



*Payment by Results  
Consultation:*

**Preparing for 2005**



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**READER INFORMATION**

<b>Policy</b> HR/Workforce Management Planning Clinical	Estates Performance IM & T <b>Finance</b> Partnership Working
<b>Document Purpose</b>	Consultation/Discussion
<b>ROCR Ref:</b>	<b>Gateway Ref: 1632</b>
<b>Title</b>	<b>Payment by Results Consultation: Preparing for 2005</b>
<b>Author</b>	DH
<b>Publication date</b>	31/07/2003
<b>Target Audience</b>	PCT CEs, StHAs CEs, Directors of Finance
<b>Circulation list</b>	
<b>Description</b>	This document outlines the developing policy background for Payment by Results and outlines progress towards implementation. It invites views on a range of questions for consultation including on managing the transition path for NHS trusts and PCTs in implementing Payment by results from 2005.
<b>Cross Ref</b>	Reforming NHS Financial Flows: Introducing Payment by Results
<b>Superseded Docs</b>	
<b>Action required</b>	none
<b>Timing</b>	N/A
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# Executive Summary

## Need for change

1. The way the healthcare system works needs to change so that patients receive a more personalised and responsive service.
2. The *NHS Plan*, together with *Delivering the NHS Plan* set out a major programme of investment, expansion and reform for the NHS over a ten-year period.
3. The vision of the *NHS Plan* is to offer prompt, convenient, high quality services which treat patients as partners. The delivery of this vision is shaped by the Government's framework of principles for public sector reform; namely:
  - High national standards and clear accountability;
  - Greater local ownership and innovation;
  - Increased flexibility for frontline staff;
  - Greater choice for patients helped by greater diversity of provision.
4. This programme of reform is supported by the highest ever sustained growth in funding. Over the years 2003-04 to 2007-08, there is an increase of £34 billion or 43% in real terms, from £56bn in 2002-03 to £90bn in 2007-08 (England); an average annual real terms increase of 7.4% a year over and above inflation.
5. The NHS is already treating substantially more people. There are significant changes in the way services are delivered which represent real progress in improving quality, especially in reducing waiting times.
6. But the aim of providing a more personalised service for patients requires:
  - Primary Care Trusts (PCTs) to commission effective services that are more responsive to patients;
  - Help from a greater range of providers delivering NHS services to common national standards which are independently inspected by the Commission for Healthcare Audit and Inspection;
  - The financing system to change to support the overall aim.

## Rolling out payment by results

7. The introduction of payment by results is necessary to support a devolved health system with care delivered by a diverse range of providers responding to patients' needs and choices. The new system:
  - Pays NHS Trusts and other providers fairly and transparently for services delivered;

- Rewards efficiency and quality in providing services;
- Supports greater patient choice and more responsive services;
- Enables PCTs to concentrate on quality and quantity rather than price.

8. In this document we identify the key decisions needed for implementing the next stage of payment by results. It outlines how these will apply to NHS Foundation Trusts from April 2004 and to all NHS Trusts from April 2005.

## NHS Trusts

9. For 2003-04 national tariffs apply to extra elective activity across 15 healthcare resource groups (HRGs) while for 6 specialties price is locally determined but HRGs cost weights are used to adjust for casemix. Failure to deliver growth in activity will lead to withdrawal of funds at national tariff. But the pace of change will accelerate:

- For 2004-05 we have identified an additional 33 HRGs making a total of 48 for which volume growth will be funded at tariff. Cost and volume contracts adjusted for case mix will need to cover all surgical and most medical specialties;
- For 2005-06 a further step change means that (nearly) all specialties will be commissioned on a cost and volume basis adjusted for casemix and moving from local to tariff prices with convergence to national tariff over 3 years.

## NHS Foundation Trusts

10. The first NHS Foundation Trusts will be established in April 2004. Additional activity will be funded at the tariff price. They will thus begin their transition path in 2004-05, a year ahead of the rest of the NHS. The arrangements proposed will be as close as possible to the overall payment by results system for NHS Trusts in 2005-6 and the transition that will follow.

## Setting the tariff

11. Our aim is a tariff that represents a fair level of reimbursement for providers and a fair price for commissioners. Where providers have high costs because they treat more patients with complex needs this should be recognised in the funding they receive. Our longer-term aim is to have a set of tariff prices which will apply irrespective of where a procedure is carried out.

12. For 2005-06 we propose the tariff will be based on the approach developed for 2003-04 but with some further key decisions:

- using spells as the basis for activity planning; and
- an approach to funding critical care.

13. In addition work is ongoing for 2005-06 on high and low cost exceptions, on funding specialised services and on reflecting technology costs in the tariff. We are consulting on these matters.

## Scope of the tariff

14. The aim is that the tariff will over time cover all activity covered by commissioning arrangements including all inpatient and day case services together with outpatient, accident and emergency, mental health, community services and elements of primary care. For expanding the scope of payment by results for 2005-06 we are limited to those for which we already collect detailed national activity and costing information. Areas most likely to be included for 2005-06 are:
- Outpatients;
  - Critical care;
  - Accident and emergency.
15. We are also considering how and when we can extend the scope of payment by results to mental health and community health services. We are particularly interested in feedback on these proposals.

## Transition from April 2005

16. From April 2005 when the tariff will cover all activity in surgical specialties and most in medical specialties there is a risk that this will profoundly change the way money flows through the system impacting on the income of some NHS providers and PCTs. To minimise any potential instability for NHS organisations we are proposing a 3 year transition period covering 2005-06 to 2007-08. The key elements of this are:
- PCTs should adopt full tariff prices from April 2005 with the proviso that their initial purchasing power will be maintained for 2005-06;
  - The move to tariff prices for Trusts should happen in 3 equal steps and the maximum efficiency saving expected over the 3 years should be 9%. Separate proposals will be needed for organisations needing to make efficiency savings above 9%.
17. We are inviting views on these proposals and more technical issues such as whether the methodology for calculating the starting point for transition should be bottom up or top down.
18. More broadly over the transition period we shall be seeking to ensure that all organisations have a manageable transition path including specialist trusts.

## Commissioning

19. Effective commissioning through service contracts that have robust risk sharing, the right incentives and performance monitoring arrangements is crucial to the successful implementation of payments by results. Funds must move with patients. The expression of patients' choices makes this doubly important. We are therefore interested to have feedback from the NHS on whether the model SLA we have published is robust enough for these purposes or if there are areas where it needs development.

## Trust financial regime

20. We are reviewing the NHS Trust financial regime to ensure that it is consistent with Payment by Results from April 2005 and are looking at surplus and deficit retention, breakeven duties, and capital investment and charging issues. This work remains at an early stage and we would welcome feedback on any other issues we should be looking at.

## Costing

21. Although there has been some improvement in the quality and consistency of costing across the NHS, it is widely recognised that quality is not yet sufficient to support payment by results across all areas of activity. We propose to introduce greater prescription in the treatment and classification of costs to ensure a level playing field between providers. This document seeks views on how this can best be achieved.

## Consultation

22. The full list of questions for consultation is at Annex C. The questions are primarily aimed at NHS Trusts, Primary Care Trusts and Strategic Health Authorities. Responses are welcome by **31 October 2003** and may be emailed to [financial-flow@doh.gsi.gov.uk](mailto:financial-flow@doh.gsi.gov.uk) or sent to:

NHS Financial Reforms Team  
Department of Health  
Room 101/102  
Richmond House  
79 Whitehall  
London  
SW1A 2NL

## Technical Papers

23. A number of technical papers have been produced by the NHS financial reforms project team to inform and support our thinking. In order to assist in the wider understanding and debate on these issues and to give considered background analysis for this consultation, these are available on our website at <http://www.doh.gov.uk/nhsfinancialreforms/technicalpapers>.
24. The following topics are covered:
- Spells as the activity measure;
  - Critical care;
  - Cost of new technology;
  - Review of levies.

# 1. Introduction

## Policy context: choice and responsiveness

- 1.1 The *NHS Plan*<sup>1</sup>, together with *Delivering the NHS Plan*<sup>2</sup> set out the next steps of the programme for the NHS that will help the provision of prompt, convenient, high quality services that treat patients as partners. The delivery and organisation of healthcare will be changed through:
- introducing explicit patient choice;
  - devolving power and responsibility to local organisations;
  - establishing national standards and independent inspection for all providers of services to NHS patients;
  - care to NHS patients provided by a plurality of providers in NHS hospitals, NHS Foundation Trusts, and the independent and voluntary sectors as well as in the community;
  - improving incentives by introducing payment by results.
- 1.2 These reforms mean changing the NHS from a top down monopoly provider to a system where different health care providers work to common NHS values, standards and systems of inspection. A more diverse and devolved NHS including the creation of NHS Foundation Trusts will help make services more responsive to the needs of the local communities they serve. Primary Care Trusts (PCTs) will be commissioning services for local people and responding to their choices and preferences. PCTs will have the stability to commission services over a longer term through 3 year planning and financial allocations.
- 1.3 As a result of these changes we will see:
- Patients starting to drive change in the NHS;
  - Helped by more information and transparency provided about health care through independent inspection;
  - Commissioning based on quality and volume – and not cost – as a result of prices being set through the national tariff;
  - More appropriate and responsive care being provided and a more personalised service for patients.

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1 The *NHS Plan* is available at <http://www.doh.gov.uk/nhsplan/index.htm>

2 *Delivering the NHS Plan* is available at <http://www.doh.gov.uk/deliveringthenhsplan/index.htm>

## How payment by results supports more responsive care

1.4 Payment by results will support these changes and improvements by:

- Use of a standard tariff to commission services which will keep transaction costs down, remunerate Trusts fairly and transparently and increase activity where this is needed to improve access;
- Money flowing to providers in support of patients' choices;
- Providing a better set of incentives to ensure that care is provided in the best setting.

1.5 Earlier this year the Secretary of State announced that:

By Summer 2004: All patients waiting 6 months will be offered the choice of an alternative provider.

By Dec 2005: All patients will be offered the choice of 4-5 providers at the point the GP agrees they need a referral and patients will exercise their choice through the booking process.

1.6 *Choice of Hospitals: Guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated*<sup>3</sup> outlines how patient choice for patients waiting 6 months will work in conjunction with financial reforms.

## Payment by results and plurality of providers

1.7 It remains our intention that payment by results will facilitate growing diversity and plurality in the provision of NHS services. The financial flows framework will apply to NHS Trusts and NHS Foundation Trusts but in the longer term will also apply to all providers of services to NHS patients – whether in the public, private or voluntary sector – and to franchised organisations.

1.8 NHS Foundation Trusts will begin the move to full use of the national tariff a year earlier than NHS Trusts, starting their transition path in April 2004 (For more details about first wave NHS Foundation Trusts' transition path see chapter 5, paragraph 5.13 onwards).

1.9 We are now considering how in the longer term – probably from 2008 after the planned 3 year transition period (see chapter 5) – we can ensure that the tariff will work effectively for all providers of care to NHS patients. The key issues relate to:

- The structure and scope of the tariff;
- How plurality of providers adopt HRGs or other service classification tools as a commissioning currency;
- How and how often the tariff is updated.

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3 Choice of hospitals: Guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated is available at: <http://www.doh.gov.uk/choice/policyguidance.pdf>. More information about patient choice is available at <http://www.doh.gov.uk/choice/index.htm>.

1.10 Chapter 2 outlines our thinking on some of these issues notably on how we propose to update the tariff for technology. Chapter 4 seeks views on how the plurality of providers might be brought within the framework of national tariffs. We will consult widely on the way forward.

## Developing payment by results

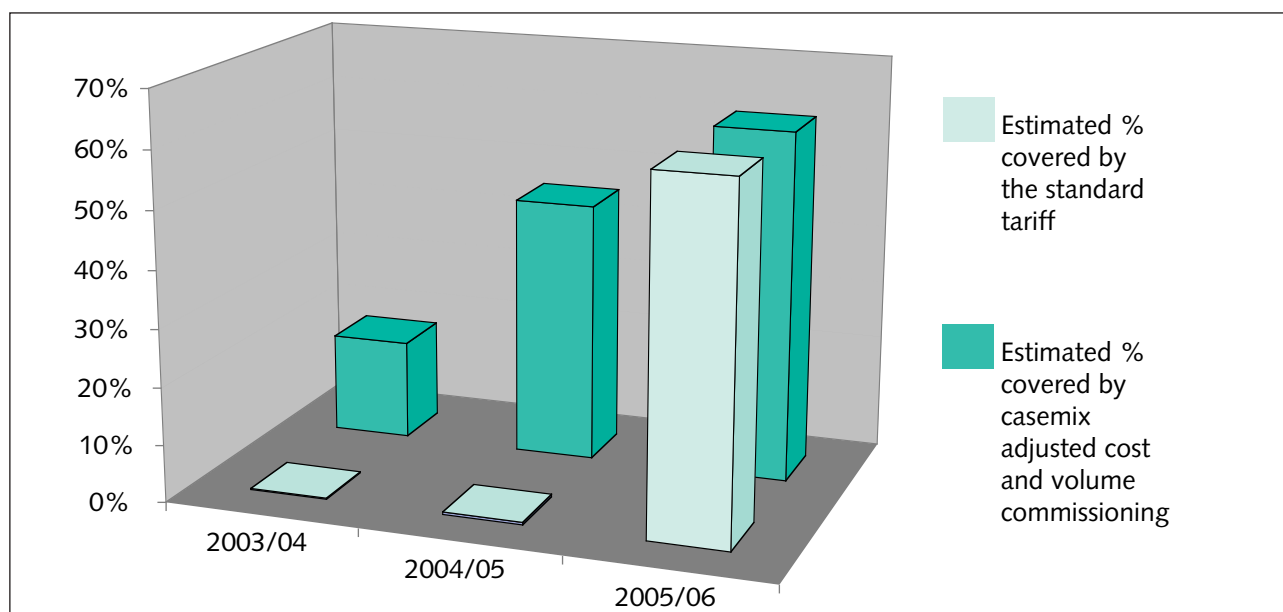
1.11 The widening of patient choice from a range of providers in the NHS and elsewhere and the introduction of NHS Foundation Trusts means that the development of the payment by results system is increasingly urgent and real. This year for 15 Healthcare Resource Groups (HRGs) national tariffs apply to extra activity over 2002/03 plan. For 6 specialties price is locally determined but national HRG cost weights used to adjust for casemix. Failure to deliver growth in activity will lead to withdrawal of funds at tariff. However, the pace of change will speed up from 2004/05 onwards:

- In 2004/05 payment by results will operate as this year, but there will be an extension from 15 to 48 specified HRGs and it will cover at least all surgical and most medical specialties. In addition first wave NHS Foundation Trusts, and the PCTs that commission services from them, will begin the transition to full implementation of the system from April 2004, a year ahead of NHS Trusts, but over a 4 year period;
- From 2005/06 for NHS Trusts (nearly) all specialties will be commissioned on a cost and volume basis, adjusted for casemix, according to nationally specified prices, along a specified transition path which will lead to a convergence at national tariff over 3 years;
- For 2005/06 we hope to extend the scheme to some non-acute services.

