REPORT ON THE TARIFF SETTING PROCESS FOR 2006/07

Executive Summary

On 31st January this year, the Department of Health published the Payment by Results tariff for 2006/07. The tariff is the prices paid for much of the activity undertaken by Acute Trusts and Foundation Trusts. However there were material errors in the tariff published in January and so it was withdrawn and re-issued. When it was re-issued, Sir Ian Carruthers asked for an independent review to examine what went well and less well with the tariff setting process for 2006/07 and make recommendations. This is the report of that review.

What went well

A full baseline exercise was conducted through SHAs and Foundation trusts, leading to a good understanding of the underlying numbers.

The tariff was published and the coverage increased compared with 2005/06. There was greater openness through the Project Transition Board and its Working Groups.

What went less well

The baseline exercise seriously squeezed the time available for checking and testing the tariff calculation process.

The tariff was materially wrong. The Department of Health intended the net impact of all the changes to the tariff to increase it by 1.5% but the impact of all the individual decisions was to increase the tariff by more than this.

The tariff was published at the end of January 2006 to be implemented at the beginning of April 2006. While this was a challenging timetable for the Department, given the need to complete the baseline exercise, it gave the NHS little time to plan on the basis of the new tariff. The lack of time to prepare was exacerbated by the need for the tariff to be withdrawn and then re-issued and by the fact that the increase of 1.5% was substantially less than the NHS was expecting. Trusts found this particularly difficult, although commissioners, whilst surprised, generally welcomed the decision.

The causes of what went less well

There were significant staff shortages, lack of experience and high turnover in the team which calculated the tariff. Due to the complexity of the tariff calculation, the chances of mistakes being made was increased. In addition there were weakness in the governance process, with a lack of clarity about the roles and responsibilities of the Project Transition Board, the main governance board for the workstream.

Whilst accepting the impact of the resource constraints identified, the Department of Health did not engage sufficiently with the NHS and communication was weaker than it needed to be. Engagement was by necessity seen as a lower priority than other work; this proved to be a mistake. The Department used the Project Transition Board and SHAs to gather NHS views, but this was not sufficient and left people in the NHS confused or surprised.

Major recommendations

- Increase numbers of staff working on the tariff calculation from 3 to 9. The Department needs to actively manage staff recruitment and retention with more succession planning and building expertise.

- Set up a small Programme Management Board

- Test the tariff over a number of weeks with a number of NHS organisations under clear privacy rules

- Publish the tariff by mid/December at the latest and set up a clear timetable for publication

- Strengthen consultation arrangements, potentially drawing on the process of utility regulators

- Consider contracting out arrangements for calculating the 2008/09 tariff - although this must not be seen as a substitute for the other actions above.

Introduction

1. On 31 January this year, the Department of Health published the Payment by Results tariff for 2006/07. The tariff consists of the prices paid to Acute Trusts and Foundation Trusts for much of the activity they undertake. In 2006/07 is expected to cover expenditure amounting to £22 billion.

2. There were material errors in the tariff. As a result, the overall increase in the value of the tariff was higher than intended and it had to be recalled. The tariff was re-issued on 17th of March 2006. At that time Sir Ian Carruthers announced that there would be a short, independent review to consider all aspects of the 2006/07 tariff setting process; identify strengths and weaknesses; and make recommendations for improvements in future. The remit did not include considering the existing responsibilities of the Secretary of State to set the tariff. (The full terms of reference can be found in Annex A.)

3. The review was led by John Lawlor, Chief Executive of Harrogate and District NHS Foundation Trust. In terms of accountability, the review team

discussed its draft findings with the Project Transition Board before reporting to Sir Ian Carruthers.

Approach taken

4. The approach taken was to review the documentation of the team, conduct a set of structured interviews and run three fast, light touch consultations. On the basis of these the review team drew up:

- What went well
- What were the problems
- What were the causes of the problems
- Recommendations

5. The documents reviewed were:

- Project plans
- Governance papers
- Terms of reference
- Risk registers

6. A total of 19 interviews were conducted with members of the Department of Health, representatives of the NHS and representatives from interested bodies such as Monitor, The Foundation Trust Network, the Information Centre and Connecting for Health.

7. The three fast, light touch consultations asked for views from:

- the Project Transition Board (the governance body of the Payment By Results programme);
- the NHS views through the Chief Executive Bulletin; and
- people in the Department of Health who worked or had worked in this area.

8. There were a total of 10 formal written responses, as well as comments received through structured interviews with Project Transition Board members, Department of Health staff and representatives of interested bodies.

What went well

9. Based on the interviews and the consultations there was a broad consensus that the process had improved:

- The government fulfilled its commitment to extent the tariff to cover non-elective care. Generally the people interviewed thought that the tariff is better than the block contract system that went before.

