, the benefits associated with transparency and fairness should increase.

The risks

46 Payment by results deliberately injects a greater element of risk into the NHS environment in order to improve financial discipline and drive the changes required for NHS modernisation. It is vital that NHS bodies manage their risks so that individual organisations, and the NHS as a whole, are not destabilised. We identified the most significant risks to individual NHS bodies in our previous report (Box C).

Box C
Key risks arising from payment by results

- The quality of the underpinning data and the scope for gaming or manipulation of the system by providers.
- The way in which the tariff is set (ensuring it properly reflects legitimate cost increases and developments in clinical practice).
The ability of trusts to improve their understanding of their costs and achieve the required efficiency gains to be financially viable in the new environment.

The ability of PCTs to manage demand for hospital activity.

The overall state of preparedness of both trusts and PCTs for the degree of change and improvement in financial management required.

Source: Audit Commission

The experience of the early implementers has reinforced, if not heightened, these risks. While most of the early implementers are positive about the change, some have struggled to put appropriate arrangements in place to manage the risks, raising concerns about the ability of the rest of the NHS to operate under the system.

The underpinning data

Payment by results hinges on good information about activity and costs. As we have reported previously, poor data quality has serious financial implications for PCTs and trusts under payment by results. Most have highlighted it as a key risk in their risk management strategies.

Data quality has been an important issue for the majority of foundation trusts and PCTs in our sample. Rather than requiring an otherwise unnecessary improvement in information systems and data quality, the introduction of payment by results highlights a shortfall in existing systems. There have been difficulties with the timeliness and accuracy of reporting, which in turn have impacted on financial management. Historical problems with trusts’ information systems and lack of comparable historical data (for example, on critical care) have made accurate planning difficult. There are also concerns about the quality of clinical coding and the impact this has on the accuracy of payments. Most foundation trusts have prioritised data quality, but the NHS as a whole still has some way to go before it is adequate. Chapter 3 discusses data quality and practical approaches to minimise the associated risks in more detail.

As noted earlier, improved information is also one of the benefits that NHS bodies can expect to derive from payment by results. It provides the impetus to strengthen information systems, giving trusts a deeper understanding of their activity (and therefore their business). They can then use this understanding to improve performance and clinical
practice. Other countries have found that richer information has been one of the most apparent benefits of payment by results, with the quality of activity and cost data improving dramatically. But it has taken time, effort and investment in information systems and people to achieve this and it is likely to take several years in the NHS context.

The experiences of countries with similar financial arrangements highlight the real potential for gaming by trusts under payment by results. By gaming we are not referring to genuine increases in activity or case mix complexity; or to genuine improvement in coding and recording of activity (which, over time, should be reflected in a lower tariff), but rather to deliberate manipulation of the system, outside of the agreed rules, for financial gain (Box D).

**Box D**

Potential gaming under payment by results

- Recording of additional (unnecessary) diagnoses and procedures, or selecting the most expensive diagnosis for a patient (up-coding).
- Discharge and readmission of patients to attract additional payments for a single spell.
- Inappropriate admissions (for example, from A&E).
- Deliberately keeping patients in hospital for more than 48 hours so that they attract the full (rather than short-stay) tariff; transferring patients out of the hospital as soon as possible after 48 hours; or manipulating patient stays so that they fall into the high outlier category.
- Mis-classifying patients into specialist HRGs, which are funded through separate arrangements.
- Cost-shifting between activities covered under payment by results and excluded services that are funded at cost.

*Source: Audit Commission*
Incentives inherent in payment by results may also lead providers to act against NICE guidance where it is in their financial interest, or to focus on profitable services or treating low-cost patients to the detriment of access and quality of care.

There is no evidence of gaming among the early implementers, but there is also a lack of adequate mechanisms to provide the necessary assurance, one way or the other. Views vary on whether it is likely to be a problem in the NHS. Many trusts believe that gaming will simply not happen, recognising that this is short-sighted behaviour that will only be damaging to them in the long run. Some trusts have taken specific steps to guard against this. However, PCTs have genuine concerns about gaming, its potential to destabilise the local health economy and their ability to identify and address this locally. More than one foundation trust in our sample acknowledged that manipulating the data would be tempting in the face of financial difficulties, particularly if robust monitoring arrangements were not in place.

Cases of perceived gaming have been reported by some PCTs in the first year, including concerns about the re-initiation of outpatient contacts using old referrals, coding (or even undertaking) multiple interventions that are unnecessary, and artificial discharge of patients in order to attract multiple payments. There have also been disagreements over the accuracy of cost calculations, and hence payments, for services not covered by the tariff.

Our concerns about the potential for manipulation by providers remain, given international evidence, the powerful incentives in place and the difficulties associated with identifying manipulation. At a minimum, PCTs need a certain level of assurance about the validity of the payments they are making, which requires both PCTs and trusts to monitor and guard against unintended error, as well as deliberate manipulation. We are working with the DH to develop an assurance framework to complement local arrangements to monitor payments and help ensure the appropriateness of payments and behaviour under payment by results. This would likely involve the scanning of national data to identify anomalies that might signal data quality issues, underpinned by a targeted external audit programme on data quality and clinical coding.

Setting the tariff

Our earlier report identified a number of risks relating to tariff setting. These included:

- the accuracy of the increases for inflation and NHS cost pressures, which were applied to historical data to create a tariff for a forthcoming financial year;
- a tariff based on complete hospital stays (spells), but having the costs based on individual finished consultant episodes (FCEs);
- clarity of definition of what is included in the tariff;
- accuracy of funding for specialist work;
- keeping pace with medical advances;
- the rigidity of a national tariff when local arrangements for providing care may vary, and the challenges this presents for service redesign and transferring care into the community; and
- funding the costs of capital, particularly where large private finance initiative (PFI) programmes are in place and result in a trust having a higher cost base for several years.

The majority of these risks still hold. The DH took steps to minimise risks associated with the tariff and broader policy design in 2004/05, for example, by removing specialist work from the tariff. However, the last year has demonstrated the potential vulnerability of the system to significant changes to coding or clinical practice, and the current instability of the tariff. The significant increase in emergency admissions, and particularly short-stay admissions (Figure 2), would have resulted in major financial instability had payment by results been operating across the NHS. The DH has now introduced a separate, lower tariff for short-stay admissions. The increase also contributed in part to the decision to defer the introduction of payment by results for non-elective care for all NHS trusts until April 2006, in view of the instability it would cause this year.

NHS bodies remain concerned about certain aspects of the tariff structure, including the usefulness of a tariff for A&E contacts; the fairness of the MFF as the basis of compensating for regional cost variations and how paying it directly to trusts will work when services are transferred to a community provider; the validity of, or need for, a separate tariff for children’s services and the extent to which adjustments to the tariff fully reflect current clinical practice and full service costs, and reward quality. There are also calls for greater transparency and independence in setting the tariff. This would instil greater confidence in, and acceptance of, the tariff across the NHS, and help to minimise large in-year changes of the kind experienced in 2004/05, which made planning and management difficult.
Financial stability and affordability

59 As noted earlier, the introduction of powerful financial incentives through payment by results will inevitably cause some financial tension and potential instability. Indeed, the government views a degree of instability as being necessary in order to achieve the degree of change required to deliver the NHS modernisation agenda.

60 Even in the early stages of payment by results greater instability at the local level is apparent. There appears to be a clear link between financial health and the relative ease or difficulty with which PCTs and trusts have operated under the new regime. Although there are exceptions to this, where local health economies are struggling financially, payment by results has tended to polarise interests, causing organisations to focus on their own interests rather than working in partnership to address issues and achieve strategic goals. This strains relationships and often leads to a greater number of disputes.

61 The financial position of the NHS as a whole deteriorated during 2004/05, with a larger number of health economies and individual institutions reporting deficits than in 2003/04 and many of those deficits increasing. Against this background, early experience suggests that the challenges of introducing payment by results are likely to increase.

62 Most foundation trusts have gained income in the last financial year. However, some have still struggled financially in the new environment. The events at Bradford Teaching Hospitals NHS Foundation Trust (discussed later in this chapter) are a case in point. In recognition of the greater level of financial risk, a few trusts established contingency funds to help maintain stability (for example, University Hospitals Birmingham created a risk reserve of £3.6 million to cover unforeseen changes in activity and income). However, in practice, these have tended to be used to cover higher than expected costs in other areas (for example, implementation of the consultants’ contract) rather than managing risks related to payment by results.

63 PCTs have also struggled, with many reporting foundation trusts over-performing against their contracts, particularly with respect to A&E admissions. Some PCTs have reported that foundation trusts were looking to reduce or exhaust their waiting lists at a rate that was simply not affordable. In such cases, they were beginning to question whether payment by results would be affordable locally, particularly if activity levels cannot be capped and they are having difficulty managing demand. Interestingly, the audited accounts for 2004/05 show that PCTs that were lead commissioners for foundation trusts, rather than struggling disproportionately, appear to have been slightly more successful in achieving financial balance than other PCTs.
Nevertheless, a number of local variations on payment by results emerged during 2004/05 to help mitigate the financial risk to individual organisations. These variations continue into the current year and include the use of caps and floors on volume. The bodies in question are aware that they are not implementing payment by results as intended, but they feel that full implementation would potentially destabilise local organisations with no benefit to the health economy or to patients.

