

Keeping Professional Executive Committee member and other clinicians in touch with key policy developments and their impact on PCTs

## 1 - Reforming NHS Financial Flows: Introducing Payment by Results

### Introduction

The Department of Health Policy "Reforming NHS Financial Flows: Introducing Payment by Results" published in October 2002 heralds a radical modernisation of NHS finances.

### Context - why is a change in financial policy needed?

Rising public expectations and greater knowledge about options for health care are driving demand for better quality services, provided promptly and conveniently at the location of their choice.

The **growth in resources** allocated to the NHS in national plans from 2003 to 2005 are at record levels and high growth is promised in the next plan from 2006 to 2008. The extra resources have many calls on them and challenging targets set for service improvements depend on the NHS achieving efficiency gains through service modernisation as well as investing growth money wisely.

**Other NHS reforms** which require the adoption of the new Financial Flows policy are:

- **Patient Choice** - the policy to offer choice to patients will benefit from the introduction of national tariffs. Standard tariffs make choice less financially complex for PCTs to manage and reduce the potential disincentives of differential provider prices.
- **Waiting Lists** - the tariffs have been set at the full national average cost of treatment which will give most providers a financial incentive to offer more capacity.
- **Modernisation** - prices based on full average cost rather than on the marginal cost of extra care give PCTs a financial incentive to redesign care pathways to improve access while avoiding some of the cost of extra capacity.

### Summary

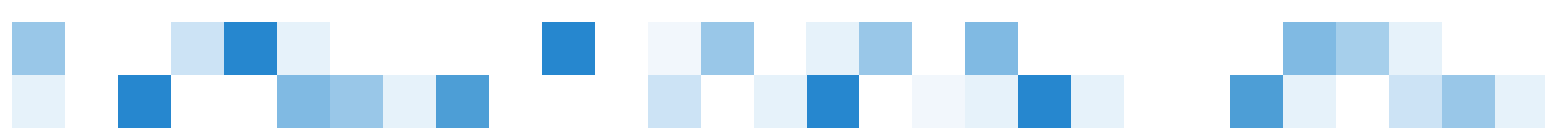
*The aim of the new financial system is to provide a transparent, rules-based system for paying Trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for casemix. Importantly, this system will ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.*


*Under the reforms to NHS Financial Flows, instead of being commissioned through block agreements as previously, hospitals (and other providers) will be paid for the activity that they undertake; so PCTs will commission:*

- *the volume of activity required to deliver service priorities, adjusted for casemix (i.e. the mix of types of patients and/or treatment episodes)*
- *from a plurality of providers*
- *on the basis of a standard national price tariff, adjusted for regional variation in wages and other costs of service delivery.*

Key Department of Health site:

[www.doh.gov.uk/nhsfinancialreforms](http://www.doh.gov.uk/nhsfinancialreforms)





Structural changes including the **devolution of resources to PCTs**, the establishment of free standing **Foundation Trusts**, the **increasing plurality of care provision** as private, voluntary, the new Diagnosis and Treatment Centres and international providers are commissioned to care for NHS patients.

**The increasing complexity of modern medicine** and the resultant sub specialisation and interdependencies between specialties require commissioning to become more sophisticated to meet patients' needs. An example is the need to commission along the whole care pathway in cancer networks which span primary, multiple secondary providers, tertiary providers and voluntary sector provision of home nursing support and hospices. Tariffs will enable the commissioning of more sophisticated patterns of care while avoiding some of the extra administrative costs which could arise from complex commissioning.