- The tariff was published despite difficult conditions in the Department of Health. The Department was facing substantial pressure at the time with an internal reorganisation and considerable focus on the financial pressures in the NHS. The results of this were that senior management focussed less on the publication of the tariff then they would have liked. Nevertheless the tariff was published.

- There was more communication between the NHS and the Department of Health than there had been previously - through the PbR Project Transition Board and its working groups and the Strategic Health Authorities

- The governance arrangements had improved in some areas, with better project management and risk registers in place.

- The tariff was not published until after there had been substantial scenario analyses setting out the impact on different Acute Trusts, Foundation Trusts and Primary Care Trusts. So it was felt that the tariff was more robust.

- There had been a substantial exercise to improve the baseline data and the data used to asses the amount of activity carried out in the NHS, ensuring that the purchaser and provider adjustment paths were more robust. But delays in data availability meant that this exercise could not be completed as quickly as hoped, which further squeezed the time available for calculations and checking.

The weaknesses of the tariff setting process

10. Despite the process being better than previous years, many of the people interviewed felt that there were still significant problems.

11. The **tariff was inaccurate.** The Department announced that they were increasing the tariff by 1.5%, but the total impact of the series of relatively small errors made on individual tariff decisions was materially more. Some PCTs reported increases of 4% and more in the cost of activity.

12. The main reasons why the tariff was inaccurate were:

- There was a data input error relating to the cost of observation wards.

- During the process of calculating the tariff, the HES data was revised, with the revised data received later than anticipated. This had cost implications but the impact of this was not fully realised.

- There were a number of other errors, for example the cost of some expensive specialised drugs and devices were effectively removed

twice. However, the impact on the overall increase in the tariff due to these errors was less material than the two mentioned above.

13. There was difficulty with engagement and communication with the NHS. Delays in receipt of data from the NHS for the baseline exercise further squeezed the time available for options to be analysed and put before Ministers. Nevertheless, publishing a tariff as late as the end of January caused substantial problems for the NHS as **it did not give much time to plan**. The beginning of the financial year was only a couple of months away.

14. The announced **increase in the tariff was smaller than generally expected**. This exacerbated the lack of time to plan. Several of the people interviewed said that there was a general expectation the tariff would increase by around 3 to 4% compared with the announced increase of 1.5%. This was of course particularly difficult for providers although commissioners were less concerned, and indeed generally pleased, by the more modest increase.[1]

15. As the tariff was withdrawn and then reissued a few weeks before the financial year, the difficulties with the lack of time to plan created further pressures on the NHS.

16. **Additional information was needed** by the NHS as well as the headline tariff changes. In particular, organisations wanted the 'grouper' and the 'spell converter'. [2] Also they wanted the technical guidance which covers topics such as how to deal with coding issues. These are important to many NHS organisations as it enables them to undertake their local calculations.

The causes of the problems

The tariff being inaccurate - resources

17. The key reason for the tariff being inaccurate was the **lack of people**, leading to insufficient time to run all the appropriate checks. There are only 3 people calculating the tariff. Initial assessments suggest that considerably more resources are devoted to calculating the tariff in the Australian system.

18. Although there has been a large increase in the PBR team from 12 to 25 people, the number of people crunching the numbers in order to calculate the tariff has not changed. The additional resources went into improving liaison with the NHS, development work on amending the scope and structure of the tariff to improve its operation, and working with other parts of the Department to ensure coherence with other reforms. All of there are essential, but

[1] Primary Care Trusts were unhappy about the changes in the purchaser parity adjustments. This was outside the scope for this review.

[2] . The grouper allocates a Healthcare Resource Group (HRG) to a finished consultant episode and establishes a specialist top up code for the episode. The spell converter is used to identify the dominant HRG and the specialist top up code for the provider spell. This allows the appropriate tariff to be allocated.

calculating the tariff has also become increasingly important. Initially it was constructed to share best practice and allow bench marking. Now more and more income flows now depend on the tariff.

19. The lack of resources was exacerbated by **high staff turnover** during critical periods - one of the key people was new and there was not much time for handover. Generally there was a difficulty with recruiting new people into the PBR area and retaining those who currently work there. Linked to the lack of people was a lack of **expertise**. It was hard to recruit people with the appropriate skills, especially Access and Oracle skills. The management of the PBR team were trying to address the issue but had not fully succeeded by the time the tariff needed to be calculated.

20. There was insufficient **documentation.** This made it harder for people who were new in post, something which was particularly important when staff turnover was high. People were aware that they needed to produce documentation but this was crowded out by other tasks. This situation appeared to have been a feature of the PBR work programme for some time.