The potential instability in the system was illustrated by the baseline exercise undertaken by the DH in the second half of 2004. Trusts, via PCTs, submitted details of planned levels of activity for 2005/06 to the DH. This was then used to inform adjustments to PCT allocations to protect their purchasing power for current levels of activity against higher tariff prices. In effect, the exercise compared local prices with the national tariff. It revealed a £1.5 billion affordability gap between current and future expenditure.

The subsequent decision to reduce the scope of payment by results to cover elective activity only in 2005/06 (except for foundation trusts) reduced planned coverage of the system from 70 per cent of hospital work to around 30 per cent, thus reducing the affordability gap to £400 million. The majority of this shortfall was covered through a single non-recurrent allocation to PCTs, leaving only a small amount, equivalent to 0.1 per cent of PCT allocations, unfunded. The decision to reduce the scope of payment by results in 2005/06 reflected the financial risks to the NHS that would result from introducing payment by results in full. The approach enabled patient choice, which relates to elective care only, to move forward as planned.

There is a case for reviewing the tariff for non-elective care, or considering other alternatives to reduce the powerful incentives and financial risk in this area. While there may not be a strong argument for caps on elective activity in an era of patient choice, the DH should consider alternative payment models for non-elective activity that provide incentives to control growth – for example, payment at a reduced level for activity above agreed levels; setting an annual limit on spending growth on non-elective activity; or two-part model comprising a payment to cover fixed costs (capacity) and activity reimbursed at a tariff based on average variable cost. A clear mechanism to identify and address potential failure of a service or organisation that becomes financially unviable under payment by results has not yet been established and needs to be a priority to safeguard access and patient care.
Preparedness

68 The experience of the early implementers has underlined the importance of adequate preparation for payment by results. Those that shadowed payment by results prior to introduction, and therefore had a much better insight into the environment and the systems and expertise required, were better able to cope with the change.

69 Auditors have identified preparedness for the new funding flows as a key risk to NHS bodies and undertook detailed work on this in 266 individual organisations. Auditors identified payment by results as a major risk because of the significance of the financial impact of the new funding system and concerns about limited management capacity and poor data quality.

70 The main message from the local audit work is that the preparedness of NHS bodies for payment by results still varies. At the end of 2004, preparedness among NHS bodies that were not yet operating payment by results ranged from those that had not yet considered the impact of payment by results on their organisation, and did not consider it a priority, through to those that had reviewed their arrangements, built capacity and were shadowing payment by results during 2004/05. Most bodies had made some but not full preparations. Among PCTs, lack of modelling of the financial impact of payment by results and overall capacity to operate in the new environment were the biggest issues. For NHS trusts, the biggest concerns stemmed from the national policy framework: changes in the design and the speed of transition.

71 These findings reinforce our concerns about the preparedness of most NHS bodies to introduce payment by results in full and the risk this presents. In this context, the change in the transition path to include elective care only in 2005/06 is a very positive development. It gives NHS trusts and PCTs additional time to prepare for full implementation, to shadow payment by results for non-elective and outpatient care and to learn from the early implementers. Assessment of existing arrangements and adequate preparation for full implementation in 2005/06 should be a priority for all NHS bodies. It also adds weight to the case for allowing local variations in how the system is applied (for example, caps and floors) during the early stages of the transition, while organisations are still developing.
Stability of the framework

One of the risks for NHS bodies that has become apparent since our last report relates to the stability of the policy framework.

The significant changes in the policy design, for example, the introduction of the short-stay tariff for non-elective admissions, have been one of the biggest challenges early implementers of payment by results have faced. These changes have undermined plans in some cases to invest or disinvest in services and foundation trusts are concerned about making such important decisions when the tariff is unstable. A number of foundation trusts expressed frustration, pointing to the need for greater stability and consistency in the policy framework if they are to plan effectively in the medium term and operate more commercially, in line with their new status. The instability and late communication of changes and guidance relating to payment by results exacerbated risks and undermined their ability to plan and manage their finances effectively.

This instability has not just affected the early implementers, but also other NHS bodies. The late decision to exclude funding of non-elective activity on the basis of payment by results in 2005/06 had serious financial implications for some NHS trusts, throwing financial recovery and investment plans based on additional income expected under payment by results into doubt. It has also had a negative impact on staff morale. However, most recognise the slower phasing as necessary, presenting an opportunity to prepare more thoroughly.

Other countries report similar instability in planning and management in the first few years of introducing similar payment models. Getting the technical detail of the policy right (for example, setting the tariff and fine-tuning the HRG classification to produce the desired behavioural response without adversely affecting clinical care) can be something of an art rather than a science. Changes and refinements are inevitable and it will take time for the system to bed in. However, significant changes in approach or policy – and even minor changes communicated late in the day – create instability and make it difficult for trusts and PCTs to understand and operate the system effectively. Avoiding large-scale changes and communicating refinements well in advance is important if the policy is to be given credibility and support in the NHS.
Conclusion

Each of the main risks highlighted in our last report and identified above – data quality, tariff setting, financial stability and preparedness and the overall need for improved financial management – have been apparent in the experiences of early implementers. The well-publicised events at Bradford Teaching Hospitals NHS Foundation Trusts (Case study 1) serve as a timely reminder of the financial risks and instability that the new financing regime can generate for individual organisations. While payment by results was certainly not the only factor behind the difficulties experienced at Bradford last financial year, it was an important catalyst, exacerbating existing weaknesses in financial management and information systems, which had not been so apparent under the previous financial regime.

Case study 1
Bradford Teaching Hospitals NHS Foundation Trust

One of the first wave of NHS trusts to become a foundation trust on 1 April 2004, Bradford Teaching Hospital was considered to be one of the high-performing NHS trusts. The Trust began 2004/05 with a budgeted surplus of £2.3 million. By November 2004, it was forecasting a deficit of £11.3 million for the year ending 31 March 2005, a variance against budget of £13.6 million, or 6 per cent of total turnover. The abrupt deterioration in the financial position led to formal intervention by Monitor and a subsequent investigation into the Trust’s financial affairs. It soon became clear that there were a number of financial management concerns, the most significant being a lack of liquidity.

A number of different factors contributed to Bradford’s deteriorating financial position, but many relate to payment by results and the change in organisational culture and management that the new financial environment (payment by results and the foundation trust regime) requires.

Firstly, the Trust used different assumptions from its commissioning PCTs about activity and income growth under payment by results in its financial planning. Assuming a higher, and optimistic, level of growth in activity, the Trust employed 300 additional staff to realise this. When this growth was not realised, the lower than planned income, combined with a higher cost base, led to liquidity problems.

Data quality was also an issue. Financial reporting systems were poor, failing to produce accurate and timely financial information, so decisions were being using
inaccurate data. The Trust suffered from invoicing problems, which stemmed from the need for more detailed and accurate information about patient treatments. Clinical coding was also reported as inadequate.

The strength of the commissioning PCTs and the level of challenge they provided also contributed. When preparing for foundation trust status, the Trust took a tougher approach to identifying, coding and charging for activity and openly expressed an intention to optimise their coding (one of the reasons for their high growth rate assumptions). In response, PCTs intensified their own scrutiny of activity data, triggering a series of disputes over payment. These primarily related to differences in opinion about what activity was within the scope of payment by results and what was outside it.

Finally, the Trust failed to change its culture in response to the new financial environment. There was a lack of understanding about how foundation status and payment by results profoundly changed the way in which the system operated and, therefore, the way in which the hospital had to be managed.

Source: Audit Commission

77 This clearly carries lessons and implications for other trusts as they move to payment by results. While there have been no other comparable cases to date, there are instances where one or more of the contributing factors outlined above are present. Other foundation trusts believe that another Bradford is not out of the question. Some trusts have asked auditors to check financial management arrangements to provide assurance that a similar situation would not arise in their organisation.

78 In summary, early implementers are mostly positive about payment by results and can point to positive changes as a result of it. They also feel that they have laid some good foundations for future years and some of the benefits are starting to be realised through stronger performance management, although this still tends to be the exception rather than the rule.

While a number of public interest reports have been issued recently, where auditors raise concerns about financial standing and performance, these cannot necessarily be attributed to payment by results.
However, payment by results is exposing existing weaknesses – underlying financial problems, inadequate financial management arrangements and poor data quality. Concerns about the risks to individual bodies and to the NHS as a whole remain valid, if not heightened. It is important that ongoing implementation is monitored carefully in order to avoid destabilisation and perverse incentives coming into play.

Partly as a result of the above, payment by results has created greater financial instability and tension between organisations. This has been exacerbated by the new and hence unstable policy framework, allied with late guidance and weak preparation in some areas.

Limiting payment by results to elective care only for NHS trusts has significantly reduced the financial risks for them and for PCTs in 2005/06. It has also given all concerned further time to prepare, which needs to be fully utilised. In order to support these preparations, the following chapter sets out practical approaches that the early implementers have taken to introducing payment by results and some of the lessons that others can learn from their experiences.
In the previous chapter, we reviewed early findings on the impact of payment by results to date, focusing on whether the expected benefits are being derived and on how the risks are being managed. Some of these risks are inherent in the policy design and will therefore be ongoing. Others are transitional, relating to the implementation of payment by results and the preparedness of NHS bodies. The organisational response from individual NHS bodies is key to managing these transitional risks.