1.12 2005/06 sees a step change in the level of NHS spend that will be covered by payment by results, as shown in figure 1 below.

1.13 The ultimate aim is that payment by results will cover all hospital and community health services. Introducing this new system of financial flows is a big task for the NHS and will require major changes to the way that services are commissioned.

Figure 1 Proportion of hospital income<sup>4</sup> covered by Payment by results



<sup>4</sup> Hospital income as defined as the 2001/02 NHS Trust and PCT provider income from commissioned services (i.e. excluding income from education, training, R&D, non-NHS income and 'other' income).

## This consultation

- 1.14 *Delivering the NHS Plan* set out the need to introduce a system of payment by results to support the movement of patients between providers, support choice and make best use of capacity. The details of the new system were published in *Reforming NHS Financial Flows: Introducing Payment by Results*<sup>5</sup> in October 2002, which provided the opportunity for those working in the NHS and others to comment on the proposals and offer real input into the development of the policy. Further technical guidance for the operation of the first year of payment by results was published shortly afterwards. We received many carefully considered and often detailed responses which provided us with valuable insight into many of the issues that concerned you. A response to the issues raised was published in February 2003 alongside guidance on drawing up service level agreements (SLAs) for 2003/04<sup>6</sup>.
- 1.15 This document outlines the work that has been taking place since October 2002, including some decisions that have been taken. However, there is a range of areas where the work is ongoing. Part of the process for identifying the best approach is to seek the views of a wide range of people. We expect that those with the greatest interest will include commissioners and providers of services to NHS patients, but we welcome responses from all who wish to comment.
- 1.16 Towards the end of each chapter you will find some specific issues that we would welcome your comments on by **31 October 2003**. A summary of the questions for consultation can be found in Annex C. In addition to the views we receive in this way we will continue to consult specific groups of stakeholders about issues of relevance to them.
- 1.17 Please email responses to [financial-flow@doh.gsi.gov.uk](mailto:financial-flow@doh.gsi.gov.uk) or send them to:

NHS Financial Reforms Team  
Department of Health  
Room 101/102  
Richmond House  
79 Whitehall  
London  
SW1A 2NL

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<sup>5</sup> *Reforming Financial Flows: Introducing payment by results* is available at <http://www.doh.gov.uk/nhsfinancialreforms/financialflowsoct02.htm>

<sup>6</sup> *Response to Reforming NHS Financial Flows*, published on 10 February 2003 and available at <http://www.doh.gov.uk/nhsfinancialreforms/financialflowsresponse.htm>

## 2. Tariff structure

### Progress to date

2.1 The aim is to set a tariff that represents a fair level of reimbursement for providers and commissioners. Where providers have high costs because they treat more patients with complex needs, this should be recognised in the funding they receive. Where providers have high costs because they are not making best use of resources, this should not be recognised in the funding they receive.

2.2 The system for determining the national tariff for 2003/04 includes a number of aspects that we expect to continue over the medium term:

- The basis for the tariff will be the annual collection of Reference Costs. We are considering ways to ensure the quality of this data is improved and is sufficient to support this process (see chapter 7);
- The tariff will be based on the mean cost of all NHS providers;
- Because of the time lag in collecting and calculating the Reference Costs, they will be uplifted for two years of inflation. This ensures that the most recent cost data is used in the next year's tariff. This will include impact of pay, prices, technology, and cost efficiency. It will be consistent with the inflation assumptions used to inform revenue allocations;
- There will be a single common tariff for inpatients and daycases weighted for proportions of inpatient/daycase cases.

2.3 Since the technical guidance for 2003/04<sup>7</sup> was published, further analysis and consultation with key stakeholders has allowed us to determine some more of the principles underpinning the tariff. These include:

- From 2004-05 activity used for SLAs will be based on provider spells;
- A proposed funding approach for critical care.

More detail is given below.

### Spells as the activity measure

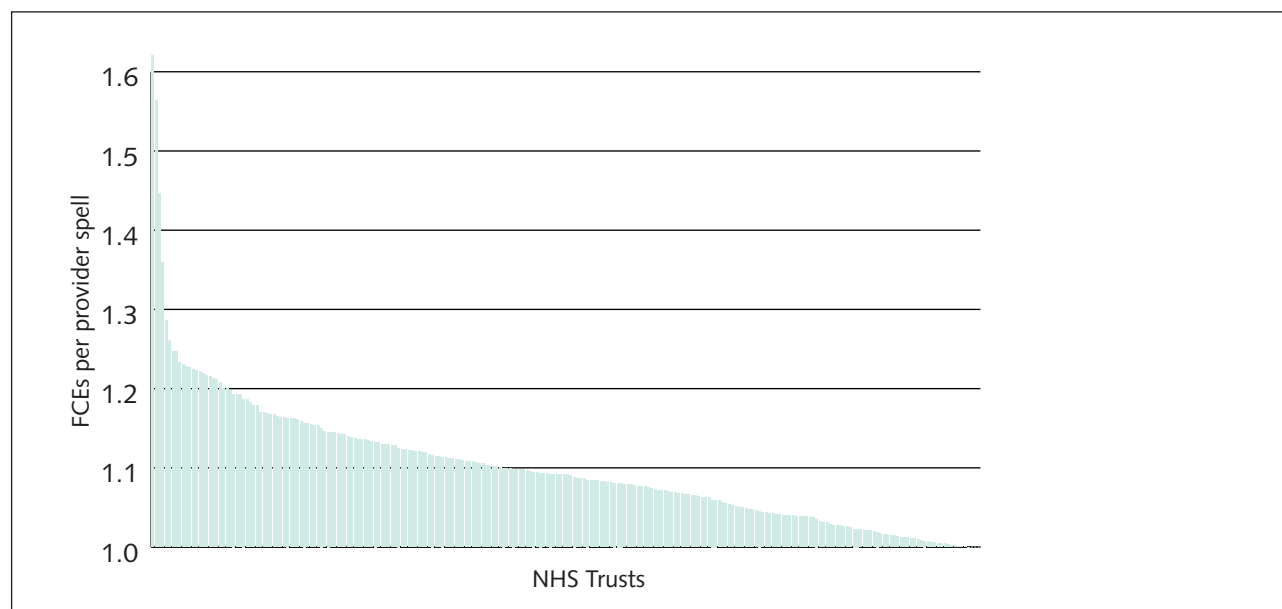
2.4 From 2004/05 the activity count used for SLAs (and contracts with NHS Foundation Trusts and other providers) will be based on provider spells. This means the activity in casemix adjusted cost and volume agreements will be weighted spells. A single provider spell includes all the finished consultant episodes (FCEs) within an inpatient stay for a particular provider.

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<sup>7</sup> The Technical Guidance for 2003/04 is available at <http://www.doh.gov.uk/nhsfinancialreforms/financialflowsdec02guidance.htm>

- 2.5 The main reason for making this transition from FCEs is the level of inconsistency in the interpretation of the FCE definition. The FCEs to spell ratio varies between 1 and 1.9 FCEs per spell. On this basis we estimate that a large number of providers would be paid up to 20% more than other Trusts for the same number of admissions.

Figure 2 FCEs per spell by provider in 2001-02



- 2.6 The use of provider spells is also more consistent with the approach used for local delivery plans (LDPs). Activity used to inform LDPs was based on the first FCE in an admission. Similarly, there is one provider spell per admission.
- 2.7 A 'spell converter' is already available to specify the appropriate HRG for each provider spell. This will be re-issued in the autumn. The spell converter will be needed to convert baselines and activity targets into spells and for monitoring purposes. A new spell converter will be issued in time for implementing the revised version 3.5 HRGs.
- 2.8 The Reference Cost collection will continue on a FCE basis, at least for the time being. This data will be matched centrally to produce a tariff for a provider spell. The tariff for a provider spell will be higher than for a FCE, in proportion to the average number of FCEs per spell.
- 2.9 More information on the use of spells as the currency for commissioning will be made available later this year. In the meantime a discussion paper is available on our website at <http://www.doh.gov.uk/nhsfinancialreforms/technicalpapers>.

## Funding of critical care

- 2.10 The approach to funding critical care is a key issue. The guarantee of adequate funding to cover the fixed costs of this very expensive service is vital to ensure that critical care capacity is available when needed. The approaches used by other countries with a tariff based funding system include:
- bundling the funding of critical care into the tariff for the inpatient stay;
  - paying a fixed tariff for each episode of critical care;
  - block funding for critical care.

- 2.11 A group of key stakeholders in critical care has worked with the Department of Health on this issue, and concluded that the best option is to have a national tariff for each critical care episode. The tariff will be implemented from 2005/06 and will include:
- an element of funding to cover the fixed costs of the expected number of patients using critical care. This will help to ensure there is sufficient critical care capacity available; and
  - an element dependent on the actual number of patients treated in critical care to cover the variable costs, to ensure that funding is available to reward providers for the absolute volume of activity they do.
- 2.12 The intention is to base the level of funding for particular services on critical care HRGs. These are currently under development for level 2 and level 3 care. There is also ongoing work to consider the appropriate split between the fixed and variable element of the tariff.
- 2.13 More information will be made available through critical care networks and other routes in the autumn. This will cover funding for level 1 care and outreach services, along with information on implementation. A technical paper outlining our analysis on critical care is available on our website at <http://www.doh.gov.uk/nhsfinancialreforms/technicalpapers>.

## Ongoing work

### Setting the tariff for elective and non elective admissions

- 2.14 We are consulting on the proposal that the same tariff and cost weights will apply to elective admissions and non-elective admissions from 2004/05 onwards. The rationale is to discourage growth in emergency activity. The combined tariff would be based on the weighted average cost for an elective HRG and a non-elective HRG.
- 2.15 This approach is consistent with the principle of using the same tariff for a HRG irrespective of where and how it is delivered. It is also in line with the approach of other countries that have adopted a similar funding system. In addition, there is some evidence of an inconsistent interpretation of the difference between electives and non-electives. This means that if a separate tariff were used, some providers would receive more income than others for delivering the same activity.
- 2.16 Data from the Reference Cost collection suggests that non-elective admissions are on average around 10% more expensive than elective admissions. An analysis of the impact of a combined tariff shows that the effect would be plus or minus less than 2% of income for all but a handful of NHS Trusts. In addition, other aspects of the funding policy will help to alleviate the financial risk to organisations that deliver a high proportion of emergency activity - see sections on 'critical care funding' (paragraphs 2.10-2.13 above) and 'high and low cost exceptions' (paragraph 2.18-2.20 below).
- 2.17 However, we are aware that there may be consequences of adopting a single tariff for elective and non-elective admissions which we have not anticipated and we would welcome views on whether the proposed single tariff represents the best way forward. As part of this consultation we will test the proposals with key players in the NHS.

## High and low cost exceptions

- 2.18 HRGs can only adjust for the casemix complexity of the 'average' patient. Typically, any particular patient will cost slightly more or slightly less than the average, although overall the impact of most patients will be averaged out.
- 2.19 Some patients will vary from the average by a large amount. This may be related to length of stay – they could have a length of stay much shorter than the average, or much longer. Alternatively, it could be related to one-off costs, such as more expensive prosthesis or drugs. The tariff for 2003/04 takes no account of this issue, because it is being used to fund a small proportion of marginal activity.
- 2.20 Once the national tariff covers the majority of activity, an additional mechanism for funding 'exceptional' patients will almost certainly be necessary.

### Exceptions related to length of stay

- 2.21 The average cost per HRG collected as part of the Reference Cost data excludes the cost of providing the care for lengths of stay well beyond the average (beyond a defined trim point)<sup>8</sup>. In 2001/02 the cost of providing this care represented around 8% of the total cost of elective care, and around 17% of the total cost of non-elective care. This shows that having a separate approach to funding patients with very short and very long lengths of stay can have a significant impact on funding. This approach should help to ensure that providers attracting significantly more patients that need a longer length of stay are funded appropriately for these patients.
- 2.22 However, it is also important that providers are not encouraged to keep patients in hospital longer than is necessary. In addition, any funding policy relating to length of stay must fit with the responsibilities of the NHS and local authorities under the Community Care (Delayed Discharges etc) Act 2003, so that there are no perverse incentives to base a discharge decision on anything other than the patient's clinical needs.
- 2.23 The approaches used by other countries with similar payment systems include:
- No special arrangements for short stay outliers or reimbursing for short stay outliers at a proportion of the full tariff; and
  - Defining a long stay trim point, and then reimbursing for the additional days at either a standard per diem rate or a rate related to the tariff for the particular HRG.