21. Several people raised the issue of **lack of IT**. For example the PBR team did not have their own server and the data were split over 14 databases, as the database system they were using will not deal with a sufficiently large database. One example was given of a process taking 8 hours where other software would have allowed this process to take 2 hours. This created more time pressure on the people doing the calculations, and so less time to run the checks they would have liked to have run. There had been a review of IT and the PBR team had been told that the IT was sufficient. Nevertheless the time taken to use the IT seems to have reduced time for checking and so contributed to inaccuracies in the tariff.

The tariff being inaccurate – the nature of the tariff calculation

22. The way the tariff is calculated contributed to the problems associated with lack of people and expertise. The original tariff design populated the components required to complete the calculations with existing, available datasets and methods and modified these to meet the needs of the PBR system. Thus, the tariff is built up from reference costs which are calculated on a different basis. The way reference costs are constructed has been built up over a number of years and is itself complicated. The relationship between the inputs (e.g. costs and baseline activity) and the final output of the calculation is complex. The complexity makes it more likely that mistakes can happen and small errors if not spotted can have a material impact on the published tariff.

23. Many inputs are required to calculate the tariff and there were **difficulties getting some of the input data**. For example the Hospital Episode Statistics (HES) arrived later than expected. And to calculate the total amount of activity covered by the tariff, the Department ran the one off baseline exercise requiring data from all trusts (not just a sample). The data from the trusts was

submitted later than planned and the process had to go at the speed of the slowest trust. This reduced the time available to check the final output.

24. There were insufficient procedures for checking the overall impact of the tariff calculation. For example, there was a lack of tables setting out the total impact that could be easily related to individual tariff decisions. This made it hard to "sense check" the numbers being produced.

25. Checking the calculations for the individual tariffs for different procedures is difficult. There is a **mechanistic link** between the inputs and the tariff. An advantage of this is that there are no subjective judgements. However if an individual tariff looks odd (for example increases significantly) officials do not feel that they can change it because they would be introducing a subjective change.

26. All of the above should be seen within the context of the need to get the tariff published as early as possible, whilst at the same time ensuring it was fit for purpose. The delays associated with the baseline exercise put further pressure on this and contributed to the checking procedures not being as robust as needed.

The tariff being inaccurate - Governance arrangements

27. Officials in the Department of Health regarded the Project Transition Board (PTB) as the governance board for the PBR programme. However, several people on the PTB thought that it did not act as a governance board and that there was not, as a result, an effective governance structure in place. Many of the issues mentioned above, such as a lack of resources, could have been raised through a programme board. But they were not discussed at the PTB as the members felt it was not their role to probe those types of questions.

28. **Internal communications** within the Department needed to be better. People were not clear about the project management structures. Time pressure and complexity of the process crowded out effective sharing of project plans.

29. Some people mentioned that they thought there was a weakness in the **Department's relationship with Connecting for Health and the Information Centre.** For example, the final version of the HES data was provided later than expected by the Information Centre and some people felt this was an example of the lack of clarity about what was expected and by when.

Engagement and communications with the NHS

30. Many of the **other problems:** publishing the tariff in January, not being able to manage expectation about the increase in the tariff and not publishing all the information wanted were driven by insufficient engagement and

communication with the NHS. Generally officials wanted to engage more, but some said that it was a lower priority than other work and so tended to get crowded out.

31. Managing expectations about the total increase proved difficult. In part this was due to the compressed timetable. Because some of the data arrived later than expected the calculations about the tariff and the total increase were delayed, leaving little time to manage getting messages out to the NHS. Also there was some nervousness about giving signals to the service before completing ministerial sign off.

32. The PTB and the working groups provided some improvement in officials' appreciation of NHS organisations' perspectives. However, the members of the Project Transition Board did not feel clear about the internal DH timetable for advising ministers and so did not know when best to feed in views.

33. As well as gathering views from the Project Transition Board (which is attended by senior people) there was on-going discussion and sharing of information with SHA leads. Nevertheless, there was a lack of understanding at a more operational level within the Department and across NHS organisations and there was no formal consultation process.

Recommendations

34. Based on the analysis of the problems and their causes the review team made the following recommendations.

Making the tariff more accurate - resources

1.1) There should be **a substantial increase in the number of people calculating the tariff**. The number of people working on the tariff should increase from 3 to 9, at least until the system has been running successfully for a few years. There should be greater succession planning. It would also be sensible to build in sufficient flexibility so that the team has the capacity needed to be able to model and calculate tariff revisions under different scenarios in the future.

1.2) There should be increased marketing of the PBR area across the Department of Health as an attractive place to work. This needs to be actively supported by senior management.

1.3) The Department should review the numbers and functions of staff in other tariff setting bodies.

1.4) In addition there should be more training and consideration given to increased flexibility to pay individuals with the necessary skills.

1.5) There needs to be a focus on strengthening **expertise** within the PBR team. In particular the Department of Health could try to recruit people with experience from other countries which use similar systems.

1.6) **There should be a review of the IT.** This needs to be done rapidly because any new system needs to be bedded down by the time next year's tariff is issued.