There was no formal pilot of payment by results prior to implementation by foundation trusts and PCTs in 2004/05. While shadowing payment by results in previous years provided an opportunity to establish the core processes and systems required, the absence of previous experience meant that early implementers were often reactive in their organisational responses to payment by results, learning about obstacles and success factors through trial and error. These early experiences provide important lessons for the rest of the NHS as they begin the transition to payment by results.

This Chapter highlights some of the practical steps that NHS bodies can take to implement payment by results effectively at the organisational level, focusing on the following priority areas:

- organisational development;
- planning and reporting;
- data quality;
- cost control;
- partnerships;
- demand management; and
- contracting.
Organisational development

Implementing payment by results brings a large organisational development agenda: new processes and systems, capacity building and a change in organisational culture to respond to the new financial environment. While payment by results provides the impetus and opportunity to strengthen organisations, the scale of the change requires a holistic approach to organisational development, which includes a review of management structures, existing capacity and an overall assessment of whether the organisation is fit for purpose in the new environment. NHS bodies need to ensure that resources are available to plan; and that there is protected time to develop the necessary systems, along with investment in training.

The early implementers varied in their approach to organisational development. The majority harnessed and strengthened existing teams, usually under the leadership of the director of finance, rather than establishing dedicated project teams. A number reviewed and restructured their management arrangements, most frequently to more closely integrate the finance, commissioning and information functions, to ensure that they were robust and effective in the new environment.

In contrast with previous reforms of this scale, very little organisational development support was provided nationally to the early implementers. PCTs in particular felt that they lacked support and that communication and guidance were biased towards foundation trusts, as if PCTs were on the periphery of the policy, rather than central to it. The speed of introduction, with three and a half months between finalisation of the policy and signing of the contracts for first wave foundation trusts, and the late release of guidance from the DH added further challenges.

A key message from the early implementers was that payment by results has been time-consuming and costly to implement. The additional burden on senior management, particularly where formal disputes arose, was often significant. Experience from other countries with similar systems points to costly implementation and a greater administrative burden. The complexity and administrative burden will increase with the introduction of practice-based commissioning and patient choice. Contract management and administration is being reviewed nationally as a result. While few early implementers formally quantified the costs (or benefits) of implementing payment by results, a conservative estimate of direct implementation costs incurred by foundation trusts and PCTs as at the beginning of 2005 is £100,000 per organisation. This includes the costs of additional staffing, consultancy, software and legal costs. The actual figure is likely to be much higher, but if applied to all acute trusts and PCTs this amounts to £50 million.
Capacity building

89 All NHS trusts and PCTs should undertake an initial and ongoing assessment of organisational capacity (resources and skills) to manage in the new environment. The early implementers tended to either informally assess capacity or respond reactively through recruiting or training staff once it became clear that additional capacity was required. A formal skills audit or capacity assessment was rarely undertaken. This was one of the areas where PCTs in particular would have appreciated support from the DH or strategic health authorities, for example, through the provision of a framework or tool.

90 The vast majority of early implementers employed additional staff (analysts, accountants and information managers) in 2004/05. PCTs focused on strengthening analytical capacity to make better use of available information and to improve planning and monitoring. Foundation trusts have almost universally strengthened their coding function and their analytical capacity. Early implementers in general highlight the importance of having at least one individual who thoroughly understands the technical detail of payment by results.

91 Establishing the necessary capacity to manage under payment by results is likely to become increasingly difficult. NHS bodies are already reporting difficulties recruiting analysts with the requisite skills and knowledge. This makes it particularly important that organisations continue to assess their capacity on an ongoing basis and recruit in advance. Benchmarking capacity and resources against peer organisations, especially the early implementers, is one way to inform a view about whether existing capacity is sufficient.

Commissioning capacity

92 Strong commissioning is essential if payment by results is to operate as intended. Early experiences with payment by results highlighted that with few exceptions (Case study 2) PCT commissioning is not currently fit for purpose. A number of foundation trusts reported that weak local commissioning was a barrier to operating effectively under payment by results. Some have been directly training their local PCTs on operating in the new environment (examples include University Hospital Birmingham Foundation Trust and Derby Foundation Trust). Findings from our audit work on the effectiveness of commissioning undertaken at 115 PCTs where this was considered a risk, including some PCTs commissioning with foundation trusts, show that only 41 per cent had the commissioning capacity needed to deliver improvement and 29 per cent did not have plans in place to address weaknesses in their arrangements.
Commissioning is clearly an area that requires attention if the benefits of payment by results, and the modernisation agenda as a whole, are to be realised. Collaboration across PCTs is a cost-effective way to increase commissioning capacity and those areas that have joint commissioning structures or clustering arrangements have found this of benefit in managing under payment by results. Lead commissioning arrangements, where a single PCT led the commissioning for a single provider, were common, although these were not always formalised – for example, through a service level agreement between PCTs – and we found few examples of joint contracts. In general, we found that PCTs did not make the most of the opportunity to cluster and collaborate in 2004/05. More than one foundation trust commented that improved PCT coordination would have made operating under payment by results much easier.

The plans to reconfigure PCTs, as set out in Commissioning for a Patient-led NHS, will result in fewer and larger commissioning bodies, which should help to strengthen commissioning capacity. There may also be additional benefit in establishing a larger, regional commissioning collaborative, such as the one in Greater Manchester, to facilitate stronger commissioning, information sharing and an integrated approach. In addition, the DH is developing a programme to strengthen PCT commissioning capacity, which should go some way towards addressing current weaknesses.

Case study 2
Stockport PCT

Stockport PCT is one of the strongest commissioners among the early implementers. It has taken a proactive and business-oriented approach to operating under payment by results. The biggest challenge for the PCT in 2004/05 was to make the organisation fit for purpose. There was limited access to learning or expertise and considerable financial exposure and little interest nationally or locally in supporting organisational development for PCTs and representing their interests.

Despite this, and forecasting a budget deficit from the beginning of the year, Stockport PCT was proactive in developing the organisation to enable it to respond to the challenges of payment by results. They identified their analytical function as an area that needed to be strengthened, engaged consultancy support to develop a capacity planning and modelling tool, employed three additional analysts to support planning and analysis in the new environment and engaged public health specialists to help check the clinical validity and appropriateness of the activity they were paying
for. This has enabled better use of available information, more robust planning and improved contract monitoring.

Source: Audit Commission

Organisational culture

Organisational commitment and engagement, and hence communication, are vital. In general, early implementers have successfully raised awareness about payment by results within their organisations through seminars and briefings. There is a good understanding among finance and information staff, but less depth of knowledge among operational department managers and consultants at NHS trusts. Engaging these groups, particularly clinicians, needs to be an ongoing priority (Case study 3).

Board and clinical engagement are particularly important. These areas are explored further below.

Case study 3
Royal Devon & Exeter Foundation Trust

Royal Devon & Exeter Foundation Trust (RDE) was running payment by results in shadow in the year leading up to implementation. This helped to engage the organisation as a whole. The Director of Finance led a series of meetings with clinicians and clinical teams during this year.

The Board drives the payment by results agenda and management ensures close integration between functions such as information, finance, service planning and delivery, receiving monthly reports on progress. The Clinical Board is engaged and well-informed about the implications of payment by results and service managers have taken a particular interest.

The Trust received training on the development of better managerial and financial systems for the use of clinicians and managers. The improved information has brought clinicians and managers closer, secured clinician buy-in and should ultimately result in the delivery of more effective and efficient patient care.

Source: Audit Commission
Board engagement

The board needs to be fully conversant with the new environment. It should understand the implications of payment by results for the organisation initially and on an ongoing basis. All foundation trusts and commissioning PCTs, with few exceptions, engaged their boards in the payment by results agenda through seminars and workshops and have modified their board reporting to reflect the new environment.

Local risk-based audit work undertaken in 2004/05 on the preparedness of NHS bodies for the introduction of payment by results found room for improvement on board engagement. While in the majority of bodies (79 per cent) boards were found to have devoted sufficient time to understanding and analysing the potential risks and issues stemming from payment by results, board reporting was considered inadequate in a number of cases, particularly for PCTs. For trusts, overall communication tended to be the bigger issue.

Given the greater degree of risk inherent in the new environment, it is particularly important that all NHS bodies have robust board reporting arrangements. These should include notification of:

- variation in activity and payments against contract (performance);
- update on risks;
- data quality (for example, levels of uncoded data, improvements in data quality); and
- national policy developments and the implications for the organisation.

Clinical engagement

International experience highlights clinical engagement as a key success factor for systems like payment by results. At trust level, clinicians need to be engaged in discussions about resources and clinical activity if payment by results is to drive operational change. Effective use of information is critical here. Establishing income and expenditure budgets and financial reporting at departmental level by HRG is an effective mechanism that a number of foundation trusts are employing. It is also important to have clinical champions, who understand and buy into the concept of payment by results. However, only one foundation trust reported that payment by results had flowed through to positive operational change in 2004/05.
Clinical engagement is required at PCT level to support effective planning, monitoring, demand management and service redesign. In order to manage hospital demand and redesign care pathways, PCTs need to have a regular dialogue with hospital clinicians, as well as management. PCTs that did not have an existing track record of engaging clinicians have found this difficult to establish.

The introduction of practice-based commissioning should enable greater engagement of primary care clinicians by PCTs. GP practices and other clinicians holding indicative budgets (for example, specialist nurses) will have incentives to validate hospital activity, manage demand and develop alternative community-based services. PCTs that gave GPs the financial incentives to validate hospital activity for their patients in 2004/05 found the level of clinical engagement to be highly beneficial.