### Specialised services

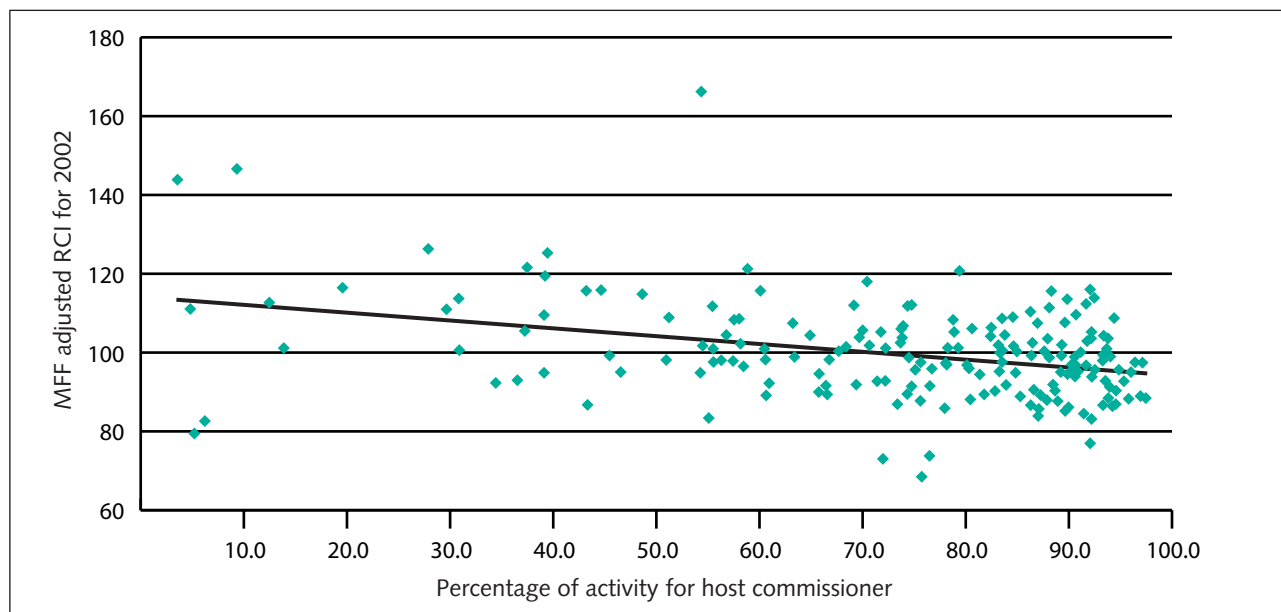
- 2.24 There is evidence that even after adjusting for HRGs, some providers have a significantly higher number of patients with complex needs. The analysis of existing patient movements below suggests that the higher the proportion of patients from outside the host commissioner, the higher their costs tend to be (excluding costs of long stays)<sup>9</sup>. Assuming that providers of specialist services tend to treat patients from a wider geographical area, this suggests that HRGs are not currently fully adjusting for the cost implications of specialist services.

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8 The formula used to determine the trim point is the third quartile, plus one and a half times the range between the first quartile and the third quartile:  $Q3 + 1.5(Q3 - Q1)$ .

9 This relationship continues to hold if the London providers are excluded from the analysis.

Figure 3 Relationship between RCI and % activity for host commissioner



NB: The host commissioner for this data was the former DHA (data prior to PCTs)

- 2.25 Further analysis will be needed once the revised HRGs are available and costed, but it is likely that payment by results will need to reflect the fact that at the moment those who are referred out of local area tend to be more complex cases. We have started focused discussions with key stakeholders (commissioners and providers) to consider possible approaches.
- 2.26 Over time, as HRGs continue to be improved to better reflect the cost implications of all services and a clear outlier policy is implemented we anticipate that adjustments for specialist services will decrease.

## Incorporating new technology into the tariff

- 2.27 The Wanless Review recognised that uptake of technology in the NHS is typically behind comparable countries<sup>10</sup>. The planned increase in funding for the NHS, the establishment of the National Institute for Clinical Excellence (NICE) and the publications of national service frameworks (NSFs) will help to reverse this trend. We must ensure that the introduction a national tariff does not put this progress at risk, by making implementation unaffordable.
- 2.28 It is useful to distinguish between
- New technology that affects the cost of a particular intervention (e.g. drug eluting stents);
  - New technology that affects the cost of a number of different services (e.g. Magnetic Resonance Imaging scanners); and
  - New technology that results in a new service (e.g. Positron Emission Tomography).
- 2.29 The process for setting the national tariff already includes a number of mechanisms for ensuring that it will be sufficient to cover the implications of new cost effective technology:

10 Wanless,D (2001) "Securing our Future Health: Taking a Long-Term View. Interim Report" HM Treasury available at [http://www.hm-treasury.gov.uk/consultations\\_and\\_legislation/wanless/consult\\_wanless\\_final.cfm](http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm)

- The current HRGs are being revised for implementation with 2003/04 Reference Costs, and there is a further revision planned;
- The cost weights are updated periodically on the basis of Reference Cost data (see paragraph 2.32 below); and
- The tariff will be subject to an annual uplift to reflect aggregate cost of new medical technology (as well as other cost increases driven by national decisions or unavoidable external price changes).

2.30 Taking these measures into account, new technology will rarely have a sufficiently large impact on the price of an inpatient intervention to make it unaffordable. However, in a minority of cases, the cost of a new technology may represent a much higher proportion of the total cost, particularly of an outpatient visit. Where a significant impact can be demonstrated, additional mechanisms may be necessary, such as:

- Adjusting the cost weight for a particular intervention to reflect cost impact of NICE guidance;
- Adjusting the cost weight for a particular intervention to reflect the cost impact of a significant new technology that is not subject to NICE guidance.

2.31 We are discussing our proposals on technology with those with an interest in ensuring that the introduction of the tariff does not reduce the capacity of the NHS to uptake new equipment and techniques. This includes representatives from NHS organisations, as well as those that supply the NHS with new technology.

2.32 Cost weights are currently updated annually to reflect changes to underlying Reference Costs. As this data becomes more stable it may make sense to leave cost weights in place for several years, only changing specific cost weights where we have clear evidence for doing so.

2.33 A discussion paper on this subject can be found on our website at <http://www.doh.gov.uk/nhsfinancialreforms/technicalpapers>.

## Adjusting for unavoidable cost differences (the MFF)

2.34 There are significant variations in the cost of delivering care in different parts of the country. This has been recognised since the Resource Allocation Working Party reported in 1976. Since then the market forces factor (MFF) has been developed, refined and used to adjust allocations for these unavoidable differences in costs.

2.35 The MFF is provider based, and for allocations purposes it is mapped to commissioners based on historic patterns of activity. The MFF consists of the following elements:

- (a) staff;
- (b) non-pay;
- (c) capital, made up of:
  - (i) land;
  - (ii) buildings; and
  - (iii) equipment.

A common MFF index of 1.00 is given to (b) and (c)(iii)<sup>11</sup>

- 2.36 The MFF is currently the best method available for recognising the unavoidable cost differences between providers. However, adjusting the tariff of individual providers means that we are using the MFF for something that it has never been used before. This brings new challenges. In some instances, providers within a few miles of each other have MFF values that are significantly different. Potentially, this could encourage PCTs to inappropriately change their commissioning patterns. Further work is needed, therefore, to ensure that the MFF is the most appropriate mechanism for setting prices. To do this, we will examine all options and listen to the views of all interested groups.

## Questions for consultation

### *Tariff for elective and non-elective admissions*

- *Does the proposed single tariff for elective and non-elective admissions from 2004/05 represent the best way forward?*

### *High and low cost exceptions*

- *Should there be an adjustment to the national tariff for inpatient activity with very short lengths of stay, and on what basis should the adjustment be made?*
- *Should there be an adjustment to the national tariff for inpatient activity with very long lengths of stay, and on what basis should the adjustment be made?*
- *Should there be an adjustment to the national tariff for patients that with significantly more complex needs (i.e. specialised services), and how should this be applied?*

### *Incorporating new technology into the national tariff:*

- *Does the tariff setting approach include sufficient mechanisms to ensure that new technology is adequately funded – see paragraph 2.27. If further mechanisms are needed, do you agree that these should only be used where the technology is demonstrably cost effective and will have a material impact on provider costs.*

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<sup>11</sup> More information on the MFF can be found at: <http://www.doh.gov.uk/allocations/capitation.htm>

# 3. Tariff scope and service classification tools

## Progress to date

- 3.1 The ultimate aim of payment by results is for all activity to be funded on the basis of the cost and volume of services provided. So far, this has focused on inpatient and day case services covered by admitted patient care Healthcare Resource Groups (HRGs). However, in addition to the proposals outlined in *Reforming NHS Financial Flows*<sup>12</sup>, we plan to include a number of further service areas in 2005/06. Due to the lead times associated with collecting costs and calculating a tariff, the scope of additional services to be included is limited to those for which we already collect detailed national activity and costing information.
- 3.2 The additional areas to be included in 2005/06 are:
- Outpatients;
  - Accident and emergency;
  - Critical care – see section 2.10-2.13 for our proposals.
- 3.3 This will mean that the services will be commissioned on a cost and volume basis with adjustment made for variation in casemix from 2005/06.

## Outpatients

- 3.4 We propose a single tariff for the bulk of outpatient services, with separate specialty level tariffs for significantly high or low cost interventions. As for inpatient and day case activity, outpatient tariffs will be based on reference costs. At present, outpatient reference costs are submitted in two parts using a combination of outpatient HRGs and specialty level costs. Most activity is of a standard nature with little variation in average cost across specialties. Analysis has shown that, in terms of the financial impact upon providers, there is little difference between reimbursing on the basis of all 329 outpatient tariffs on the one hand or a single outpatient tariff on the other. Some high and low cost interventions are significantly different from the average, justifying the need for separate tariffs in these areas.
- 3.5 Options for outpatient tariffs will also consider the most appropriate unit of currency (i.e. an outpatient episode or first and follow-up), commissioning of non-consultant-led activity and incentives to shift minor procedures from a day case to an outpatient setting where appropriate.
- 3.6 Mental health outpatient services are likely to be excluded due to the implausibly wide variation in reported costs.

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12 *Reforming Financial Flows: Introducing payment by results* is available at <http://www.doh.gov.uk/nhsfinancialreforms/financialflowsoc02.htm>

## Accident and emergency

- 3.7 There will be block funding for fixed costs and activity based funding for variable costs using A&E HRGs to adjust for broad differences in casemix. We propose a split tariff on the basis of the proportion of costs that are either fixed or variable for accident and emergency services because we do not wish to provide the same incentives to increase activity in A&E as for elective care but need to ensure there is sufficient capacity and fair payment for activity carried out.
- 3.8 In developing proposals for the funding of A&E services we will also consider the appropriate commissioning mechanism – i.e. whether commissioning is the responsibility of each individual PCT or the host PCT.

## Next steps

- 3.9 The proposals covering all three of these areas will be reviewed by expert reference groups representing commissioners, providers, members of the information community and key policy stakeholders. These groups will include some of those who volunteered to help in developing proposals in response to the last consultation in October 2002. The proposals outlined above are therefore provisional and may be subject to change.
- 3.10 When added to the plans for commissioning admitted patient services, the proportion of expenditure to be covered by cost and volume commissioning is likely to be around 60% of hospital income<sup>13</sup>.
- 3.11 From 2005/06, admitted patient activity will be commissioned on the basis of cost and volume agreements at specialty level using version 3.5 HRGs to adjust for variation in casemix. In addition, a number of HRGs will be commissioned individually. Version 3.5 HRGs are being developed by the NHS Information Authority (NHSIA) to ensure that they better reflect clinical practice and to improve resource homogeneity. The statistical and clinical stages of development are complete, leaving the technical assurance and piloting stages remaining. A list of the version 3.5 HRGs will be issued with the Reference Costs Guidance in October 2003. This will be used to cost 2003/04 activity and will form the tariff for 2005/06.
- 3.12 For PCTs commissioning with first wave NHS Foundation Trusts, we aim to publish national tariffs for the commissioning of inpatient, day case and outpatient activity from 2004/05, which will be based upon version 3.1 HRGs.

## Ongoing work

- 3.13 We are also considering how to include mental health and community health services in the medium term. At present, costs are collected at a broad level using a number of currencies and classifications. These classifications have been developed from a pragmatic perspective rather than the more detailed statistical and clinical development of HRGs. We have analysed the currently available information and concluded that it is not yet robust enough to use. We wish to develop groupings and classifications that meet the following tests:
- Meaningful to both commissioners and providers;
  - Variation in costs across providers not due to differences in casemix or costing methodology;

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<sup>13</sup> Hospital income as defined as the 2001/02 NHS Trust and PCT provider income from commissioned services (i.e. excluding income from education, training, R&D, non-NHS income and 'other' income).

- Consistent with policy objectives particularly patient choice;
- Minimise the administrative burden on the NHS in terms of data collection;
- Minimise any potentially perverse incentives.

3.14 We are aware that the UK has already spent a lot of time attempting to develop casemix tools for mental health. There have been several iterations but as yet there is not a sufficiently robust set that meet the criteria. We are also aware that Australia has developed classification tools in this area. These have also been introduced into New Zealand. We are awaiting the results of the New Zealand evaluation but are considering piloting Australian, or New Zealand variant, casemix tools for payment by results.

3.15 As the scope of the Reference Cost collection is expanded so that it covers virtually all of HCHS spend (see chapter 7) we will work to bring other areas not covered by payment by results in 2005/06 under the scheme. In the meantime these services will continue to be commissioned under existing arrangements. Examples of services which fall into this category are palliative care, learning disability services, and IVF and other fertility treatments.

## Questions for consultation

- *Are there any examples of locally produced casemix tools that been successfully used in commissioning mental health or community health services?*
- *Would any PCTs and Mental Health Trusts be interested in piloting mental health casemix groups that have already been developed in other countries, for commissioning purposes?*

## Broader issues for the longer term

3.16 We are in the early stages of discussions to determine the specification for casemix and classification tools to be used for commissioning in the future. Forthcoming reviews of HRGs are likely to include:

- a revision of OPCS procedure codes;
- the development of setting independent HRGs to provide incentives to deliver services in the most appropriate setting;
- unbundling of components of care to enable commissioning of care packages;
- improving the applicability of HRGs to children, specialist activity and those with chronic illnesses.

3.17 Where appropriate, we will consider non-HRG service classifications, drawing on international experience.

## 4. Commissioning, risk sharing, plurality and choice

### Progress to date and ongoing work

4.1 The move to payment by results heralds a fundamental change in the way that NHS care is commissioned and funded. Plurality of provision means that a wider variety of providers (NHS and non-NHS) will be entering the system, and the rollout of patient choice (both for patients waiting for 6 months and choice at the point of referral) will increase the complexity of commissioning arrangements.

4.2 Commissioning involves two key strands of activity:

- Contract management and monitoring; and
- investment in service delivery and service redesign.