## The components of the Financial Flows Policy

**Standard National Tariffs** have been developed using the national Healthcare Resource Group analysis of treatments and costs. HRGs have a number of shortcomings including that they mainly cover acute care at present, but the scope is being widened to encompass the majority of care. HRGs have some advantages:

- The data exists and has been produced annually for 6 years
- The variation in costs and volumes between procedures and organisations has reduced substantially as the NHS became aware it may be used for tariffs
- There was substantial clinical involvement in developing the HRG definitions so they reflect UK practice but it was done seven years ago and needs updating to reflect modern practice and the latest technologies
- Prices derived this way reconcile to the expenditure and resources actually available in the NHS


The Department of Health is responsible for adjusting price tariffs for inflation and cost pressures, which avoids PCTs repeating that analytical work hundreds of times across the country each year. The DoH has adopted the role of price regulator in this reform, in other countries that role has been given to independent bodies


The tariffs are adjusted for market forces factors to reflect regional variations in costs, the adjustment mirrors that used in the resource allocation formula (weighted capitation) used for PCTs.

The policy is being implemented gradually to give the NHS time to adapt working processes to take advantage of the opportunities. It is also being refined, for example, work to bring Healthcare Resource Group definitions up to date and extend their scope beyond acute care.

The **initial stage from April 2003** includes commissioning all additional care for the top 15 waiting list HRG codes on a cost per case basis at national tariff prices. These include cataracts, hips, knees, arthroscopies, cardiac procedures and breast surgery. The tariff prices give providers a financial incentive to deliver extra volumes of care in these HRGs up to the levels agreed by PCTs. If a provider underperforms on the agreement then PCTs will have the resources back to buy elsewhere.

It also requires PCTs to commission the 6 main waiting list specialties (Ophthalmology, Cardiothoracic Surgery, ENT, Trauma & Orthopaedics, General Surgery, Urology) using cost and volume agreements with national standard case mix weighting. This replaces the block agreements used in many areas since the abolition of the internal market in 1997. Block agreements operate on the basis of best endeavours with little or no penalty for underperformance whereas in cost and volume agreements there is a case mix weighted financial adjustment for under or over performance.





These implementation arrangements result in PCTs paying at national tariff prices for extra care in the 15 specific HRGs but at current locally negotiated prices for all other care.

There are significant variations in relative costs between trusts with some as high as 20% above tariff and some 20% below, so local purchasing power varies considerably according to which trusts a PCT commissions from. The published national reference cost index gives PCTs a clear view of the relative costs of all NHS providers and that information should be used as part of the commissioning process. The aim is for commissioners to encourage higher performance to meet local needs and to buy elsewhere if providers cannot deliver.

The **second stage of implementation from April 2004** is expected to include more individual HRGs and commissioning all surgical specialties on a case mix weighted, cost and volume basis. It is of note that, although there are circa 600 HRG codes, the top 40 (by volume and by value) cover 70% of elective care.

The **third stage from April 2005** will see all care commissioned on a case mix weighted, cost and volume basis at national tariff prices.

Local health communities are free to run ahead of these stages as some communities are better prepared in terms of information and current commissioning agreements than others.


## Key issues

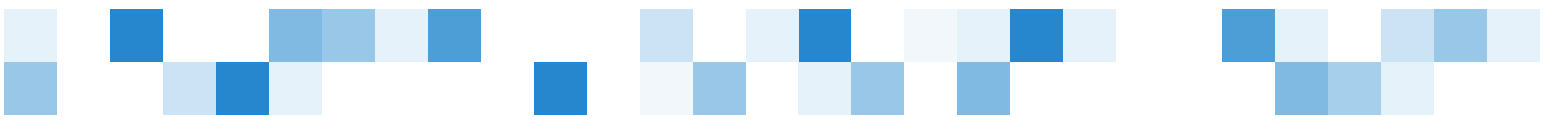
When redesigning care pathways PCTs will need to make **local arrangements to share the tariff price**. An example would be if the PCT can improve quality and efficiency by providing post operative rehabilitation of patients after a hip replacement in a community or community hospital setting and reduce the acute care length of stay. Then because the HRG tariff price includes rehabilitation the acute trust and PCT would need to agree fair shares of that price according to which organisation carries out which element of the care.