**Recommendations on organisational development**

PCTs and NHS trusts should:

- Use the opportunity to prepare thoroughly for payment by results during 2005/06 and ensure that they are fit for purpose, shadowing the full system where possible, including:
  - securing sufficient resources to plan and manage in the new environment;
  - allowing protected time to develop the necessary systems; and
  - investing in staff training.
- Review board reporting arrangements and ensure that they are adequate for the new environment, benchmarking against foundation trusts and early implementer PCTs.
- Engage clinicians through reporting on income and expenditure or devolving budgets to departmental level (trusts), through regular dialogue with hospital clinicians and providing incentives to primary care clinicians using practice-based commissioning.
- Actively seek to learn from early implementers of payment by results and others that have relevant knowledge of expertise that might be useful and fully explore opportunities for collaboration in order to build capacity.
Strategic health authorities should:
- Work with the DH to provide greater support for PCTs and trusts to put the necessary arrangements in place, with greater emphasis on capacity building.

The DH should:
- Commit to timely release and communication of balanced guidance and tools to support NHS bodies (both commissioners and providers) in introducing payment by results.
- Provide additional resources for organisational development to support implementation of payment by results over the period to 2008/09 – particularly for PCTs.

Planning and reporting

103 PCTs and trusts face a greater degree of risk in the new environment. Robust planning and reporting are even more critical with the introduction of payment by results - failure to produce accurate and timely reporting with which to manage the financial position and accurately plan services and finances in the short and medium term has serious consequences. These areas were identified in the joint National Audit Office/Audit Commission report, Financial Management in the NHS, as requiring improvement, particularly forecasting. Inaccurate profiling of budgets and failure to distinguish between recurrent and non-recurrent costs were identified as particular problems.

104 Payment by results provides a much better basis for accurate and meaningful planning and reporting, including a stronger link between service and financial planning. However, NHS bodies need to develop the skills and systems to realise this and need to make this a priority. At the most basic level, planned activity under payment by results needs to be reconciled to the budget-setting process. Our 2004/05 audit work identified NHS bodies where this was still not occurring.

Foundation trusts and the majority of early implementer PCTs strengthened their planning and reporting systems in the lead up to, or following introduction of, payment by results. A number engaged consultancy support to develop more sophisticated modelling and reporting tools for the new environment. However, there were difficulties in several areas stemming from poor planning (for example, use of inaccurate or inconsistent assumptions about activity growth) and late and incomplete reporting of data, which led to financial instability and disputes.

Strong planning and reporting in the new environment requires:

- a thorough understanding of the principles and mechanics of payment by results;
- improved information and improved application – data quality is crucial (see later section);
- a robust and responsive planning and forecasting model, based on accurate and consistent assumptions that are rigorously challenged by managers and clinicians;
- a deep and consistent understanding of the business environment, including activity volumes and case mix, costs, health needs and factors influencing demand and supply of services, such as seasonal trends, changes in epidemiology, uptake of patient choice and overall capacity in the local health economy; and
- systems that facilitate accurate and timely reporting on, and management of, the organisation’s financial position.

Joint planning workshops across a health economy, often facilitated by the strategic health authority, are a particularly effective way to establish a set of common assumptions to use as the basis for planning. In some cases, PCTs and trusts have taken this a step further and use a single planning model to underpin a contract. A common perspective on activity and affordability provides a more robust basis for financial planning and less likelihood of subsequent financial instability of the kind exemplified in Bradford (Case study 1).

At trust level, payment by results requires strong links between financial and patient information systems to support better financial planning, monitoring and reporting; and between clinical and financial performance – for example, through devolving budgets or reporting on income and expenditure at departmental level. Where foundation trusts have established these links, and robust financial management arrangements are in place, this is starting to flow through to performance management and drive changes at the operational level (Case study 4). However, these cases were still the exception at the end of 2004/05.
Case study 4
Cambridge University Hospitals NHS Foundation Trust

The more rigorous financial management that payment by results requires, with the need to manage income and expenditure against activity, has provided an opportunity for Cambridge University Hospitals NHS Foundation Trust to review individual services on the basis of their profit or loss to the organisation.

Through the provision of detailed financial reports to service directorates and devolving budgets to this level, clinicians have become interested in the cost of their service and in assessing the drivers of cost. An example is the re-costing of the foot and ankle surgical service to assess the impact of combined operative techniques on costs and likely income; and a review of service sub-contractor prices in renal dialysis.

The introduction of a detailed income report, outlining service directorate income performance against planned profile, has increased understanding of the importance of service volumes and improved attention to appropriate discharge. Clinicians and managers alike are now aware of the financial and service impact of improvements in discharge volumes by day of the week or reducing lengths of stay over time by specialty, which is showing positive changes in performance.

The Trust is in the process of changing its accounting practices, moving to a profit centre approach at department level, in order to give managers and clinicians greater accountability, thus further strengthening the link between clinical practice and finances.

The Management Team has also established an investment appraisal board, which will formally consider investment opportunities on the basis of full cost-benefit analyses. The better information available under payment by results supports a more rigorous approach to this.

Source: Audit Commission

Among PCTs, payment by results stimulated the development of a more robust planning and analytical function, with the improved availability and quality of data facilitating stronger financial planning and emphasis placed on developing modelling skills (Case study 5). However, some early implementer PCTs made few changes to their planning and reporting arrangements. Medium-term planning and establishing the link between financial and capacity planning are particular challenges that will need to be addressed in future years.
Case study 5
Stockport PCT

Stockport PCT made a number of changes to its financial management arrangements in response to payment by results. Planning and accurate forecasting have been a key focus.

Understanding activity levels (both quantity and quality), the costs of services provided and population needs was the first hurdle. The PCT has been actively developing service specifications, designing a set of high-level clinical pathways within each specialty. The vision is to have these specifications linked to a directory of services and to have providers accredited for provision of these services. Progress has been made in the development of a quality and performance framework, which incorporates Standards for Better Health, Local Development Plan and Monitor targets and locally agreed priorities for performance improvement. This framework rewards quality improvement and is also being developed for PCT community services.

The planning tool that has been developed for capacity and activity planning supports financial forecasts from three years down to a week. It is used on a weekly basis for management purposes and on an annual basis for the review of strategy. The tool allows for a range of scenarios linked to capacity and parameters such as the uptake of patient choice.

The PCT undertook the activity and financial modelling on which the contract with Stockport Foundation Trust is based. The Trust validated the outputs so that the two parties have used consistent assumptions in their planning and have not duplicated effort. The model has been tested on historical data to ensure robustness. However, they recognise that they are still learning to understand the behaviour of patients and providers in the new environment and to build accurate assumptions into their financial planning. Management processes have not been perfected. For example, the PCT did not accurately model the takeup of patient choice in the community, which has been lower than expected and has affected the accuracy of their capacity and financial planning.

Source: Audit Commission
Recommendations on planning and reporting

PCTs and NHS trusts should:

- Develop a thorough understanding of the business environment in which they operate and use joint planning and consistent assumptions across the health economy.
- Ensure that they have robust planning and forecasting models, sufficient analytical capacity and protected time for planning and analysis and they must make better use of the information available to support this.
- Prioritise improvements in medium-term planning and forecasting.

Trusts should:

- Use the richer management information generated under payment by results to strengthen performance management, engaging service managers and clinicians through the production of reports on activity and financial performance and through devolving budgets to department level to drive operational change.

Strategic health authorities should:

- Facilitate joint planning across the health economy to encourage use of consistent assumptions.

Data quality

Good information systems that produce high-quality data on clinical activity and cost are important for sound management and delivery of patient care. Under payment by results, they are also of critical importance to financial and risk management, as discussed in Chapter 2. Other countries with funding mechanisms like payment by results have invested heavily in upgrading information systems and in improving data quality (Germany is one example). As part of investment planned under NHS Connecting for Health, a comprehensive electronic Care Records Service should be in place by 2010, which will go some way towards achieving this. However, trusts still need to strengthen their internal arrangements to produce timely and accurate data.
Clinical coding

Coding of diagnoses and procedures is particularly important under payment by results, as these codes are two principal determinants of the HRG that the patient is assigned to, which in turn determines income. Incomplete coding translates to loss of income for trusts, while inaccurate coding leads to inaccurate payments, which can impact negatively on the finances of providers or commissioners.

We have previously highlighted weaknesses in clinical coding at NHS trusts, pointing to significant levels of uncoded activity, outdated patient administration systems and weak coding arrangements. Payment by results provides the incentives to improve data quality and we can already see the increased priority this is being given across the NHS.