In practice this will mean a wide range of activities from setting priorities, controlling volumes, helping decide appropriateness and selecting clinical networks.

4.3 As more providers enter the NHS market, PCTs need robust contracts or service level agreements (SLAs) in place that are actively monitored. PCTs need to employ the discipline of commercial contracting and compliance and, where delivery is not satisfactory, take action to address shortcomings.

### Service level agreements and contracts

4.4 In February 2003 we published a 'model' SLA to illustrate risk-sharing, activity and payment schedules under payment by results<sup>14</sup>. SLAs for 2003-04 should have two new sections:

- Part A: to cover the increase above baseline in activity for the 15 HRGs (details below). This activity should be funded at the national tariff; and
- Part B: a cost-and-volume agreement that should cover a minimum of six specialties. This should at local price but set in weighted episodes.

4.5 Building on the 'worked example' spreadsheet which illustrated the approach to adjusting activity for casemix, a 'casemix tool' was also published in February<sup>15</sup>. The tool is designed to make it easier for providers to convert data on activity, cost and the assumptions on growth into the numbers needed for Parts A and B of the model SLA. The casemix tool and instructions have been substantially revised to show how you can:

- use either 2002/03 or 2001/02 data as the base;
- use the tool to look at activity only; and
- use the costing facility as the starting point for SLA prices.

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14 The model SLA is available at [www.doh.gov.uk/nhsfinancial\\_reforms/sla.htm](http://www.doh.gov.uk/nhsfinancial_reforms/sla.htm)

15 The worked example and casemix tool are both available at <http://www.doh.gov.uk/nhsfinancialreforms/tools.htm>

- 4.6 We are considering the development of the casemix tool to make it useful for monitoring weighted episodes in year.
- 4.7 Part of the phased implementation of payment by results is to increase the number of procedures where growth activity is funded at the national tariff from 15 in 2003/04 to between 30 and 45 in 2004/05. The provisional list below brings the total to 48. The key aim of this is to support the delivering of the maximum waiting times targets and to facilitate the increase in patient choice. In both 2003/04 and 2004/05 the HRGs predominantly cover elective procedures with large numbers of long waiters. Local health economies that wish to extend cost and volume commissioning using HRG based casemix adjustment for more activity are encouraged to do so.

## Designated HRGs for 2003/04

HRG Code	HRG Label	Total No of FCEs	Percentage Electives	Approximate total spend (£m)
Q11	Varicose Vein Procedures	39,916	99%	£34
J05	Intermediate Breast Surgery <50 w/o cc	15,241	99%	£12
J04	Intermediate Breast Surgery >49 or w cc	10,686	98%	£10
J03	Major Breast Surgery incl Plastic Procedures <50 w/o cc	10,176	99%	£19
J02	Major Breast Surgery incl Plastic Procedures >49 or w cc	23,832	98%	£47
H10	Arthroscopies	95,447	95%	£81
H04	Primary Knee Replacement	35,132	99%	£168
H03	Bilateral Px Knee Replacement	887	99%	£5
H02	Primary Hip Replacement	38,121	95%	£166
H01	Bilateral Px Hip Replacement	341	98%	£2
E15	Percutaneous Transluminal Coronary Angioplasty (PTCA)	27,624	54%	£72
E04	Coronary Bypass	20,337	72%	£127
E03	Cardiac Valve Procedures	7,467	77%	£63
B03	Other Cataract Extraction with Lens Implant	10,047	99%	£7
B02	Phakoemulsification Cataract Extraction with Lens Implant	222,429	99%	£149

- 4.8 The following provisional list of 33 additional HRGs for 2004/05 is subject to change following further consultation. Information on the procedures included in these HRGs is available from the NHS Information Authority or by emailing us at [financial-flow@doh.gsi.gov.uk](mailto:financial-flow@doh.gsi.gov.uk).

## Provisional list of additional HRGs for 2004/05

HRG Code	HRG Label	Total No of FCEs	Percentage Electives	Approximate total spend (£m)
L28	Prostate Transurethral Resection Procedure <70 w/o cc	7,445	94%	£11
L27	Prostate Transurethral Resection Procedure >69 or w cc	21,705	87%	£39
G14	Biliary Tract – Major Procedures <70 w/o cc	30,942	89%	£49
G13	Biliary Tract – Major Procedures >69 or w cc	9,959	77%	£23
G12	Biliary Tract – Very Major Procedures	2,483	63%	£7
G11	Biliary Tract – Complex Procedures	561	65%	£3
F75	Herniotomy Procedures	8,487	89%	£7
F74	Inguinal Umbilical or Femoral Hernia Repairs <70 w/o cc	56,712	95%	£47
F73	Inguinal Umbilical or Femoral Hernia Repairs >69 or w cc	24,710	86%	£29
F72	Abdominal Hernia Procedures <70 w/o cc	8,414	90%	£10
F71	Abdominal Hernia Procedures >69 or w cc	3,031	80%	£6
E16	Other Percutaneous Cardiac Procedures	7,786	70%	£16
E14	Cardiac Catheterisation without Complications	95,320	79%	£91
E13	Cardiac Catheterisation with Complications	1,901	59%	£3
M04	Lower Genital Tract Complex Major Procedures	240	98%	£1
M03	Lower Genital Tract Major Procedures	23,999	98%	£42
M02	Lower Genital Tract Intermediate Procedures	53,841	89%	£32
M01	Lower Genital Tract Minor Procedures	27,215	93%	£13
L30	Prostate or Bladder Neck Minor Endoscopic Procedure (Male and Female)	19,348	99%	£7
L29	Prostate or Bladder Neck Intermediate Endoscopic Procedure (Male and Female)	5,580	94%	£6
H09	Anterior Cruciate Ligament Reconstruct	1,205	94%	£2
H22	Minor Procedures to the Musculoskeletal System	44,586	95%	£24
H21	Muscle, Tendon or Ligament Procedures – Category 2	6,334	84%	£9
H20	Muscle, Tendon or Ligament Procedures – Category 1	11,671	90%	£10
H19	Soft Tissue or Other Bone Procedures – Category 2 <70 w/o cc	39,817	45%	£54
H18	Soft Tissue or Other Bone Procedures – Category 2 >69 or w cc	5,989	63%	£15
H17	Soft Tissue or Other Bone Procedures – Category 1 <70 w/o cc	45,933	90%	£44
H16	Soft Tissue or other Bone Procedures – Category 1 >69 or w cc	15,811	73%	£23
H15	Hand Procedures – Category 3	851	96%	£1
H14	Hand Procedures – Category 2	13,422	97%	£15
H13	Hand Procedures – Category 1	49,237	99%	£31
H12	Foot Procedures – Category 2	16,786	99%	£19
H11	Foot Procedures – Category 1	8,150	97%	£7

## Developing SLAs and contracts for 2004/05 and 2005/06

- 4.9 SLAs and contracts will be based on a consideration of the incentive effects for all partners. Agreements between PCTs and Trusts will need to have explicit and robust risk management arrangements. Commissioning will increasingly need to cover a diversity of providers including providers from the independent sector, NHS Foundation Trusts and possibly overseas. These changes together with the end of price negotiation and ‘block’ agreements will mean that it is vital that agreements:

- are built on robust modelling (e.g. including referral rates) and realistic activity levels;
- include explicit agreements on funding where there is over and under-performance; and
- are flexible enough to allow funds to follow the patients' choices.

4.10 The Department is producing model template contracts for PCTs to use with an increasingly plural range of providers including NHS Foundation Trusts, NHS Trusts, DTCs and GPs with a special interest. NHS Foundation Trusts will have legally binding contracts with their commissioners from 2004/05.

## Risk management

4.11 The move away from block agreements means that PCTs can no longer simply pass all risk of over-performance to Trusts, just as they do not bear all the risk of underperformance. Moreover, the removal of price negotiation means that pressure from over-activity cannot be alleviated by 'doing a deal' on price. Properly managed, these changes will provide the right incentives across the system. Volume risk will not shift entirely to PCT but for many services will continue to be shared with providers. But it is the responsibility of PCTs to manage the challenges this also presents, particularly around managing spending.

4.12 This will require:

- proactive arrangements for managing demand;
- robust monitoring;
- ceilings and/or trigger points well ahead of situation getting critical; and
- clearly understood and agreed procedures.

4.13 All of this will entail explicit agreements in SLAs or contracts as well as the clear commitment of organisations to deliver.

4.14 For services where volumes are small and unpredictable but high cost, it would be prudent for PCTs to enter some form of risk pooling arrangement. The arrangements would need to include mechanisms that provide incentives to manage demand. Risk pooling arrangements are already in place throughout the NHS for specialised services. One option is to use this model as a starting point for developing the arrangements now needed.

4.15 The vast majority of NHS activity is covered by a small number of SLAs. However, most organisations also have a long tail of small value SLAs where the administrative burden of agreeing and monitoring an SLA might be disproportionate. It may be possible to extend the arrangements for risk pooling to include activity currently covered in small value SLAs.

4.16 The introduction of the standard national tariff in England will not only affect English Trusts and commissioners. There are well-established planned flows of patients across borders in both directions as well as non-elective treatments covered through the Out of Area Treatments (OATs) arrangements. We are working with cross-border partners to minimise distortions to patient flows and maintain incentives to efficiency. As part of this, we propose to begin using the standard national tariff, rather than individual Trusts Reference Costs, as the basis for reimbursing OATs across borders.

## Out of Area Treatments (OATs)

- 4.17 Since March 1999, reimbursement for Out of Area Treatments (OATs) has been through annual non-recurring payments, through host PCTs, to the provider Trusts. These are based on activity data and local provider costs two years in arrears. The value of the adjustment is incorporated into the SLA between the host PCT and the NHS Trust. The Trust manages the difference (positive or negative) between the OATs adjustment and the value of OATs activity in-year. This currently covers approximately £160m worth of activity.
- 4.18 The OATs arrangements are primarily for emergencies, since elective care should largely be covered by SLAs. It is possible that Choice will in due course lead to an increase in the number of elective cases that fall outside SLAs.
- 4.19 The OATs system will continue for a further year until the end of March 2005. The OATs adjustment in 2004/05 will be costed using national tariffs (MFF adjusted) rather than at local Trust costs.

## Replacing OATs

- 4.20 The current OATs system provides certainty for PCTs and Trusts in budgeting for NHS activity outside their SLAs. It is unpopular with some Trusts, which believe that it does not fairly reimburse them for rising levels of out of area activity. Some Trusts also claim that it inhibits development of new and innovative services because of the time lag in payment. (The contrary view from some commissioners is that it is a useful brake on supply-driven activity that PCTs do not wish to commission.) Irrespective of this, the current OATs system is inconsistent with payment by results, plurality of provision and patient choice.

## Principles for non contract activity 2005/06 onwards

- 4.21 In considering how to improve the payment for activity outside SLAs we believe that the following principles are important:
- The overwhelming majority of elective activity (and *all* specialised services activity) should be included in SLAs in the first instance while patients are being offered 4 or 5 choices at point of referral. Over the longer term more elective activity may fall outside SLAs as a result of the exercise of patient choice. In order to minimise the extent of activity outside SLA/contracts:
    - PCTs and providers should enter into flexible agreements (for example to cover activity up to an agreed sum) where there are regular but variable levels of patient activity; and
    - PCTs should commission collaboratively on a risk-sharing basis where individually there are low and/or unpredictable levels of patient activity.
  - For activity that nevertheless remains outside SLAs:
    - The arrangements should be consistent with the principles of payment by results and, for elective activity, should support the operation of patient choice and diversity of provision;
    - Transaction costs and bureaucracy should be minimised, for example by use of existing data flows and a single payment mechanism;

- The system should be capable of adapting to any future changes in the way that small value SLAs are commissioned;
- All activity should be paid for at the relevant national tariff (MFF adjusted); and
- PCTs should only pay for activity for their own population.

## Options for the Longer Term

4.22 There are three main ways in which activity outside SLAs can be paid for:

- Costs are met by the main commissioner PCT for that provider; or
- Costs are met through the main commissioner PCT, with some form of reimbursement to the main commissioner based on historical activity data. This might be done annually (as with the current OATs system) or periodically, e.g. in line with the three-year allocations cycle); or
- Costs are met by the PCT responsible for that patient on a current basis, with or without a risk-sharing arrangement.

We have identified the following broad options for consideration.

### Option 1 – Abolition of OATs

4.23 OATs would be abolished. Trusts that undertake activity outside SLAs would need to be paid, and that responsibility would fall to the main commissioner PCT for that provider. This would be very simple but would introduce perverse incentives for PCT referral patterns that might impact on choice and plurality of provision. It would also be unfair on PCTs that host Trusts which take on a large volume of such activity.

### Option 2 – Direct payments for activity outside SLAs

4.24 A system of ‘non-contract treatments’ (NCTs) for activity outside SLAs could be introduced, similar to the old extra-contractual referral (ECR) arrangements, but with payment at national tariff rather than local cost. This would be consistent with both choice and the plurality agenda. However, it would need to address the disadvantages of the previous ECR system, including bureaucracy and increased risk to the financial stability of PCTs.

### Option 3 – PCTs Risk Sharing

4.25 Risk sharing arrangements could be introduced for PCTs to minimise the risk to their financial stability through unplanned high cost NCTs

4.26 The risk sharing arrangements could be based on weighted capitation shares, or on historical data. The former would be simpler, but would be unfair on PCTs that have a larger proportion of their activity in SLAs. Either option could be operated at a national or an SHA level.

### Assessment of Options

4.27 The abolition of OATs (option 1) would be inconsistent with PCTs’ responsibility for commissioning and funding health care for their populations. It would introduce perverse incentives for referrals to Trusts with which PCTs did not have SLAs. The current distribution of OATs, both by provider and

by responsible PCT, is highly variable – net allocation adjustments range between +£4 million and –£1 million. This option would cause major destabilisation and unfairness for PCTs that are main commissioners for Trusts with significant activity outside SLAs.

