Health

Summary

February 2008

audit commission

# The right result?

Payment by Results 2003-07

# Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Recommendations

## The DH should:

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

## All providers of acute NHS services should:

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

## All PCTs should:

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

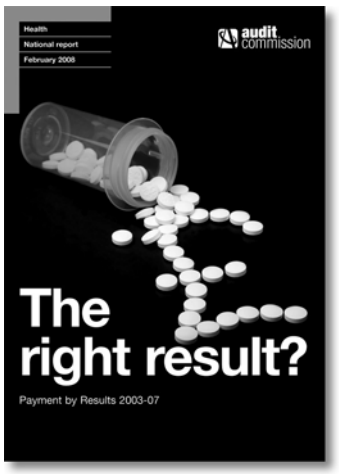
- Take the lead in exploring, with providers, the use of local flexibilities, including unbundling, and the development of local tariffs for services currently excluded from the scope of PbR and new currencies that, for example, take account of significant innovation in service delivery currently not supported by the tariff.

## All SHAs should:

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

## All PCTs, trusts and SHAs should:

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

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