A review of levels of uncoded data at all acute trusts showed an overall increase as a percentage of total activity between 2003/04 and 2004/05 for both foundation trusts and other acute trusts, although they are lower at foundation trusts (Figure 5). These figures may change once the national 2004/05 data has been fully validated. However, among our sample of foundation trusts at least half reported uncoded activity levels at the end of the reconciliation period as being between 1 and 2 per cent. They are (and should be) aiming to reduce this to 0 per cent. Levels of uncoded activity are higher at other acute trusts.
The table below shows the average number of diagnoses coded per case in 2003/04 and 2004/05. The average has increased slightly for all acute trusts, at a marginally higher rate for foundation trusts than other acute trusts. Looking at foundation trusts in particular, the average number of diagnoses recorded ranges from 1.3 through to 5.7.
Table 1
Average number of diagnoses coded per case in 2003/04 and 2004/05

<table>
<thead>
<tr>
<th></th>
<th>2003/04</th>
<th>2004/05</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation trusts</td>
<td>2.44</td>
<td>2.57</td>
<td>5.32%</td>
</tr>
<tr>
<td>Other acute trusts</td>
<td>2.39</td>
<td>2.47</td>
<td>3.39%</td>
</tr>
<tr>
<td>Total all trusts</td>
<td>2.39</td>
<td>2.48</td>
<td>3.68%</td>
</tr>
</tbody>
</table>

Source: HES (provisional data for 2004/05)

The average number of diagnoses currently recorded by public hospitals in Australia, which have been operating under payment by results for over a decade, is just over three diagnoses\(^1\), whereas in the United States it is closer to six diagnoses. We can expect to see a corresponding increase in the average number of diagnoses recorded by NHS hospitals in response to payment by results.

Foundation trusts have universally prioritised improvements in coding timeliness and accuracy. They have invested in their clinical coding function, employing additional coders and health information managers, improving coder status and training and restructuring and improving coding practices, for example, to code directly from doctor notes rather than discharge summaries (which improves coding accuracy, but requires more resources). Case studies 6 and 7 illustrate approaches taken by an NHS trust and a foundation trust, respectively.

Case study 6
Mid Staffordshire General Hospitals NHS Trust

As an earlier applicant for foundation trust status, Mid Staffordshire General Hospitals NHS Trusts shadowed payment by results during 2004/05. The Trust installed a new patient administration system two years ago and has a good track record of data quality, including low levels of uncoded data. Despite this, management has prioritised improvements to ensure that coding is as accurate and timely as possible and the Trust currently completes all coding within 15 days of month end.

\(^1\) 2003/04 hospital admissions data, Department of Human Services (Victoria).
It places great importance on assuring its commissioning PCTs about its data quality. It has demonstrated the information pathway to the PCTs, covering how information is recorded as patients move through the system and how activity is counted, coded and traced back to the originating PCT. Recognising the importance of data sharing, it intends to allow commissioners open access to the patient database in order to be able to interrogate and analyse activity information. It is working with local PCTs to analyse and understand this information and to create a shared understanding.

Source: Audit Commission

Case study 7
Stockport Foundation Trust

Stockport Foundation Trust recognised the importance of having sound clinical coding arrangements early on and employed additional coding staff as part of its preparation for payment by results. Coding is done directly from case notes and the Management Team has increased the emphasis placed within the organisation on timely and accurate case notes. While coders are deliberately not given access to information about tariffs and the financial implications of their coding, the importance of completeness is stressed. The Information Manager reviews coding practices and meets the coders once a week to raise any systematic issues with coding.

The Trust now achieves full coding completeness (no U-codes) within 20 days of month-end. In addition, the Finance and Information Team monitors the coding backlog closely and is aware at any given point of how much money it is worth, so that it can manage any financial risk associated with uncoded activity in the interim.

Source: Audit Commission

Clinicians need to be aware of the importance of, and incentives for, accurate coding. Trusts have approached this in various ways, for example:

- establishing a clinical champion to address coding in directorates that have high levels of uncoded data;
- addressing coding accuracy at source through the consultant appraisal process; and
- devolving budgets to clinical department so that managers and clinicians are more aware of the financial implications of inaccurate coding.
Trusts should also be reporting regularly to their boards on coding performance data completeness and levels of uncoded data. Some trusts have found it helpful to benchmark their coding performance against others, producing comparative reports on coding and data quality on a regular basis.

The NHS clinical coding environment is set to change quite substantially in the future. The vision is that SNOMED CT, a dictionary of terms that can be used to describe clinical care, will be gradually phased in as the coding standard for all trusts by 2010. Foundation trusts that have already introduced SNOMED are finding that they can increase the direct involvement of clinicians in coding their patients with this modernised approach, although there are still some cultural barriers to engaging clinicians in coding, which need to be overcome. The introduction of SNOMED has important implications for the NHS coding approach and the supply of clinical coders. The existing International Classification of Diseases (ICD) and Office for Population Censuses and Surveys (OPCS) classifications used for diagnoses and procedures would no longer be central to the coding environment and more direct involvement of clinicians in coding would potentially reduce reliance on dedicated clinical coders.

In the meantime, however, clinical coders remain central to the process. Supply of coding staff is an issue, with some trusts reporting problems in attracting and retaining staff. We can expect to see an increase in the pay and status of clinical coders in the next few years. Consideration needs to be given at the national level to the education and supply of clinical coders.

In addition, improvements to the quality of the ICD and OPCS classifications, which are currently out of date and do not adequately reflect clinical practice, and the basic tools that are used to capture and code data need to be a priority at the national level if improvements in data quality are to be realised.

The Systematized Nomenclature of Medicine Clinical Terms.
Other data quality issues

NHS Connecting for Health will require most NHS trusts to invest in their information systems and migrate data between systems. Several NHS trusts, including foundation trusts, implemented new systems in 2004/05, and found that the level of disruption was greater than expected. In extreme cases, it resulted in no activity information being available for the majority of the financial year. Under payment by results, where income is based on activity levels, this exposes trusts to considerable financial risk. Trusts and PCTs need to be aware of the risk that this presents and, if possible, put in place contingency arrangements to protect against loss of income due to associated data-quality issues. One foundation trust negotiated a block contract for 2004/05, which set a minimum level of income; while another based financial reports on estimates rather than actual activity.

Further challenges are presented by the extension of payment by results to cover community services and mental health, where data quality is considerably poorer than for the acute sector. Practice-based commissioning will also require improvements at hospital level in the generation of timely and accurate discharge summaries, so practices can monitor patient activity.

Recommendations on clinical coding

NHS trusts should:

- Prioritise improvements in coding information (strengthening coding arrangements where necessary), monitoring their coding backlog and benchmarking the quality and timeliness of their coding with other trusts within the health economy and across the patch.
- Where investment in new information systems is planned under NHS Connecting for Health, carefully assess the cost implications, the impact on data quality and timely reporting and the implications of this for income under payment by results.

The DH should:

- Review the education of clinical coders and prioritise the development of coding tools that are up to date and that support the data-quality agenda.
Cost control

Understanding and controlling costs, while being key to good financial management, becomes increasing important for all NHS bodies under payment by results. Even foundation trusts that are considered relatively efficient are finding that they need to focus on cost improvements under payment by results.

All NHS trusts need to ensure that their costing systems are robust enough to enable them to manage their costs in line with the national tariff and make sound decisions about investment and disinvestment in services and opportunities for improving productivity. They should be aware of their position against reference costs and changes in this position, understand their cost pressures and be able to benchmark unit costs against the tariff. Reference costs should be an integral part of internal costing systems that are used to submit data to inform the tariff and for internal management purposes, to inform decision making.

Our work on reference costs in 2003/04 raised concerns about accuracy and the latest set of reference costs submitted in 2004/05 shows significant variation in costs, not all of which can be put down to clinical variation. For example, reference costs for a relatively straightforward procedure, such as a bilateral primary hip replacement, show a variation of £2,772. Where NHS trusts do not use reference costs for their own management purposes, they are less likely to prioritise the accuracy of their reference cost submissions. This in turn impacts on the validity of the national tariff and makes use of the national tariff for benchmarking against internal costs and making investment or disinvestment decisions less reliable. Indeed, the feedback from trusts during 2004/05 has been that, while they are starting to consider disinvestment in services, the tariff does not yet have sufficient credibility to be used as the basis for decisions about, for example, cost reductions.

Evidence from this study suggests that substantial improvements in costing systems are required. While some trusts are making good use of their reference cost information – for example, using strategic health authority-wide costing clubs to benchmark, and using the information to inform business cases about service investment and disinvestment – many do not appear to be using reference cost information at all to support internal management. One NHS trust has prioritised costing systems sufficiently highly to invest in patient-level costing systems, considering that this is warranted in the new environment. While international experience suggests that advanced information systems that support
patient-level costing are not essential for payment by results – the priority is accurate recording of patient activity – a good understanding of costs and cost pressures is absolutely critical.

**Recommendations on cost control**

**NHS trusts should:**
- Review and strengthen internal costing systems, using the data not only to inform reference costs but to inform decision making.
- Invest time in understanding how costs change, particularly finding out about the trigger points for significant additional costs.
- Be aware of their reference cost position and how it is changing, understand the cost pressures and fully assess cost improvements required in the medium term, monitoring progress against this.

**The DH should:**
- Review and strengthen the NHS costing manual and look at how reference costs are used to inform the national tariff.

**Partnerships**

Maintaining positive relationships is vital to the successful implementation of payment by results. This has been continually emphasised by the DH in the lead up to payment by results and its importance is reflected in the Code of Conduct for Payment by Results, to be issued in late 2005. The Code will set out principles for best practice.

To achieve its objectives, payment by results requires a healthy tension between commissioners and providers, while retaining a community focus, collaborative spirit and trust between partners. Early implementers found this difficult. Payment by results is seriously testing the PCT-foundation trust relationship, even in areas where this was historically good. While most NHS bodies are committed to moving forward in partnership there has been a definite increase in tension. A number of formal disputes resulted in independent arbitration in 2004/05, some of which were quite small in value yet took a considerable amount of time to resolve, raising questions about proportionality and sustainability.
While this is partly due to the newly commercial focus associated with foundation trust status, most early implementers feel it is payment by results that is creating the tension. There have been particular difficulties in London, possibly due to the number of large tertiary providers that are not closely associated with a community.