- 4.28 Option 2 also creates a risk to PCTs' financial stability and potentially high levels of transaction costs.
- 4.29 PCTs risk sharing (option 3) would address the issue of risk to PCTs and, as indicated below, could be operated with a system to minimise transaction costs.
- 4.30 Option 3 would require the development and maintenance of a database of activity outside SLAs along the lines of the fully automated system originally proposed for OATs for 2003/04. A system could be developed using data already submitted by Trusts to NWCS. It could also be developed to process payments to Trusts on a periodic, quarterly basis, possibly using the NHS Bank or another lead organisation. This would enable costs to be met by PCTs either directly or through local risk-sharing arrangements.
- 4.31 We are looking at the circumstances in which option 2 would be desirable eg for some elective activity and those where option 3 would be better and we would welcome views on this.

## Non English patients

- 4.32 The current OATs arrangements apply with minor modifications to cross-border patient flows to and from Scotland, Wales and Northern Ireland. The options for the future outlined here apply only to England. Future arrangements for cross-border flows will be developed which take account both of the agreed option for England and of the wider development of policy in Scotland, Wales and Northern Ireland, as well as the specific funding arrangements for the Channel Islands, the Isle of Man, and certain British Dependant Territories. There will also be compatible arrangements for capturing overseas patients activity and costs.
- 4.33 Cross national border patients will attract the appropriate (MFF adjusted) tariff for the service classification/ HRG for which they are treated.

## HRGs and service redesign

- 4.34 Investment in service delivery and service redesign is an integral part of the commissioning process for PCTs, which includes activity on assessment of population needs, strategic planning and developing delivery plans. It requires skills and expertise in analysis and forecasting, skill mix review, good information flows, and an evidence based understanding of current activity in both secondary and primary care settings. It also requires drive to take measured risks in tackling poor service delivery both in terms of costs and appropriateness and innovation to tackle things differently.
- 4.35 To become effective commissioners, greater partnership working will be crucial. PCTs will need to develop open and mature relationships with their GPs (to ensure effective service redesign), GP practices, other PCTs, acute providers, social care and independent providers.
- 4.36 The Department of Health (including the Modernisation Agency) has a work programme to support PCTs to ensure effective commissioning and contracting. We are currently working with the NHS and other organisations to facilitate change and to strengthen existing arrangements which will ultimately benefit patients. In particular NatPaCT are stimulating the formation of PCT networks to share

information, analysis and commissioning expertise and this is a way of strengthening PCTs' commissioning without formally merging PCTs.

- 4.37 Through making resource use explicit and strengthening the links between payment and work done, payment by results will provide the tools and the incentive to aid service redesign. We want to ensure that where packages of care cross the boundary between different providers payment by results continues to encourage recent service developments aimed at improving the way services are delivered, irrespective of the setting.
- 4.38 The aim is to develop HRGs in such a way as they can be used as costed components of care pathways. In developing HRGs for the longer term we will seek to make them setting independent. This will provide incentives to deliver services in the most appropriate setting. For 2003-04 we have suggested a way to enable commissioners to continue to fund the redesign of services that include the 15 HRGs designated this year.
- 4.39 We will work with the NHS to develop a more systematic approach before the national tariff is fully in place from 2005-06. We will start with rehabilitation and based on this experience may look to expand any principles developed to cover other areas.

## Plurality of providers

- 4.40 It remains our intention that payment by results will facilitate growing diversity and plurality in the provision of NHS services. In the medium term, it is a firm principle that all providers of NHS services – public, private and not-for-profit - will be brought within the same overall financial framework of payment by results.
- 4.41 A procurement process is currently under way which will lead to a number of PCTs signing five year contracts with independent providers of new Diagnosis and Treatment Centres (DTCs). These providers will not be directly subject to the payment by results regime for the duration of these five year contracts (payment will be determined by negotiation, as part of the competitive procurement process). Potential independent providers have been told that the expectation is that, after the end of these initial contracts, PCTs will commission services from them within the same payment by results framework. Work will be starting in the autumn with the private sector on making the transition to tariff by the end of the current procurement process.
- 4.42 It is also likely that NHS bodies will continue to commission services from other independent (private and voluntary) providers for elective surgery and other types of care. At present such services tend to be commissioned to address specific capacity constraints, which may make the exclusive use of national tariff prices impractical in the short-term.

## Questions for consultation

### Feedback on implementing SLAs

4.43 Feedback on how the SLAs for 2004-05 might be developed and how far the existing draft SLA meets commissioners' needs would be helpful for the future development of model SLAs and contracts.

- *What further support is needed on how to contract for activity and move funds through SLAs?*
- *What are the problems with monitoring by weighted FCEs in-year?*
- *We would welcome feedback on developing the casemix tool to allow it to convert FCE based monitoring information into weighted FCEs.*

### SLAs and choice

4.44 The risk sharing proposals within the SLA may need to be expanded to take account of the commitment to choice at 6 months from April 2004 and choice at the point of referral from December 2005. Work is in hand on developing an approach to managing risk around choice.

- *What additional issues for the SLA are raised by policies on choice at 6 months from Summer 2004 and choice at the point of referral from December 2005?*
- *Would it make sense to extend risk pooling to include activity currently covered in small volume SLAs?*
- *Or does this work best under local arrangements e.g. via a lead PCT?*
- *What can we do to encourage/support this?*

### Risk sharing arrangements for elective and non-elective care

4.45 The national tariff will remove price negotiation. This means that arrangements for managing under and over-performance need to be absolutely clear and contain the right incentives as. Variations in volume will not be accommodated through individual price negotiations in the future. Risk sharing will be based on cost and volume agreements based on weighted episodes at specialty level. SLAs will have relatively narrow tolerances and clear agreements on funding adjustments for under or over-performance.

- *Would it be helpful to have national guidelines on tolerances and funding adjustments?*
- *What support would be helpful in allowing you to handle risk as payment by results extends to cover most activity?*

## Plurality of providers

4.46 We would welcome views on how, in the medium-term, new providers and services such as independent (private and voluntary) providers for elective surgery and other types of care can be brought within the framework of payment by results using national tariffs.

- *What are the key steps that would need to be taken to bring all providers of NHS services – public, private and not-for-profit – will be brought within the same overall financial framework of payment by results?*
- *Over what period might it be possible to bring these services and providers with the framework of national tariffs?*
- *What are the likely obstacles and risks?*

## Out of Area Treatments (OATs)

- *Do you support the replacement of OATs by a system of non-contract treatments, with risk-sharing for PCTs, based on historical levels of activity outside SLAs, established at SHA level (option 3)?*
- *Or are there circumstances when a system of 'non-contract treatments' (NCTs) for activity outside SLAs with payment at national tariff rather than local cost (option 2) might work better?*
- *Do you agree with the proposal to develop a national system based on existing datasets to minimise transaction costs associated with both data collection and payment processes for activity outside SLAs?*

# 5. Transition

## Progress to date

### Introduction

- 5.1 If introduced overnight on the basis of current reference costs payment by results would change the way money flows through the system impacting on the income of some NHS providers and the purchasing power of the PCTs that commission services from them. To minimise any potential instability for NHS organisations there will be a transition period from 2005/06 to 2007/08. The transition process is designed to ensure that the move to the tariff is manageable and the financial impact does not lead to any undue destabilisation of NHS organisations.

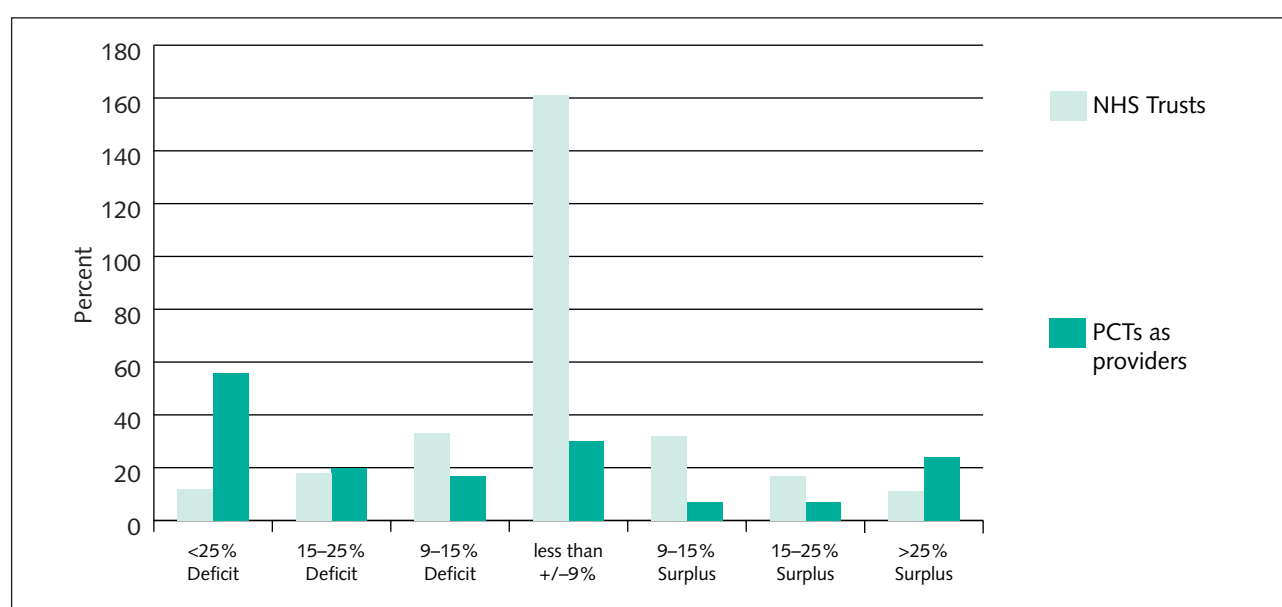
### Principles

- 5.2 The following set of principles has been identified for the transition process:
- The overall revenue impact of the transition process should be minimised and ideally should be cost neutral at a national level;
  - Where possible the transitional arrangements should be limited to managing only the impact of the move to the national tariff;
  - PCTs' purchasing power for 2005/06 should be maintained in the first instance regardless of their distance from target. The move to tariff for NHS Trusts should be spread equally over the three years 2005-06, 2006-07 and 2007-08 with some limited exceptions. This would mean moving 33% towards tariff prices in 2005-06, 66% in 2006-07 and full tariff prices in 2007-08;
  - The arrangements for NHS Foundation Trusts should be the same as those for NHS Trusts with the exception of those organisations who become NHS Foundation Trusts on 1 April 2004, a year ahead of the main implementation phase of payment by results. Special arrangements will be made for these organisations which will as close as possible to the overall payment by results arrangements; and
  - The currency, both in terms of the activity measure (FCE/FFCE/Spell) and the casemix adjustment (HRG 3.5 plus other service classification tools), used for the national tariff will be as far as possible the same throughout the transition period for NHS Trusts.

## Transition Impact Analysis

- 5.3 An initial impact assessment has been undertaken on the basis of the transition path above. It is based on moving from current costs to national average cost (as a proxy for the national tariff). This indicates that, for all of the activity covered in Reference Costs in 2002 (£26bn), £1.3bn would move between provider organisations and £0.75bn between PCTs. If only inpatient and daycase activity is included (£14bn total cost in 2002 Reference Costs) then the movement falls to £0.6bn between NHS providers and £0.4bn between PCTs.<sup>16</sup>
- 5.4 The chart below shows the distribution of the impact and shows that 160 Trusts would have faced an impact of less than 10%. However, the overall impact is affected by extremes at each end of the distribution of which the vast majority were PCTs as providers, as illustrated in the chart below. This may well indicate that in some cases their submitted costs were not robust.

Figure 4 Deficits/Surpluses on All 2002 Reference Cost Collection Activity (total = £26bn)



## Ongoing work

### NHS Provider Transition

- 5.5 For NHS Trusts the transition process is designed to move them from their current position where income is based on local cost to a point where income will be based on the national tariff adjusted for the market forces factor and commissioned through casemix adjusted cost and volume agreements. There are therefore two key elements to the transition of NHS providers:
- The impact on their income of the change in the basis of price; and
  - The different risk sharing arrangements inherent in casemix adjusted cost and volume agreements.

16 These costs have been uplifted to 2003/04 prices

- 5.6 Each NHS provider will need to agree with their Strategic Health Authority (SHA) a starting point for the transition process, in terms of both activity and the current price of that activity. There are two broad options for setting this starting point:
- **Option 1** is a top down approach using the 2003/04 Reference Costs as the basis for calculating the starting point for transition; and
  - **Option 2** is a bottom up approach where NHS providers use their 2004/05 SLAs as the basis for calculating the starting point for the transition process.
- 5.7 The first, top down approach, would use the information that will be provided in the Reference Cost collection exercise for 2004, i.e. information for the 2003/04 financial year. The total cost and activity declared in this return would form the starting point for the transition process. Local costs would be uplifted in the same way as the national tariff from the 2003/04 base to 2005/06. The advantage of this option is that it uses the Reference Cost data that is already collected and held centrally. However, it assumes that there is strong link between the Reference Costs submitted and the implied local prices and activity within current SLAs. The Reference Cost data may also need amending for any significant service changes, between 2003/04 and 2005/06, already agreed as part of the Local Delivery Plan (LDP). Reference Costs would also need adjusting for any accounting changes that came in to effect after 2003/04 for which no adjustment was made in the 2004 reference costs.
- 5.8 The second option is a bottom up approach that uses local SLA planned activity and values to impute local prices for HRGs or the other service classification tools. The starting point for this would be the planned activity for 2004/05 as set out in the LDP and SLAs. This activity forms the basis on which the three-year transition path will be assessed. Exceptionally, where the LDP indicates that there will be a significant reduction in this base activity during the transition years then the provider would need to agree with their commissioning PCTs and SHA a more appropriate base. This approach would require extra work to be undertaken by the NHS and would also require an addition central return of SLA data. However, much of the underpinning analysis to support this approach should have already taken place in order to casemix adjust the providers SLAs.
- 5.9 This bottom up approach has the advantage of excluding non recurring costs and activity from the starting points. It would also more accurately reflect agreed local prices which may well be different to the overall Reference Costs of a provider organisation.
- 5.10 In general all NHS providers will move to the national tariff over the three-year period from 2005/06 to 2007/08 at the same pace in equal steps. They will move 33% towards tariff prices in 2005-06, 66% in 2006-07 and full tariff prices in 2007-08.
- 5.11 The following table illustrates the transition path for four providers. It uses the National Reference Costs Index (NRCI) as a proxy for the starting point for transition and assumes that the national tariff is equal to an NRCI of 100. This is consistent with the initial impact analysis described at the start of this chapter.