1.7) The tariff calculation and process should be **completely documented**.

Making the tariff more accurate - the nature of the tariff calculation

1.8) The Department needs to review the tariff calculation. In particular it should:

- Review the tariff calculation to try to make it **simpler**
- Base the tariff on **sampling techniques** rather than requiring every trust to submit data
- Consider altering tariffs if they do not make sense, even if the data says otherwise
- Ensure greater **sensitivity analysis** of the data so there is clearer understanding of the impact of changes in the inputs to the tariff
- The Department should introduce **greater macro testing** of the tariff. This could include developing a few simple models of the tariff to "sense check" the numbers coming out of the calculations.
- The calculations should be **audited** independently

1.9) There should be **increased testing with the NHS,** including testing in individual NHS organisations/communities areas under strict secrecy rules. This could include testing several options if the Department is particularly concerned with ensuring confidentiality.

Making the tariff more accurate – the governance and process management arrangements

1.10) There should be a **governance** group of approximately 7 people whose role is to ensure that the process is on track to deliver the tariff without errors. They should report to senior Department of Health officials and feed into the Project Transition Board. There needs to be greater clarity about who is making the key recommendations to ministers. The remit of the Project Transition Board should be clarified and if it remains the same size its role should be for consultation and the testing of ideas.

1.11) **Relationship with Connecting for Health and the Information Centre.** The Department should consider putting in place robust Service Level Agreements with Connecting for Health and the Information Centre.

1.12) A detailed timetable should be drawn up and committed to. As part of developing this timetable, there should be a critical path analysis to determine all the inputs affecting the tariff construction and dissemination, and contingency plans if key data do not arrive on time.

Involving the NHS

2.1) **The tariff should be published by mid December at the latest.** There could be a pre-commitment that this will happen. For example it could be announced in a ministerial speech or Departmental publication.

2.2) There should be a review of the consultation process. In particular the Department should review the processes of other price-setting bodies e.g. Ofgem, Ofcom. They should not copy them slavishly; however they should examine the timetable and type of engagement that they undertake. As part of the consultation process, a timetable for producing the tariff should be published including when the NHS can feed in views. The Department should include greater consultation with clinical bodies as well as NHS management.

2.3) Engagement between officials and the NHS needs to be prioritised at a working level. This should be with providers and commissioners and with both managerial and clinical staff.

2.4) There should be a focused PBR communications plan, clarifying the motivation behind introducing PBR and the benefits. This should also stress that it is the responsibility of the NHS to provide good quality, timely data.

2.5) There is a clear desire for **stability in 2007/8**. In particular, it was felt important to let the data for elective and non elective care bed down before trying to extend the use of the tariff into areas such as critical care and mental health. There was also a desire for more indication of how the tariff will develop beyond 2007/8. The only area where quick progress was thought to be important was unbundling the tariff – ensuring that the tariff can be broken down into separate parts which would facilitating providing elements of patient care in different settings.

Contracting out the tariff calculation

3.1) One possible solution that was raised by several officials was contracting out the tariff calculation. The Department should consider the advantages and disadvantages of contracting out. For example, many of the skills required for calculating the tariff are in short supply in the civil service. Contracting out the calculation would force some of the other recommendations including a clearer timetable and improve documentation.

3.2) Nevertheless the Department would need to consider the decision about contracting out the calculation very carefully. For example, there is a question about whether it could guarantee providing the data to the body responsible for calculating the tariff. If the data had not been collected for whatever reason, the tariff might not be published, or might be published very late. Also, if the Department changes the basis of the tariff calculation (e.g. moved from using average costs to a best practice model or based on costs built up from the component parts) then it is possible that the contracting out arrangements would not be used.

3.3) Whatever the decision about contracting out, it is important that the Department does not wait until a decision about the contracting out is made before taking forward the other recommendations.

Annex A Terms of reference

Review of the tariff setting process within the Department of Health:

Terms of Reference

To consider all aspects of the 2006/07 tariff setting process; to identify strengths and weaknesses; and to make recommendations for improvements in future. The team will take as a given the existing responsibilities of the Secretary of State to set the tariff.

In particular the review will consider:

- The timetable for setting the tariff
- Adequacy of data collection and modelling
- Transparency and openness in the tariff setting process
- The availability of adequate resources and expertise
- Adequacy of the structure, clarity and documentation of databases used in the tariff calculations
- Communications and consultation
- Adequacy of links with other key policies and processes in DH
- The ability of the NHS reasonably to predict and assess the impact of tariff options locally
- Other aspects of the process which the review team believes to be important

Governance

The review team will report to the PbR Project Transition Board, which will make recommendations to Sir Ian Carruthers.

Timing

The review will report by mid-April.

Review Team

The review team will be led by John Lawlor, CE of Harrogate and District NHS Foundation Trust