Some of the contributing factors cited by early implementers include:

- perceived limitations in PCT commissioning capacity;
- over-reliance on the contract;
- poor communication; and
- inconsistent expectations (for example, around planning assumptions or business rules).

Financial pressure contributed to polarisation within a health economy, although there were exceptions to this. With the growing number of NHS bodies facing financial difficulties and the link between foundation trust risk rating and budget surplus, we can expect that maintaining good relationships across the health economy will continue to be a challenge. Some lessons have been learnt from the experiences of the early implementers (Box E).

**Box E**

*Maintaining good partnerships under payment by results*

- Focus on building trust and maintaining transparency through data sharing; open communication; risk-sharing arrangements, where appropriate; and joint planning.

- Agree a common view of the health economy’s needs, its financial position and how demand should be addressed. This should help to deliver a common, realistic set of expectations.

- Reach a common understanding of the main clinical pathways. The data should not reveal unexpected and unwanted changes in clinical practice and patient pathways.

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1 To achieve the best risk rating of 1, foundation trusts need to plan and achieve a budget surplus of around 10 per cent (margin on earnings before interest, taxes, depreciation and amortisation).
Avoid over reliance on the contract to the detriment of the spirit of the agreement and of partnerships and learn to have constructive dialogue over issues (but do not be afraid to argue).

Ensure that chief executives are engaged and have bought-in to payment by results and its implications, managing relationship at the most senior level.

Minimise the potential for disputes by agreeing parameters and processes in advance.

Maintain commitment to partnership working and community focus and enshrine this in the contract or in a separate statement of principles.

Source: Audit Commission

Strategic health authorities have an important role to play in promoting partnerships across NHS bodies – in particular, through facilitating joint planning and demand management initiatives. To date, they have undertaken this with varying degrees of success. Payment by results will increase the importance of their role in assessing and managing the implications across the patch.

Recommendations on partnership

PCTs and NHS trusts should:

Prioritise maintaining positive partnerships; learning strategies to achieve this from the experiences of early implementers (Box D).
Demand management

Demand management is a core commissioning function. The current Public Services Agreement (PSA) target to reduce the number of emergency bed days by 5 per cent has helped to concentrate the minds of PCTs on managing demand in the community. However, the introduction of payment by results adds financial incentives, as managing acute sector demand is essential for limiting PCTs’ financial exposure due to activity growth.

A number of good examples of demand management initiatives have been put in place across the NHS, including:

- strategic health authority-wide referral management systems to support capacity planning and provision;
- referral and booking centres (Colchester introduced one in October 2004 for orthopaedics and saw an immediate reduction in referrals of 40 per cent);
- the development of alternative (tier 2) services in the community, for example, using GPs with special interests;
- additional training for staff at nursing homes, designed to reduce calls to A&E, for example, when an elderly person falls;
- community-based end of life schemes; and
- the use of case managers to target patients who are regularly admitted or re-admitted to hospitals, usually due to chronic illness, in cooperation with the trust.

Overall, payment by results had increased the focus of PCTs on demand management, but some early implementers were distracted by the technical detail of payment by results. Others had difficulty engaging clinicians and therefore made little progress in this important area. We found a number of examples where demand management initiatives were not working well or where overly optimistic assumptions had been made about the degree to which initiatives would reduce hospital demand. In places, the development of alternative community services apparently stimulated latent demand or the impact of service redesign was neutralised by contractual changes for GPs, which, locally, may have reduced access to out-of-hour’s services and increased A&E attendances. PCTs will only benefit from demand management initiatives if they reduce referrals and admissions and it costs less to provide services in the community. This requires careful assessment of the options for alternative service provision.
Demand management initiatives cannot be established overnight. Those PCTs that prioritised demand management prior to payment by results have been the most successful. For example, Greater Manchester Strategic Health Authority has been encouraging development of alternative services across its PCTs since 2002. Bolton PCT, which is yet to introduce payment by results as the basis for its contracts, sees demand management as the single most important area to focus on in preparing for payment by results, and has developed a number of alternative services (for example, a new community-based musculoskeletal service). These alternatives have reduced referrals by over 6 per cent per year.

There is a definite and deliberate tension between the incentives for PCTs to manage demand and treat patients in an appropriate setting, and the incentives to trusts to increase their activity where costs are lower than the tariff. If demand management and service redesign initiatives are to work well, PCTs need to get acute trusts to sign up to them. However, demand management initiatives could potentially reduce activity and income at acute trusts. PCTs and trusts can work together effectively to manage this tension (Case study 8).

Case study 8
Homerton Foundation Trust

Homerton Foundation Trust has actively engaged with local PCTs on demand management initiatives. This is partly due to a strong community focus within the Trust, but it is also due to the associated risks stemming from lower demand for services and, ultimately, a reduction in income. An example is referrals for locomotor services, which are likely to go down by 50 per cent. They are keen to develop solutions jointly with the PCT in order to achieve the right balance of activity and income.

The Foundation Trust’s main commissioner, City & Hackney PCT, places great importance on service redesign. They cannot afford acute services at the national tariff and have been focusing on redesigning patient care pathways.

The Trust sits on a joint commissioning board, which manages projects aimed at reducing avoidable admissions and managing demand in the community, looking at areas such as dermatology and rheumatology. It is trying to be creative about deriving benefits from the demand management projects to help reduce the adverse impact on the Trust’s overall financial position and is focusing on being a provider of community care.
services. For example, enhanced anti-coagulation services provided by GPs will take activity out of the hospital setting. However, consultants’ advice will still be needed.

The Foundation Trust has negotiated an increase in the provision of consultants’ advice to GPs, so although tariff payments will reduce, other payments will increase.

The commissioning board is actively looking into establishing pooled budgets for disease groups (for example, paediatric asthma) based on clinical pathways, with the budget being held by a single organisation. This would be a good risk management strategy and would be positive for patient care, although quantifying the primary care elements of the pathway will be a challenge. However, the Homerton would wish to hold the budget in some cases in order to have appropriate incentives, and this may not be palatable to PCTs or other clinical groups.

The Homerton also highlights the need for the strategic health authority to take an economy-wide view of capacity. This will ensure that if payment by results forces any structural changes, they are in the interest of the local community.

Source: Audit Commission

Difficulties in unbundling the national tariff to facilitate changes in care pathways add to the challenge of managing demand. The national tariff assumes that hospitals provide care and work with community services in similar ways. Where alternative care pathways are in place, for example, where patients stay in hospital for a shorter period because community hospitals provide some post-operative care, the national tariff will overcompensate the acute hospital and the PCT will pay for the service twice. In time, it will be possible to unbundle the tariff. The next version of the HRG classification, to be released in 2008/09, will enable the tariff to be separated into its component parts (for example, pre-acute, acute and post-acute services) so that funds can be fairly allocated between different providers, thus facilitating service redesign. In the meantime, tariff-sharing arrangements can be negotiated between parties according to a national set of rules included in the 2005/06 technical guidance. A limited number of diagnostic tariffs are available and can be used where agreement has been reached between commissioners and providers to move diagnostic activity in significant volumes to an alternative provider. However, a number of PCTs have found these arrangements difficult to negotiate.
Practice-based commissioning

Practice-based commissioning provides an important demand management tool, giving GP practices the financial incentives to engage in service redesign and manage their referrals.

Although most PCTs only began to implement practice-based commissioning this year, a few early implementer PCTs had already made considerable progress in 2004/05 – building practice-level data into contracts; providing information to practices on their patient activity and expenditure; and providing incentives for GPs to validate the data by checking referral and treatment information against their own records (Case study 9).

Case study 9
East Devon PCT

East Devon PCT recognises that demand management is crucial to managing the risks associated with payment by results. It began preparing for payment by results several years ago. The Devon PCTs began looking at service and investment strategies in anticipation of payment by results, considering options for reducing expenditure in secondary healthcare and agreeing to direct 50 per cent of new growth in income into primary care. Following this, the PCTs began to develop strategies for managing referrals and prescribing, and managing demand in the community.

Practice-based commissioning is seen as a key mechanism for managing risk under payment by results and they have deliberately progressed this agenda. They have devolved indicative budgets to practice level and provide practices with the information they require to manage their budgets (with varying responses). GPs are paid to do this, and to validate data submitted by the Trust to support payments. The incentive for them is that they retain 50 per cent of any savings generated. The practices generate questions about the appropriateness of hospital activity and, in some cases, have become champions of data quality (although at least one practice has reported that they have not yet achieved any savings). The PCT is committed to building the business expertise of their GPs in order to underpin the move to full practice-based commissioning.

Despite this progress, the PCT acknowledges that there is a need to further strengthen community services; develop more community-focused care protocols, improve information sharing and strengthen the monitoring of emergency admissions.

Source: Audit Commission
Practice-based commissioning should not be seen as a panacea to the potential ill-effects of payment by results. It will create its own challenges. The quality of data on community services remains poor. Some PCTs are struggling to obtain accurate activity data at PCT level, let alone practice level. Administrative complexity has prompted proposals for a centralised payment mechanism. Meanwhile, practices are concerned about the level of risk they will face and the reliability of information flows. The quality and timeliness of discharge information received by GPs still requires significant improvement. It will be difficult to insist that all practices remain within budget and careful discretion will be required at PCT level to avoid postcode rationing, as some practices try to remain within their budgets.