	2004/05	2005/06	2006/07	2007/08
Trust A	108	105.3	102.7	100
Trust B	110	106.7	103.5	100.4
Trust C	94	96	98	100
Trust D	80	82.4	84.8	87.4

5.12 However, there will need to be an exceptions policy for those providers who need to make an efficiency saving above a pre-set limit. We propose that this limit should be 9% (3% per annum)<sup>17</sup>. In order to maintain the national zero net revenue impact this would need to be balanced by a limit on the level of increase in income for those organisations below a certain limit.

## NHS Foundation Trusts Transition Path

5.13 In general NHS Foundation Trusts will be treated in exactly the same way as NHS Trusts. NHS Foundation Trusts will be given the opportunity to implement the tariff early. NHS Foundation Trusts will start the transition path in 2004/05 a year ahead of the rest of the NHS.

5.14 However because of some uncertainties and decisions that still need to be taken about the way payment by results will be implemented the Department of Health will offer NHS Foundation Trusts a choice of implementation paths. The main uncertainties include:

- **Timing** The first NHS Foundation Trusts will be established in 2004/05 a year ahead of the main implementation phase of payment by results across the NHS. This means that the national tariff published for 2004/05 will be less robust than that for 2005/06 e.g. we will be using an earlier version of the Healthcare Resource Groups, which form the activity basis for the tariff;
- **Scope** The coverage of payment by results for first wave NHS Foundation Trust in 2004/05 may not be the same as the coverage of payment by results in 2005/06. For example, improvements in the information on critical care means that interim measures may be needed in 2004/05; and
- **Levy Review** The results of the review of the levies for teaching and research will not have been implemented and the impact of any change may be significant and not quantified when the tariff for 2004/05 is produced. Thus locking an NHS Foundation Trust into an agreed transition path may throw up significant problems if the levy review substantially changed its tariff.

5.15 As a result the Department of Health has agreed that for first wave NHS Foundation Trusts only that all agreed additional activity over the 2003/04 baseline commissioned from NHS Foundation Trusts will be paid at the full national tariff rate (rather than the locally agreed (marginal) rate which will apply to new activity for NHS Trusts outside the 15 HRGs). No support will be given to NHS Foundation Trusts whose marginal costs are greater than the national tariff.

5.16 NHS FTs will also be given the option of either:

- i) Seeing their current prices levels, for current (baseline) work (defined as work commissioned in 2003-04), phased into the full tariff over four years, i.e. they will move 25% towards tariff prices in 2004-05, 50% in 2005-06, 75% in 2006-07 and full tariff prices in 2007-08; or
- ii) receiving current (2003-04) price levels for baseline activity (2003-04) until 2007-08 when they will move onto the full tariff. This is akin to an income guarantee - but only on the proviso that the NHS FT maintains its current level of activity, i.e. volumes will continue to be subject to a payments by results philosophy. These price levels will be uplifted each year for price changes by the same amount that the national tariff is increased.

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<sup>17</sup> This assumes that the distribution of organisations around the national average is symmetrical in total cost terms. Further work is required to ensure that the limit set will deliver a zero net impact nationally.

- 5.17 We expect that first wave NHS Foundation Trusts who are likely to be adversely affected by the levy review or whose costs are greater than the tariff will chose the second option. Note if this second option is less beneficial to NHS Foundation Trusts than the transition path offered to NHS Trusts they would have the option to go onto the wider transition path at any point over the period.
- 5.18 PCTs will be funded for the marginal impact of these different transition path so as to ensure that they are not faced with higher prices when dealing with NHS FTs with respect to the wider transition path, i.e. we will ensure that PCTs will be in no worse position in contracting with NHS Foundation Trusts just because they are implementing the tariff faster.
- 5.19 These arrangements are designed to mitigate the uncertainties that they face in moving to a more robust commercial framework.
- 5.20 A briefing paper will be published shortly which will address in more detail the transition and other payment by results issues for first wave NHS Foundation Trusts.

## Mechanism for distributing transition funding to NHS Trusts

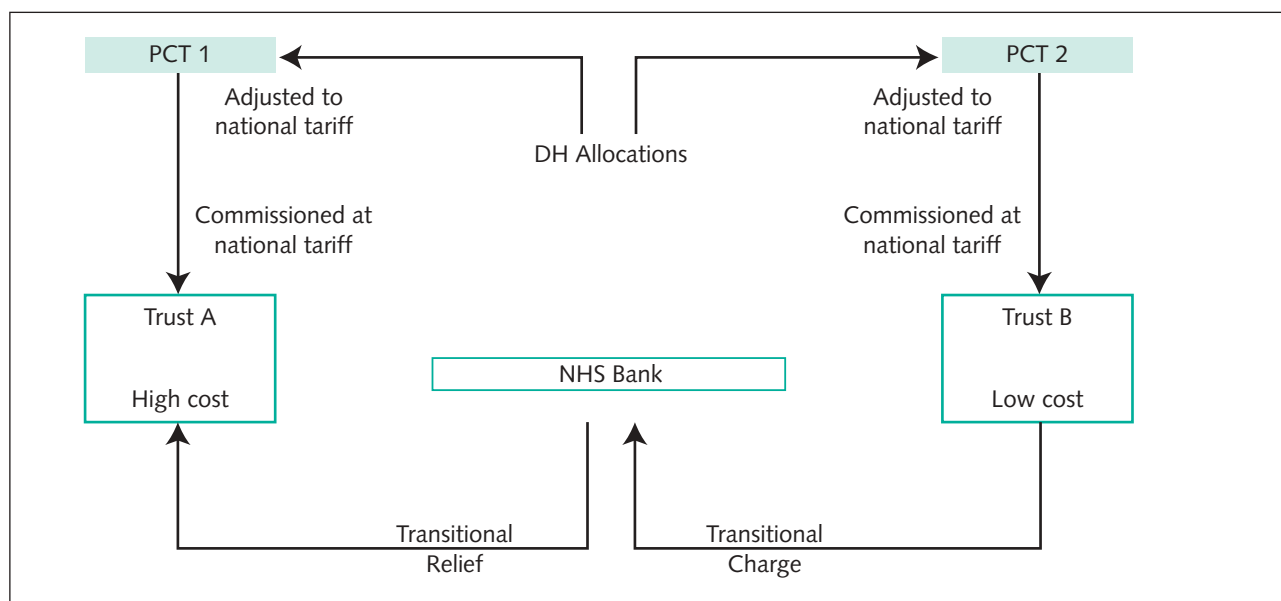
- 5.21 We are planning to use the NHS Bank to move funds between providers during their transition over three years (or four in the case of first wave NHS Foundation Trusts). This movement of funds would adjust for the difference between the organisation's point on its transition path and the national tariff that it will receive from its providers. This funding would not, of course, be repayable by the Trust. Figure 5 (para 5.32) shows how this might work schematically.

## PCT Purchasing Power

- 5.22 The principle stated above was that PCTs should be fully compensated for the impact of the move to the national tariff of their providers. Otherwise this would lead to some PCTs (dealing mainly with high cost Trusts) receiving a windfall gain, whilst others (dealing mainly with low cost Trusts) would experience additional costs.
- 5.23 We propose to move PCT funding and commissioning to the national tariff from the start of 2005/06. This would allow PCTs funding to be adjusted for the national tariff and for them to start to commission at the national tariff from day one of the new system. This would also be consistent with the introduction of patient choice, as PCTs would have funding for their existing level of activity at the national tariff so they could redirect it to alternative providers if appropriate. In order to do this it will require adjustments to PCT allocation for 2005/06. Moving PCT funding to the national tariff from 2005-06 means that the next round of allocations to PCTs will be informed by PCTs' distances from target which take full account of the rebasing for the national tariff.
- 5.24 The objective would be to reset the baselines for 2005/06 SLAs so that they reflect the same level of service/activity included in 2004/05 SLAs but using the national tariffs instead of local prices. Exceptionally where LDPs indicate significant changes in service delivery patterns these would need to be reflected, where appropriate, in the baseline and associated adjustments to allocations.

- 5.25 In the same way as for NHS providers there are two possible options for doing this:
- Option A: a top-down approach mapping the impact on individual Trusts of moving to national tariffs based using either provider option, to PCTs through the purchaser/provider matrix. This matrix is derived from Hospital Episode Statistics (HES) data and is used in the resource allocation process to map Trusts' MFFs to purchasers; and
  - Option B: a bottom-up national recosting and remapping exercise to recalculate 2004/05 SLA values using national tariffs.
- 5.26 Option A would be similar to the modelling exercise that has been carried out on current data to assess the potential range of impacts on PCTs and Trusts. It would be less transparent than option B, in that it would not be based on data owned at Trust/PCT level. Its main advantage is that it would not involve the NHS in substantial work to a very tight timescale.
- 5.27 The main disadvantage to this approach is that the adjustments to PCT allocations would be based on 2003 HES data for the mapping from providers to PCTs, which might be significantly different from the 2004/05 SLA baselines. Also, HES data currently only covers inpatients and day cases, although its coverage is due to be extended to outpatients - the pattern of financial flows from PCTs to Trusts for inpatients and day cases is not necessarily representative of overall financial flows. On the other hand the differences might not make a material difference to the financial impact on PCTs There would inevitably be a level of margin of error.
- 5.28 Option B is theoretically the most transparent and most appropriate option. It would start from the "correct" starting point of 2004/05 SLAs rather than 2003/04 Reference Costs. Most parts of the country have experience of doing recosting and remapping exercises over the past few years. It would be the logical next step if the bottom up approach was undertaken by NHS providers in setting their starting point.
- 5.29 This option also has the advantage of allowing the impact on purchasing power to be calculated at the specialty level as opposed to the organisational level with the top down approach. This would be particularly important where a PCT only commissions a limited range of specialties from a provider and those specialties' relative efficiency may not reflect the overall efficiency of the organisation.
- 5.30 It has two major disadvantages:
- The process is time-consuming, although as a final recosting and remapping it may be appropriate. However, much of the work needed for this would already have been undertaken in order to casemix adjust SLAs. Coverage would need to be complete for this option to be viable; and
  - The post-internal market recosting and remapping exercises had a built in bottom line control in that they were required to be a zero net sum for each individual Trust. As part of the transition to a national tariff this bottom line control would not apply (the values for individual Trust would by definition not be zero), but there would need to be an overall zero net sum nationally.
- 5.31 A further issue would be timing. It would be necessary for SLA values to be clearly agreed early enough in the year for the process to be undertaken in time for allocation adjustments to be made for 2005/06.
- 5.32 In macro terms the process can be simplified as shown in figure 5:

Figure 5 Possible flow of funds during transition period



## Review of Levies

- 5.33 One of the factors that is believed to contribute to the wide range of Reference Costs, both at HRG level and at Trust level in the National Reference Costs Index (NRCI), is distortions attributable to the learning and development (MPET – Multi Professional Education and Training) and research & development (NHS R&D) levies.
- 5.34 In commenting on the consultation document *Reforming NHS Financial Flows*, several SHAs and NHS Trusts highlighted that moving to national tariff prices could benefit Trusts with higher than average income from sources such as the MPET and NHS R&D levy budgets. Comments stressed that it was important to ensure there is a level playing field.
- 5.35 In our response we indicated that we recognised the concern that individual Trusts were either over- or under-compensated through the income they receive from the levy budgets for the additional costs they incur on these activities. We recognised the need to review these budgets alongside the introduction of payment by results relating to patient care income.
- 5.36 From the point of view of payment by results, the objective of reviewing current costs and funding of learning and development and R&D is to determine whether:
- at individual Trust level, there is significant cross-subsidisation between patient care on the one hand and MPET and R&D on the other, thus distorting individual Trusts' HRG costs; and
  - as a result, at an aggregate level, overall expenditure contributing to national average HRG costs is significantly over- or under-stated.
- 5.37 The intention of the reviews is that levy budget and patient care funding streams will be rebased to correct significant distortions, i.e. any significant cross-subsidy from the levy budgets will be transferred to Trusts' patient care funding streams through their PCT commissioners, and vice versa for any significant cross-subsidy from patient care. The rebasing will take effect from 2005/06 baselines, so that:
- there will be a zero net impact on Trusts' overall income in the short term, but Trusts' transition path to full impact of the national tariff will change as a result of any rebasing; and

- PCTs' real purchasing power will be unchanged in the short term as a result of the rebasing, but their distance from target will change and this will affect the distribution of growth in the next three-year settlement.
- 5.38 However, as 2005/06 tariffs will be based on 2003/04 Reference Costs, the effect of any rebasing will need to be reflected in 2003/04 HRG costs as if the rebasing had been applied in 2003/04. Thus the timescale for the reviews is that they should be completed and the outcomes agreed by a deadline of March 2004.
- 5.39 First wave NHS Foundation Trusts will not know the impact of this review when they need to undertake their initial financial planning. The income guarantee available to them during the transition process will help to provide some financial stability given that the impact will be uncertain.
- 5.40 A progress report on the action being taken to review these levies, and the timescale, is available at <http://www.doh.gov.uk/nhsfinancialreforms/technicalpapers>.

## Questions for consultation

- *Do you think that the underlying principles for transition are appropriate? Would you want to add any others to this list?*
- *Is it reasonable to use reference costs as a proxy for local prices when setting the starting point for the transition process for NHS providers?*
- *Would you prefer the top down or bottom up approach to setting the starting point for NHS provider transition?*
- *Do you think that a 3% per annum efficiency gain is appropriate? What is the maximum level would you suggest is achievable per annum during the transition process?*
- *Which option would you choose for mapping the provider impact to their commissioners?*
- *For the purposes of mapping the provision of services to the commissioner of those services, is it reasonable to assume that the community services are commissioned and provided by the same PCT?*

## Broader issues for the longer term

- 5.41 For the transition process the key consideration is those organisations that need to make an overall efficiency saving of more than 9%. The policy relating to these outlier organisations is currently under development. However, it is clear that in order for the national zero revenue impact to be maintained special arrangements will also need to be put in place for those organisations who would be due to increase their income by more than 9%.<sup>18</sup>
- 5.42 The levy reviews are intended to ensure that, as far as possible, the introduction of payment by results for patient care takes place on a level playing field. For both learning and development and R&D, further work will continue beyond these reviews to develop the commissioning processes to ensure that the activity undertaken in providers meets the needs of these services, is responsive to their priorities and is delivered efficiently and effectively. The introduction of payment by results will not have an adverse impact on investment in learning and development for staff.