There is a national debate about whether separate tariffs should be developed for **acute care delivered in a primary setting**. One school of thought is that adhering to a single price regardless of setting will incentivise cost effective primary providers to offer more treatments. The contrary view is that some of the primary care (mainly premises) costs are already funded from a different budget and that the primary provider could be being paid twice for those costs. This issue will be part of this summer's national consultation on the next steps for the Financial Flows Policy so PCTs will have an opportunity to influence the decision.

The Department of Health has ensured that the Financial Flows Policy is congruent with **PCT resource allocation policy**. The same regional market forces factors have been used. It is likely, as tariffs attain comprehensive coverage in April 2005, that PCT allocations will be adjusted to reflect average national prices and that all care will be sold at those prices. This will mean PCTs pay the same price for treatments regardless of which provider is used and will make it easier to manage patient choice. It will leave all PCTs with the same purchasing power.

Another major issue is how will **trusts manage their expenditure to match income** earned from national tariffs. The Department anticipates managing this over a three year transitional period from 2005 to 2008. The challenge for high cost trusts getting down to the average will be greatly eased by the growth resources and the need to expand NHS capacity which gives them the chance to earn more resources and that the average will rise toward them. The issues are different for lower cost providers. It will not be as simple as 90<sup>th</sup> percentile trusts receiving a 10% bonus with no strings. They will need to find out why they are lower cost and do that in the context of care standards in the NHS Plan and National Service Frameworks and workforce development plans. A hospital may be lower cost because it is working in run down buildings or with old equipment or with insufficient doctors, nurses and other clinical staff to meet the rising quality standards of the new NHS.





Local health communities will need to **consider national tariffs when developing business cases to expand services**. Before the Financial Flows policy, the key financial test was “can the health community afford the preferred option?”. Now one has to ask whether the options are viable at national tariff prices for the extra care they will produce.

The tariffs bring a new dimension to costing local capacity plans and place more emphasis on exploring options for **admission avoidance or redesigning care pathways** because just buying more of the existing pattern of care will carry a substantial price tag. This needs to be built into PCTs' financial strategies now rather than waiting until full implementation in 2005.

Tariffs move the emphasis of commissioning toward quality and the collaborative redesign of care pathways and away from cost because the price becomes a given.

The recent (August 2003) consultation paper about the next steps or the “Payment by Results” policy brings three changes. It proposes:

- Extending the tariff to cover 33 more HRGs from April 2004. That means most elective care will be covered by tariffs
- Including nearly all acute specialties in case mix weighted service level agreements from April 2005
- Changing the acute activity currency to “spells” from “finished consultant episodes” to counter FCE inflation

These changes are all in line with the direction of the original proposals which will continue to drive changes in commissioning.

There are a number of potential risks in the Financial Flows Policy including that **providers may select only the patients who are easier to treat** (for example people with no co-morbidities). There are some counters to that, firstly the clinical dialogue and collaboration between PCTs and providers, particularly as more clinical networks

develop, will ensure the focus of institutions is on meeting real needs not gaming the system. A second counter is that there are plans to develop a fair price per day in addition to the treatment tariff for patients who have to stay longer in hospital for clinical reasons. The current refinement of HRGs being conducted for the Department by the NHS Information Authority is informed by clinical reference panels and gives the opportunity to distinguish difficult cases from straightforward ones. Commissioners and Strategic Health Authorities will need to keep a watchful eye for gaming and ensure the policy is kept up to date for those issues as it evolves.

The incentive to add capacity may encourage thresholds for intervention to fall thus drawing in more patients. That could **threaten waiting list reduction targets** and financial stability. Clinical agreement about thresholds is a key aspect of the commissioning and planning dialogue between PCTs and trusts and is an essential part of care pathway redesign.

### In conclusion...

The Financial Flows policy is a powerful tool for commissioners in an increasingly complex and dynamic care environment. It requires considerable thought and energy to be addressed to it during the lead in period to full implementation in April 2005. The implementation is on an exponential curve and it will be hard to catch up if the lead in period is not used to prepare for the later stages.



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