**Recommendations on demand management**

**PCTs should:**

- Plan and develop demand management and service redesign initiatives for high-cost, high-volume services now, using incentives, engaging clinicians and trusts in the process and learning from other initiatives that have been put in place elsewhere.
- Use utilisation reviews to assess the appropriateness of admissions in order to inform themselves about local use of activity and future development of community services under demand management initiatives.
- Monitor the impact/success of existing demand management initiatives and try to quantify this, using the findings to inform future strategies.

**Trusts should:**

- Assess the implications of the demand management initiatives that are underway in the health economy for their business and engage with PCTs.

**Strategic health authorities should:**

- Promote and support demand management and service redesign initiatives, focusing on capacity planning and support to put arrangements in place.
The DH should:

- Clarify arrangements for the reimbursement of unavoidable regional costs to community healthcare providers, as MFF payments are currently paid directly to trusts.
- Prioritise the early development of unbundling rules to help facilitate service redesign.

**Contracting**

This section considers issues relating to the contracting process, including contract design and negotiation, risk management and monitoring. Although legal contracts are only in place for NHS foundation trusts and independent providers, it is expected that PCTs and NHS trusts will base their 2005/06 service level agreements on the DH’s model contract. Therefore, the contract management issues highlighted here are relevant to all NHS bodies.

**Design and negotiation**

Contract design and negotiation was a difficult process for most early implementers in 2004/05, particularly given the short period between release of the guidance and the date the contract needed to be in place (1 April 2005, for many).

The model contract issued by the DH was heavily criticised by most early implementers for not reflecting reality on the ground – however, all parties used the model as the basis for their 2004/05 contract, making changes to varying degrees that included:

- inclusion of different schedules or approaches to clinical quality;
- requirements relating to partnership working;
- local requirements on information provision; and
- local arrangements for unbundling the tariff where there were high numbers of community beds (prior to the release of guidance on tariff sharing).

Contract negotiations were time consuming, focusing on activity levels rather than quality. Agreeing the activity baselines for payment by results activity, assumptions on activity growth and consistent classifications (which services were covered by the tariff) was often the most challenging and time consuming aspect.
Negotiations were particularly difficult in parts of London, with PCTs finding that some providers did not want to negotiate on activity levels, demand management arrangements, reporting or indeed, any contract clauses. In the case of one foundation trust, no contracts had been signed with any of the PCTs by the end of 2004 due to breakdowns in negotiation. This may be partly due to a perceived or real lack of commissioning expertise and confidence among the PCTs.

Risk management

We have already highlighted the greater degree of risk inherent in the payment by results environment. This is the case for both providers and commissioners and it increases the importance of a robust approach to risk management.

Risk management and risk-sharing strategies should be agreed jointly by PCTs and trusts and built into contracts or service level agreements. All early implementers appeared to do this, although not always comprehensively and not always in line with national policy. As discussed in Chapter 2, several variations on payment by results were in place locally, including explicit (or implicit) caps on elective activity; elective activity over or under the planned activity levels paid or subtracted at 50 per cent of the tariff, and the use of floors on activity to prevent loss of income as a result of poor data quality (with any additional activity funded at 50 per cent of marginal cost). These arrangements were negotiated locally and reflect concerns that full payment by results could potentially destabilise organisations. However, they do not comply with national policy and the DH is likely to be stricter on non-compliance in the future.

Among the risk management mechanisms available to PCTs, in line with national guidance, are:

- defining trigger points, which require that once activity levels have reached this point, the provider must notify the commissioner;
- building re-admission targets into the contract; and
- discounts for short-stay admissions (this has now been incorporated into the policy framework in the form of a short-stay tariff).
Not all early implementer PCTs systematically built trigger points and re-admissions targets into their contracts. On the whole, PCTs felt that they had not been as thorough about assessing and managing risk during 2004/05 as they should have been.

Our 2004/05 audit work on the preparedness of NHS bodies for payment by results found that while risk sharing arrangements were in place in existing service level agreements, there had often not been a formal discussion between parties about a strategic long-term approach to risk sharing. In looking at whether PCTs and trusts were equipped to implement payment by results from April 2005, risk sharing was identified as the single biggest area requiring improvement. Where risk sharing arrangements had been agreed between PCTs, they were often not formalised.

**Contract management**

Use of actual contracts once they are in place has been varied. While some PCTs and trusts have adhered to their contracts closely, in some cases using it as a project management tool, others have barely referred to it. Ideally, the contract should underpin the relationship, as opposed to the reverse. Time invested upfront in clarifying how issues will be handled avoids difficult debates at a later stage.

There were a number of formal disputes during 2004/05, with the disputed amounts ranging from quite small – 0.2 per cent of payments – to a more significant 3 per cent. Informal discussion and a sense of proportion should have resolved some of the issues that have been raised formally. The absence of precedents to underpin discussions (and at the extreme, arbitration) and the complexity of the issues have made dispute resolution a challenge. They point to the need to build a body of knowledge and ensure consistent judgements and outcomes. Consideration should be given to standardising the process of dispute resolution, or at least establishing consistency in the process from dispute through to mediation, arbitration and outcome.

**Monitoring**

All early implementers established formal monitoring arrangements, which include reporting and analysis, payment reconciliations and regular contract monitoring meetings.
To date, most PCTs have struggled to put comprehensive and cost-effective monitoring arrangements in place, particularly in complex commissioning environments such as London. However, even in simpler environments, PCTs have struggled to gain assurance that the data submitted to them as the basis for payment, and hence the payments themselves, are correct. Accurate and timely reporting of activity data is of course crucial, and a number of PCTs raised concerns about the failure of trusts to submit timely and accurate data in the right format. Penalties for late data submission are included in the model contract, but the evidence is that PCTs tend not to enforce this clause.

Approaches that PCTs have taken to monitoring activity and payments against the contract ranged from reliance on basic reconciliations against summary reports, usually in areas where there are fewer financial pressures, through to more comprehensive arrangements for data validation, pattern analysis and audit. Case study 10 illustrates a more rigorous approach to PCT monitoring.

Case study 10
Stockport PCT

Stockport PCT has a dedicated team to monitor activity and the appropriateness of payments. The team comprises three information analysts and two public health experts. A staged process is used to monitor payments under their contract with the Foundation Trust:

1) Data validation: raw data is regrouped into HRGs using their own routines, cleaned and then reconciled with plans. The cleaned data is then run through a number of analytical routines to identify any anomalies.

2) Clinical review: clinicians review the activity data to assess appropriateness of the clinical pathway and therefore payment implied by the data (for example, looking at multiple births or readmissions).

3) Audit: where the PCT has concerns about data quality, the team checks against the medical records.

The first two stages are run on a monthly basis, but the third has rarely been applied. A formal coding audit has been undertaken by an external consultancy in the short-stay admission unit. This audit was agreed by both parties.

The PCT has also used a utilisation review tool to analyse admissions and will use this regularly to readjust planning assumptions.
In addition to validation of data, which has raised queries about the classification of patients (for example, the treatment of patients admitted to the observation unit in Accident and Emergency), the PCT also wanted to be satisfied about the Foundation Trust's cost allocation between tariff and non-tariff services. They conducted a detailed review of the cost allocation model, which was extremely time-consuming and the issue is now resolved.

While these processes are a good example of the type of monitoring arrangements that all PCTs need to have in place, Stockport PCT feels that it does not have the resources to properly execute this approach and gain the necessary level of assurance about data quality. As a result, they are exploring a clustering approach with other Greater Manchester PCTs.

Source: Audit Commission

158 Our audit work on the preparedness of NHS bodies to implement payment by results in 2004/05 found that 50 per cent of the PCTs at which audits were undertaken do not have validation arrangements in place to ensure the accuracy of information received from provider trusts.

159 There is a tendency to rely on aggregate monitoring reports submitted by trusts, rather than using raw data to validate activity. And only a few PCTs have undertaken a review against medical notes; commissioned an external audit of data quality; or undertaken a utilisation review to assess appropriateness of admissions, for example, through using the Appropriateness Evaluation Protocol, which was developed for use in auditing admission practices in US hospitals over 20 years ago and is now widespread in its use. Some PCTs feel that they lack the capacity and credibility to properly challenge trusts about their activity and payments.

160 In order to monitor payments effectively, PCTs should at minimum be:

- agreeing activity profiles across the year to avoid spurious variations being reported;
- reconciling aggregate monitoring reports with monthly downloads of raw data from the National Clearing Service (NCWS) and analysing data down to HRG level;
- comparing monitoring data with the expected activity profile and prior years to identify possible changes in coding or clinical practice;
- raising queries with the trust about variances in activity levels; and
● conducting critical reviews to monitor consistency of coding rules and validate activity, using statistical analysis, dialogue with clinicians and manual checks.

161 Clinical input into monitoring is required to review the appropriateness and avoidability of admissions. In preparation for practice based commissioning a few PCTs (such as in Devon and Bradford) have provided GPs with incentives to validate activity data for their patients. While this is the most effective strategy for challenging the appropriateness of admissions and data quality, if practices are willing, it does not change the need for robust PCT monitoring. GPs themselves need a certain level of assurance that the data on their patients is correct.