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18 9% is only an approximation at this stage as it assumes that the distribution of organisations around the national average is symmetrical in total cost terms.

# 6 Trust Financial Regime

## Progress to date

- 6.1 In *Reforming NHS Financial Flows: Introducing payment by results*<sup>19</sup>, we said that there was a need to review the existing Trust Financial Regime (TFR) in order to ensure that it is consistent with payment by results. This work is now under way. It needs to be set against three other developments:
- The Government has announced the intention that all NHS Trusts should be in a position where they are able to apply for NHS Foundation Trust status by 2008. NHS Foundation Trusts have a finance regime set out in the Health and Social Care Bill 2003 that is currently before Parliament. Any changes to the TFR will need to be consistent with the NHS Foundation Trust regime, and where possible help prepare Trusts for Foundation status. And the rate at which Trusts achieve Foundation status has a significant bearing on the extent to which changes to the existing TFR are required;
  - A shadow NHS Bank has been established, providing £100m of special assistance in 2003/04 held by SHAs (As set out in *Raising Standards: Improving performance in the NHS*<sup>20</sup>). The NHS Bank will have an additional £50 million per year from 2004/05 in the form of grants for poorer performers to implement their improvement programmes. There are other ways in which the role of the Bank could be extended as outlined below; and
  - The change in the discount rate from 6% to 3.5%. This increases differences in the cost of capital between the public and private sector, and we need to consider how this variation sits alongside a single national tariff.

## Ongoing work

- 6.2 The TFR Review is addressing four main issues: i) surplus retention, ii) deviations in cost from tariff; iii) capital charging; and iv) the response to financial failure. Each of these is outlined in more detail below.

### Surplus retention

- 6.3 We have been clear that under payment by results Trusts should be able to retain surpluses as an incentive to improve efficiency. Similarly they will remain liable for any in-year deficits. Under Resource Accounting and Budgeting (RAB), there is a carry forward arrangement by which Trusts are already able to retain surpluses. The net surplus or deficit made by each health economy is returned to SHAs the following year. SHAs are then responsible for passing these back to the organisations in their economy. We are reviewing these arrangements to see how we could provide greater certainty for organisations where surpluses originate. One possibility is that carry forward arrangements could be co-ordinated by the NHS Bank.

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19 This document is available at <http://www.doh.gov.uk/nhsfinancialreforms/financialflowsoc02.htm>

20 This document is available at <http://www.doh.gov.uk/raisingstandardsnhs/supportandrewards.htm>

## Deviations in cost from tariff

- 6.4 Chapter 5 set out the transition scheme to support Trusts as they move towards tariff, assuming they close the gap between their reference costs and the tariff over the 3 years 2005-06, 2006-07 and 2007-08. However over and above this there are a number of reasons to expect that Trusts' income under tariff will not always be sufficient to cover their expenditure. The possibilities include:
- Additional income being provided as part of a recovery plan from a deficit position, or a Trust may enter a deficit position if it is not able to live within tariff;
  - Up-front revenue costs of new investment. This can include the capital charges paid on new facilities before they are opened;
  - New capital schemes may be built with initial spare capacity as they are anticipating increases in demand a number of years ahead; and
  - Existing major public capital or PFI schemes where there may be affordability issues under tariff.
- 6.5 In considering our response to these issues, our view is that any additional support that is provided to Trusts over and above the tariff should be as transparent as possible. Nor should it put at risk the incentives for efficiency that underpin the payments by results policy.
- 6.6 Chapter 5 (paragraph 5. 21) explained that transitional support for NHS Trusts would probably be distributed in a transparent way through the NHS Bank. This would be non repayable. Our current thinking is that any further requirement by Trusts for additional support for the reasons in paragraph 6.4 above would also be provided transparently by the NHS Bank. Such support could be provided as income to the Trust. Depending on the reason for the support the Trust may be expected to demonstrate (by increased efficiency or cost reductions) that the support has been properly employed.
- 6.7 There are other options such as the Bank providing explicit loans, or allowing PCTs to top-up the tariff. The former is closer to the Foundation Trust finance regime, but could lead to difficulties with the statutory duty to breakeven (and changing this would require legislation). An example of the latter is that we have said that PCTs should be able top-up the tariff for one year only to cover up-front revenue costs of new investment. Other circumstances could be carefully defined, but the greater the number of exceptions to the tariff we allow, the more likely the incentives for efficiency would be put at risk. And there would not be a clear separation of PCT and Trust financial positions.
- 6.8 NHS Bank resources count against the Department's Expenditure Limit. There are therefore issues as to how the Bank would be funded, and how much funding would be required. In the case of the initial three year transition, the proposition is that this would be zero sum nationally. We would therefore need to establish arrangements that can be used to move money from Trusts with costs below tariff, to Trusts with costs above tariff. The Bank could manage this process.

## Capital charging

- 6.9 The reduction in the discount rate increases the diversity in the cost of capital. Trusts will face capital charges of 3.5%. PFI (where the cost of capital affects the unitary charge) and unregulated borrowing by NHS Foundation Trusts will be at private sector rates. And new public sector borrowing by NHS Foundation Trusts will be in the form of interest bearing debt at National Loan Fund rates.

- 6.10 We need to consider whether these differences matter in the context of a single national tariff. As part of the TFR review we are therefore reviewing the capital charging regime. A particular issue we wish to consider is whether the cost of capital should be based on the PDC (or interest bearing debt) owed to the Secretary of State, rather than the value of relevant net assets.
- 6.11 Such an approach offers a number of potential advantages. It avoids the volatility that can occur when assets are revalued. It provides incentives to ensure the effectiveness of capital expenditure. It prepares Trusts for the finance regime they will face as Foundation Trusts. And it creates more of a level playing field between different types of providers, helping to reduce the number of circumstances in which there might need to be exceptions to the tariff, as discussed above.

## Addressing financial failure

- 6.12 Ultimately Trusts will need to keep costs within the tariff, and provide good quality healthcare that attracts activity from PCTs (and ultimately patients themselves under patient choice). Payment by results therefore increases the need for good financial management. There is consequently a greater risk of financial failure, and we will need to be clear how this risk will be managed.
- 6.13 Currently SHAs have a clear role in performance management and agreeing recovery plans. And, in the very few cases where a Trust does not show sufficient capacity to turn its performance around, or where performance does not improve, SHAs and the Department consider whether to franchise the management. On achieving Foundation status, Trusts will have a clear failure regime set out in legislation. We will however need to consider whether payment by results and any changes to the TFR mean that changes to existing arrangements should be made in the interim.

## Questions for consultation

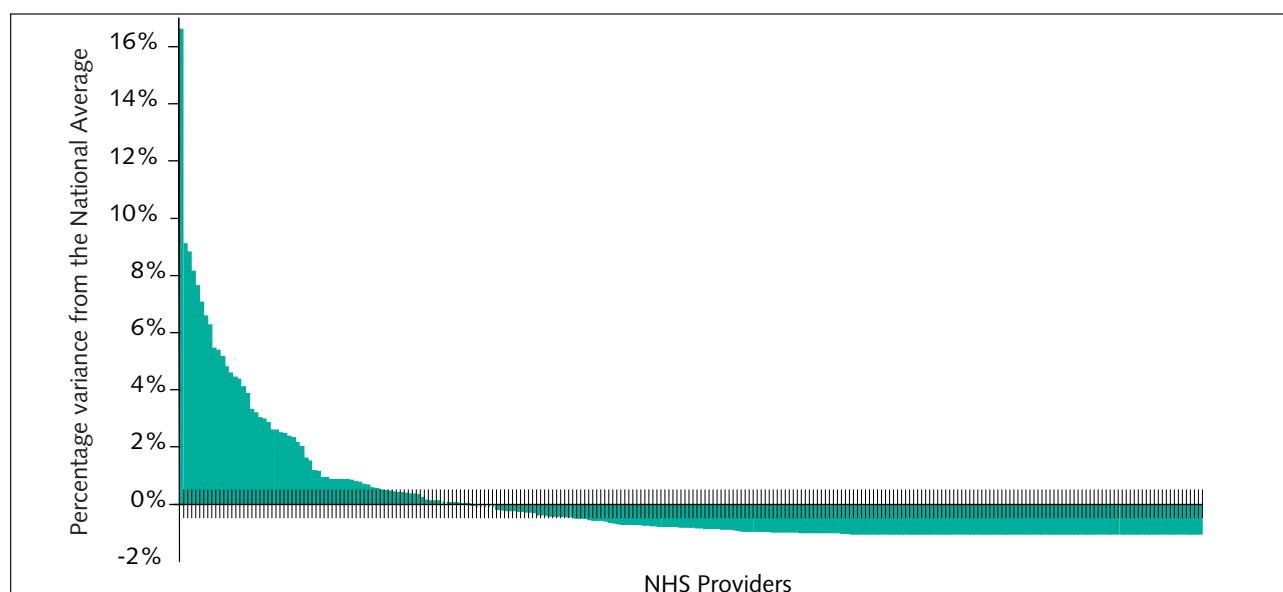
- *Have we correctly identified the implications of payment by results for the Trust Financial Regime? Are there other issues or possible options we should be exploring?*
- *This work is at an early stage and further work is required to develop the options. As with the other areas of work, before reaching conclusions we will discuss the options with a range of stakeholders. Those with a particular interest in being involved in this development work should contact us by email at [financial-flow@doh.gsi.gov.uk](mailto:financial-flow@doh.gsi.gov.uk)*

# 7. Costing

## Progress to date

- 7.1 The 2002 Reference Cost exercise covered over £25bn of NHS expenditure<sup>21</sup>. This accounts for almost 89% of hospital and community spending. The 2003 collection<sup>22</sup> expands this to a wider range of NHS providers including the emergency activity of ambulance services. PCTs commissioning services from independent providers will also be included. This expansion will mean that the target set in 1997<sup>23</sup>, of covering virtually all HCHS spend will be achieved.
- 7.2 Providers of NHS services will be required to continue to submit detailed costs. This will include NHS Foundation Trusts and DTCs. For 2004 we will seek to extend this to the voluntary and charitable sectors.
- 7.3 There has been some limited improvement in the quality of the Reference Cost data. Payment by results will give a positive and real incentive to improve, often dramatically, the quality of the costing systems and costing information. The range of costs reported by acute trusts has reduced over the last 3 years. We expect this to continue as more consistent and rigorous cost allocation methodologies are used. We expect to see a similar improvement from the non-acute sector. However, there remains an unexplainable variation in the reported costs for many clinical procedures. Costing and activity recording must be improved.
- 7.4 Of particular concern is the volume of activity that some organisations do not allocate or record to a specific procedure of speciality. The range of this unallocated activity for 2001/02 is shown in figure 6 below.

Figure 6 Percentage variance by NHS Trusts and PCTs from the national average percentage of uncoded activity



- 7.5 The costs of these unallocated activities were pro-rated over reported activity for the 2003/04 tariff. This is not a sustainable long-term position.

21 Details available at <http://www.doh.gov.uk/nhsexec/refcosts.htm>

22 More information available at <http://www.doh.gov.uk/nhsexec/costing.htm>

23 See the 1997 White Paper The New NHS Modern, Dependable available at <http://www.doh.gov.uk/nhsind.htm>

## Ongoing work

- 7.6 The recently reconstituted National Costing Strategy Group is currently considering proposals for improving costing. These include data inspection and greater prescription in the processes of costing. Such a move would counter concerns over the inconsistent treatment of costing techniques. It would also enable more meaningful comparisons of the components of costs.
- 7.7 Alongside greater prescription may be a case for the specification or development of a standardised national costing model. Some smaller countries (e.g. the Republic of Ireland) have such a common system. It ensures consistency and also enables a robust approach to data quality to be developed. However, it could be costly and burdensome to develop and maintain. We seek views on the merits of such a development.
- 7.8 The proposed Version 4 HRG revision expands significantly the number and scope of services being defined. It will allow the grouping of treatments and procedures which do not currently have codes. This will have a significant impact on costing, activity and management information processes. Currently, we are scoping the potential impact of a review and would appreciate views in due course on the impact on costing and activity processes and systems, with regard to unit cost analysis
- 7.9 The entire Reference Costing process is deemed by some to be bureaucratic, elaborate and disproportionately expensive. The current tariff structures are based upon the full national data capture. For the future it would be possible to ease the burden of costing by either:
- a) Using sampling methods on a rolling basis to cover all service categorisation groups, to inform the tariff setting process;
  - b) Relying upon the costs produced by a selected number of providers who are known to have 'quality' costing systems; or
  - c) Developing a normative approach to costing so that a national standard costing model is used that is informed by best clinical practice, together with a contribution of a) and b) above.
- 7.10 However, it remains the case that individual organisations will need to understand better their own cost base and cost structure. The balance between that needed to satisfy a robust national tariff, and also deliver appropriate local information must be addressed.

## Question for Consultation

- *What process should be developed to incorporate the costs of unallocated/ unclassified activity into the long-term tariff.*
- *Would greater prescription in the treatment of costs be welcomed?*
- *What are the key issues that need to be considered in drafting guidance to ensure comparability in approach?*
- *Are there other steps that could be taken in the short and medium-term to standardise the costing methodology?*
- *Should we consider the development of a standard costing model?*
- *Should we formalise the audit/inspection regime for costing?*
- *Should we consider alternatives to a full annual national Reference Costing collection exercise? If so, what?*

# 8 Monitoring and Evaluation

## Progress to date

- 8.1 The actions that need to be taken by PCTs and Trusts to implement Payment by Results in 2003/04 were set out in *Reforming NHS Financial Flows: Introducing Payment by Results* and the technical guidance that followed this (both available from <http://www.doh.gov.uk/nhsfinancialreforms/>).
- 8.2 All PCTs and NHS Trusts should be meeting the minimum requirements set out in these documents; namely that PCTs should have:
- Cost and volume SLAs with providers, adjusted for casemix using HRG cost weights for at least 6 clinical specialties; and
  - HRG level SLAs for 15 key procedures with agreed activity above the 2002/03 baseline funded at national tariff.
- 8.3 We have established a network of liaison links with each SHA. They will play a key role in assisting in the two-way communication necessary for successful implementation. Their role will be to:
- Monitor the progress of implementation;
  - Provide a local point of contact of NHS organisations;
  - Establish a network of expertise and support;
  - Disseminate briefing from central DH team;
  - Provide informal feedback to DH team; and
  - Identify local development sites where needed.
- 8.4 Initially we will ask them to track implementation in 2003/04 and 2004/05 by collecting data on:
- Activity levels agreed in the designated HRGs;
  - Actual increases in activity levels within the designated HRGs;
  - Number, value and percentage of agreements that have been casemix adjusted and are agreed on a cost and volume basis;
  - Failures to deliver agreed increased activity within the designated HRGs; and
  - Volume and values of activity that has been moved to different providers by commissioners as a result of the implementation of payment by results.
- 8.5 We will meet regularly with them to consider this data, and to reconsider any actions needed to ensure successful implementation. The list of these contacts is attached in Annex D.

- 8.6 The NatPaCT competency framework (available from <http://www.natpact.nhs.uk/>) includes key competencies which will be needed to implement payment by results. This should be used as a guide/checklist by PCTs to assess their general organisational level of preparedness.
- 8.7 In the medium term, we will wish to carry out detailed evaluation of the progress and impact of payment by results and will be working with the SHA liaison leads to assess the ongoing support needs within the NHS.
- 8.8 Planning for this evaluation is currently underway and it is intended that the evaluation process will have several phases, the results of each phase informing the next stage of the implementation of the policy.

## Questions for consultation

- *Are the proposed monitoring measures appropriate and comprehensive?*
- *Are there any other measures that would be appropriate?*
- *At what point in the year should the monitoring be undertaken?*

# Annex A – List of relevant publications and resources

Delivering the NHS Plan:

<http://www.doh.gov.uk/deliveringthenhsplan/index.htm>

NHS Financial Reforms section of Department of Health website (includes detailed Frequently Asked Questions section):

<http://www.doh.gov.uk/nhsfinancialreforms/>

Reforming NHS Financial Flows: Introducing Payment by Results:

<http://www.doh.gov.uk/nhsfinancialreforms/financialflowsoct02.htm>

Our response to Reforming NHS Financial Flows:

<http://www.doh.gov.uk/nhsfinancialreforms/financialflowsresponse.htm>

Technical guidance for 2003/04:

<http://www.doh.gov.uk/nhsfinancialreforms/financialflowsdec02guidance.htm>

Technical papers referred to in this document:

<http://www.doh.gov.uk/nhsfinancialreforms/technicalpapers>

Casemix adjustment tool:

<http://www.doh.gov.uk/nhsfinancialreforms/casemixtool.htm>

NHS costing web page:

<http://www.doh.gov.uk/nhsexec/costing.htm>

NHS Information Authority home page:

<http://www.nhsia.nhs.uk/def/home.asp>

National Primary and Care Trust Development Programme home page:

<http://www.natpact.nhs.uk/>

General queries or questions should be addressed to our Mailbox at [financial-flow@doh.gsi.gov.uk](mailto:financial-flow@doh.gsi.gov.uk).

# Annex B – The consultation criteria

The Cabinet Office Code of practice on written consultation includes a list of consultation criteria that must be reproduced in consultation documents. These are:

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage.
2. It should be clear who is being consulted, about what questions, in what time-scale and for what purpose.
3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain.
4. Documents should be widely available, with the fullest use of electronic means (though not to the exclusion of others) and effectively be drawn to the attention of interested groups and individuals.
5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation.
6. Responses should be carefully and open-mindedly analysed, and the results made widely available, with an account of the views expressed, and reasons for decisions finally taken.
7. Departments should monitor and evaluate consultations, designating a consultation co-ordinator who will ensure the lessons are disseminated.

# Annex C – List of questions for consultation

Please email responses to [financial-flow@doh.gsi.gov.uk](mailto:financial-flow@doh.gsi.gov.uk) or send them to NHS Financial Reforms Team, Department of Health, Room 101/102, Richmond House, 79 Whitehall, London, SW1A 2NL by **31 October 2003**.

## Tariff Structure

### Tariff for elective and non-elective admissions

- Does the proposed single tariff for elective and non-elective admissions from 2004/05 represent the best way forward?

### High and low cost exceptions

- Should there be an adjustment to the national tariff for inpatient activity with very short lengths of stay, and on what basis should the adjustment be made?
- Should there be an adjustment to the national tariff for inpatient activity with very long lengths of stay, and on what basis should the adjustment be made?
- Should there be an adjustment to the national tariff for patients that with significantly more complex needs (i.e. specialised services), and how should this be applied?

### Incorporating new technology into the national tariff

- Does the tariff setting approach include sufficient mechanisms to ensure that new technology is adequately funded – see paragraph 2.27. If further mechanisms are needed, do you agree that these should only be used where the technology is demonstrably cost effective and will have a material impact on provider costs.

## Tariff scope and service classification tools

- Are there any examples of locally produced casemix tools that been successfully used in commissioning mental health or community health services?
- Would any PCTs and Mental Health Trusts be interested in piloting mental health casemix groups that have already been developed in other countries, for commissioning purposes?

## Commissioning

### Feedback on implementing SLAs

- What further support is needed on how to contract for activity and move funds through SLAs?
- What are the problems with monitoring by weighted FCEs in-year?
- We would welcome feedback on developing the casemix tool to allow it to convert FCE based monitoring information into weighted FCEs.

### **SLAs and choice**

- What additional issues for the SLA are raised by policies on choice at 6 months from Summer 2004 and choice at the point of referral from December 2005?
- Would it make sense to extend risk pooling to include activity currently covered in small volume SLAs?
- Or does this work best under local arrangements e.g. via a lead PCT?

### **Risk sharing arrangements for elective and non-elective care**

- Would it be helpful to have national guidelines on tolerances and funding adjustments?
- What support would be helpful in allowing you to handle risk as payment by results extends to cover most activity?

### **Plurality of providers**

- What are the key steps that would need to be taken to bring all providers of NHS services – public, private and not-for-profit – will be brought within the same overall financial framework of payment by results?
- Over what period might it be possible to bring these services and providers with the framework of national tariffs?
- What are the likely obstacles and risks?

### **Out of Area Treatments (OATs)**

- Do you support the preferred option of replacement of OATs by a system of non-contract treatments, with risk-sharing for PCTs, based on historical levels of activity outside SLAs, established at SHA level (option 3)?
- Or are there circumstances when a system of ‘non-contract treatments’ (NCTs) for activity outside SLAs with payment at national tariff rather than local cost (option 2) might work better?
- Do you agree with the proposal to develop a national system based on existing datasets to minimise transaction costs associated with both data collection and payment processes for activity outside SLAs?

## **Transition**

- Do you think that the underlying principles for transition are appropriate? Would you want to add any others to this list?
- Is it reasonable to use reference costs as a proxy for local prices when setting the starting point for the transition process for NHS providers?
- Would you prefer the top down or bottom up approach to setting the starting point for NHS provider transition?
- Do you think that a 3% per annum efficiency gain is appropriate? What is the maximum level would you suggest is achievable per annum during the transition process?
- Which option would you choose for mapping the provider impact to their commissioners?
- For the purposes of mapping the provision of services to the commissioner of those services, is it reasonable to assume that community services are commissioned and provided by the same PCT?

## Trust Financial Regime

- Have we correctly identified the implications of payment by results for the Trust Financial Regime? Are there other issues or possible options we should be exploring?
- This work is at an early stage and further work is required to develop the options. As with the other areas of work, before reaching conclusions we will discuss the options with a range of stakeholders. Those with a particular interest in being involved in this development work should contact us by email at [financial-flow@doh.gsi.gov.uk](mailto:financial-flow@doh.gsi.gov.uk)

## Costing

- What process should be developed to incorporate the costs of unallocated/unclassified activity into the long-term tariff.
- Would greater prescription in the treatment of costs be welcomed?
- What are the key issues that need to be considered in drafting guidance to ensure comparability in approach?
- Are there other steps that could be taken in the short and medium-term to standardise the costing methodology?
- Should we consider the development of a standard costing model?
- Should we formalise the audit/inspection regime for costing?
- Should we consider alternatives to a full annual national Reference Costing collection exercise? If so, what?

## Monitoring & Evaluation

- Are the proposed monitoring measures appropriate and comprehensive?
- Are there any other measures that would be appropriate?
- At what point in the year should the monitoring be undertaken?

# Annex D – List of Strategic Health Authority contacts on payment by results

NAME	STRATEGIC HEALTH AUTHORITY
Neil Brent	Avon, Gloucestershire and Wiltshire
David Self	Bedfordshire and Hertfordshire
Rachel Hardy	Birmingham and The Black Country
Ken Burns	Cheshire and Merseyside
John Maddison	County Durham and Tees Valley
Ismail Bafeji	Cumbria and Lancaster
Paul Goodwin	Dorset and Somerset
Rick Tazzini	Essex
Stephen Orpin	Kent and Medway
Johnathan Stephens	Greater Manchester
Julie Renfrew	Hampshire and Isle Of Wight
Julie Tyler	Leicestershire, Northamptonshire and Rutland
Ruth Derrett	Norfolk, Suffolk and Cambridgeshire
Mike Joyce	North and East Yorkshire and North Lincolnshire
Trudy Wilk	North and East Yorkshire and North Lincolnshire
Garry Sired	North Central London
David King	North East London
Louisa Dallmeyer	North West London
Mick Harrison	North West London
Wendy Jones	Northumberland, Tyne & Wear
Michael Turner	South East London
Richard Bailey	South West London
Davina Ross	South West Peninsula
Mike Curtis	South Yorkshire
Derek Harwood	Surrey And Sussex
Steven Bliss	Thames Valley
Debbie Stiles	Trent
Andy Hardy	West Midlands South
Richard Upton	Shropshire and Staffordshire
John Barber	West Yorkshire

# Annex E – Glossary of terms

## **Casemix**

The mix of types of patients or treatment/healthcare episodes.

## **Casemix adjusted payment**

Casemix-adjusted payment means that providers are not just paid for the number of patients they treat in each specialty, but also for the complexity or severity of the mix of patients they treat. We propose to use the average reference costs for each HRG as a basis for adjusting payment to Trusts for the complexity of patients they treat.

## **Commissioning**

An overarching term, embracing the strategic planning of services, the procurement and contracting of providers, and the monitoring of delivery, including patient outcomes.

## **Cost and volume agreements**

Cost and volume commissioning agreements are specific about the volume and mix of services and price per case that the PCT pays for. Cost and volume agreements are not demand-driven or open-ended. Typically a cost and volume agreement will specify a cap on the volume of services based on plans and forecasts, together with provisions that clarify the respective responsibilities of the PCT and provider in the event that the volume of services differs from the planned level. Commissioning agreements should also cover other dimensions of service delivery and performance, including quality and access times.

## **FCE**

Finished Consultant Episode. The period of time that one hospital inpatient spends under the care and responsibility of one consultant.

## **NHS Foundation Trust**

*Delivering the NHS Plan* chapter 7 (available at <http://www.doh.gov.uk/deliveringthenhsplan/index.htm>) and *NHS Foundation Trusts, eligibility and criteria* (available at <http://www.doh.gov.uk/nhsfoundationtrusts/index.htm#down>) set out plans for NHS Foundation Trusts.

## **HCHS**

Hospital and Community Health Services. The main elements of HCHS funding are the provision of both hospital and community health services. HCHS provision also includes funding for those elements of Family Health Services that are discretionary.

## **HRG**

Healthcare Resource Group – groupings of treatment episodes which are similar in resource use and in clinical response.

## **Internal market**

The system of competition among NHS hospital Trusts that operated from 1990-1997. During this period, purchasers (Health Authorities and GP Fundholders) were encouraged to use price competition as a basis for determining where to refer patients.

**Market Forces Factor**

An index used in resource allocation to adjust for unavoidable variation in input costs. It consists of components to take account of staff costs, London weighting, land, buildings and equipment.

**NatPaCT**

National Primary and Care Trust development programme.

**OPCS**

In the context of this document used to refer to OPCS4 codes, which are used to classify procedures in the NHS.

**Pathways of care**

This refers to the sequence of steps or encounters a patient has with the health service for a given condition. The components making up a complete pathway may include primary prevention, advice and reassurance, diagnosis, treatment, rehabilitation, continuing care, secondary prevention, and palliative care. It may also involve coordination with social services as well as family and community support. Streamlining the patient care pathway, and increasing coordination, communication along the pathway are critical elements of improving patient experience, as well as improving efficiency and outcomes.

**Reference Costs**

Reference Costs are the costs of NHS Services provided from NHS resources for NHS patients. They are derived using the detailed approach to costing health services (set out in the NHS Costing Manual). The aim is to achieve comparability by using a consistent approach to costing services.

**SLA**

Service Level Agreement.

**Spells**

A spell is a hospital stay from admission to discharge. A spell might cover more than one Finished Consultant Episode and where it does, the spell will be assigned to the key element of the care (unlike 'First FCEs' which are simply assigned to the first element of the patient's care).

**Standard service classification tools**

Groupings of healthcare episodes using standardised international and national data definitions, used to provide a manageable method for measuring the activity carried out by healthcare providers, measuring resource use, and relating this to the health need of patients and the outcomes of care.

**Trimpoint**

Trimpoints are set by NHSIA for HRG and define the length of stay beyond which a case is considered to be an outlier (significantly longer or shorter than the population average) in terms of length of stay. Reference costs make use of trimpoints, with costs of care beyond the trimpoint costed separately as excess bed-days, to prevent distortion of the average cost of a HRG by outlier cases. In 2003/04 we will not use separate outlier payments and the national tariff and relative values will be increased to take account of the number of excess bed-days.









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32673 1P 900 Aug 03 (CWP)  
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First published: August 2003

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