162 A number of PCTs are looking to the introduction of the Secondary User Service (SUS) under Connecting for Health (it was due to be in place from June 2005, after being delayed from April) to significantly improve their ability to reconcile and monitor trust activity data. SUS will replace the NCWS, providing one national standard for information flows. While it should greatly reduce the time spent on reconciliation of activity data between trusts and PCTs, and reduce issues with quality (including timeliness of reporting), there are limitations. PCTs will not be able to rely on SUS during the transition until trust data quality has improved, and it will not provide data to support any local arrangements under contract that vary from the national framework. Therefore, PCTs need to ensure they do not rely on SUS for monitoring purposes in the short term, and have other arrangements in place.
The Audit Commission considers that a more systematic approach to providing assurance on payments and behaviour under payment by results is required to complement local PCT monitoring arrangements. A national framework should be established which would involve national scanning, benchmarking of activity profiles to identify potential data quality issues, underpinned by a programme of random and targeted audits (focusing on clinical coding), and a set of penalties. We are developing a proposal for the DH about how such a framework would work.

In part, the relaxed approach to contract monitoring among the early implementers results from a deliberate decision to be less rigorous in the first year, due to uncertainties, and to focus limited resources on demand management and service redesign. The most cost-effective arrangements for monitoring involve an element of trust – PCTs will need to place some reliance on data submitted by trusts, and trusts can provide assurance on their data quality through, for example, open communication and information sharing, a zero-tolerance policy with respect to gaming and sharing findings from data quality audits and the like. However, core monitoring arrangements still need to be in place.

Recommendations on monitoring

PCTs and trusts should:

- Avoid too much reliance on the contract as the basis for the relationship between commissioner and provider.
- Have a clear and consistent understanding of the approaches to classification, counting and coding which are reflected in the baseline and agree to maintain in-year consistency.
- Spend time upfront agreeing business rules related to reporting, monitoring, communication and dispute resolution.
- Have a clear risk management framework (ideally joint) enshrined in the contract and monitor this regularly.
- Agree locally to a proportionality rule for formal dispute procedures and ensure there are open communication channels for informal queries from PCTs to trusts, to minimise formal disputes.
PCTs should:

- Establish robust local monitoring arrangements to provide assurance on data quality and appropriateness of payments, while enabling them to understand the reasons behind activity changes for planning purposes.
- Have clear arrangements in place for reporting of information (and related penalties for lateness) which do not rely on the Secondary User Service (SUS) in the short term and which are enforced.

Trusts should:

- Provide assurance to commissioners and other stakeholders on the data through establishing a zero-tolerance policy on gaming, sharing audit findings on data quality, and being open and responsive to queries.

The DH should:

- Continue to refine the model contract in light of the experiences of early implementers, in particular focusing on the areas relating to the provision of information, monitoring, payments and dispute resolution.
- Establish a comprehensive and robust strategy and framework for policing, or providing a greater level of assurance on, payments and behaviour under payment by results, which meets the needs of local and national stakeholders.
Conclusions

165 Payment by results raises many challenges for the NHS as a whole and for individual health bodies. Some organisations, particularly foundation trusts, have used payment by results as an opportunity to strengthen internal management and as a result are seeing a positive change. However the majority are still grappling with the complexity of the system and the size of the change agenda. There are further refinements required to the policy framework and there are a number of obstacles to overcome. It is too early to judge if payment by results will meet its objectives.

166 International experience with similar payment mechanisms suggests there are some clear determinants of success. These include:

- clear and consistent policy objectives over time;
- investment in information systems;
- availability of robust support services;
- clinical engagement; and
- open communication channels between players.

167 In the more successful cases (for example, Australia), countries have promoted the view that payment by results is a change in organisational culture, rather than a payment mechanism to ensure that all services are provided at average cost, which is neither possible nor desirable. These findings are reinforced by early experiences with payment by results in the NHS.

168 The early implementers have learnt from their experience in the first year, and expect future years to be easier. Contract negotiation should be simpler and data quality should improve. However, they will face new challenges, as payment by results is extended to cover other services, patient choice is expanded, and there is greater use of the independent sector. This could reduce open information sharing, lessen community focus and increase internal organisation focus.
However, 2005/06 and 2006/07 will be a particularly challenging time for other NHS trusts and PCTs that have not operated in this new environment, especially given the deterioration in many organisations’ financial position over the last year. The risks to individual NHS bodies and the NHS as a whole from payment by results are still very much present. All bodies need to regard improvement in financial management and data quality as a high priority. Maintaining a health economy-wide approach to engagement and partnership working will also be fundamental, despite the clear incentives to be institutionally focused.

Organisational development must be a priority in 2005/06 and beyond, particularly for PCTs who need more support to develop in their role as commissioners and to control demand more effectively. The Audit Commission is committed to support this through its audit work and other activities, such as seminars and further reports. We have also produced a set of questions for boards to ask themselves in the light of the early implementers’ experience. This is attached at Appendix 1. PCTs and trusts might wish to use this to assess their own arrangements.

Finally, the overriding view of those organisations that have already implemented the new payment system is that it is a positive change that should bring about genuine and long-lasting improvements to the NHS. However, this is not guaranteed. NHS bodies, the DH, regulators and other key organisations, need to draw on the lessons from early implementers in 2004/05, to face the challenges, and commit to realising the benefits that payment by results can bring.
Appendix 1: Questions for boards

Questions for all NHS board members

Organisational development

1. Have we allocated sufficient time and resources and identified the skills required to implement and operate under payment by results?

2. Do members of staff at all levels, clinical and non-clinical, as well as non-executive directors, understand the implications of payment by results for the organisation and for their role?

3. Have we reviewed (and, where necessary, strengthened) the links between our finance and information functions?

4. Are we actively seeking to learn from early implementers of payment by results? Has this learning been shared with the board? Is this information being used in our planning for the payment by results roll-out?

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

Planning and reporting

6. Are we engaged in joint analysis and planning across the health economy and using this to underpin our own financial and operational planning?

7. How have we made and challenged the assumptions underpinning our short- and medium-term planning?

8. Have we reviewed our arrangements for reporting financial and activity information (on quantity and quality) internally and externally against the experiences and practices of the early implementers, and made any changes required?

Partnerships

9. What steps are we taking to maintain or develop strong partnerships in light of the early implementers’ experiences?
Contracts and monitoring

10 Do contract parties have a clear understanding of reporting requirements, dispute resolution procedures and monitoring arrangements?

11 Do we have agreed baselines and a clear understanding of how activity will be counted and coded on a consistent basis with the baseline?

12 Have we thoroughly assessed the risks to the organisation under payment by results and are strategies for managing them built into our contracts and agreements? Are the risks reported to the board on a regular basis in a useful format?

Questions for acute trust board members

Organisational development

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

Planning and reporting

14 What proportion of our activity is coded as unclassified (u-codes) at the end of each reconciliation period? What are we doing to improve the timeliness and accuracy of our clinical coding?

15 Will we be investing in new information systems under Connecting for Health? Have we considered the implications of migrating data between systems for data quality, regular reporting and invoicing?

Contracts and monitoring

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

Demand management

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

18  What is our current reference cost position and how has it changed over time?
19  What improvements have we made since auditors last reviewed the accuracy of our costing and the accuracy and completeness of our activity data?
20  How do our own estimates of cost pressures compare with the tariff and what are the implications?
21  Do we understand our current cost structure? Where are local costs more or less than tariff and do we understand why?
22  What estimates have we made on the level of cost improvement/productivity gain required in the medium term? What steps are we taking to achieve this and are these sufficient?

Questions for PCT board members

Organisational development

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

Partnerships

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

Contracts and monitoring

25  Have we reviewed our monitoring arrangements to ensure that they are sufficiently robust to provide us with assurance on the quality of data and appropriateness of payments?
26  Do we need to increase investment in our information systems or increase analytical resources to make better use of the available data? Or can we put shared arrangements in place with other PCTs?
27  Could we further strengthen our risk management arrangements through joint contracts or agreements with other PCTs?
28  Do we have formal arrangements in place to ensure that trust reporting is timely and that contingencies and penalties are in place in the event it is not?
29 How will we audit data quality, costs and appropriateness of admissions and treatment where concerns are raised and cannot be resolved through queries to the trust?

30 What steps are we taking to check the appropriateness of patient pathways implied in the data?

**Demand management**

31 Do we know our priority areas for limiting or reducing demand for hospital care? What is our strategy? What assumptions and data underpin this? Are we considering the quality of patient care as well as cost, in these proposals?

32 How successful have our existing demand management initiatives been?

33 How are we currently engaging GPs and other clinicians in initiatives and how can we improve this?

34 How are we going to ensure that the acute trusts support, and are involved in, our plans to redesign services?

35 What ideas and plans do GPs have for demand management and service redesign and how can we support them under practice-based commissioning?

**Questions for SHAs**

36 Have we undertaken a recent health economy-wide review of the impact of payment by results on providers and commissioners?

37 How fit for purpose are the health bodies in our economy to operate in the payment by results environment? Are they sufficiently prepared?

38 How are we helping those bodies that are less prepared to strengthen their arrangements?

39 Are we supporting joint planning and analysis across the health economy?

40 What else can we do to support demand management and service redesign across the health economy? For example, would it be helpful to adopt SHA-wide referral systems?
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