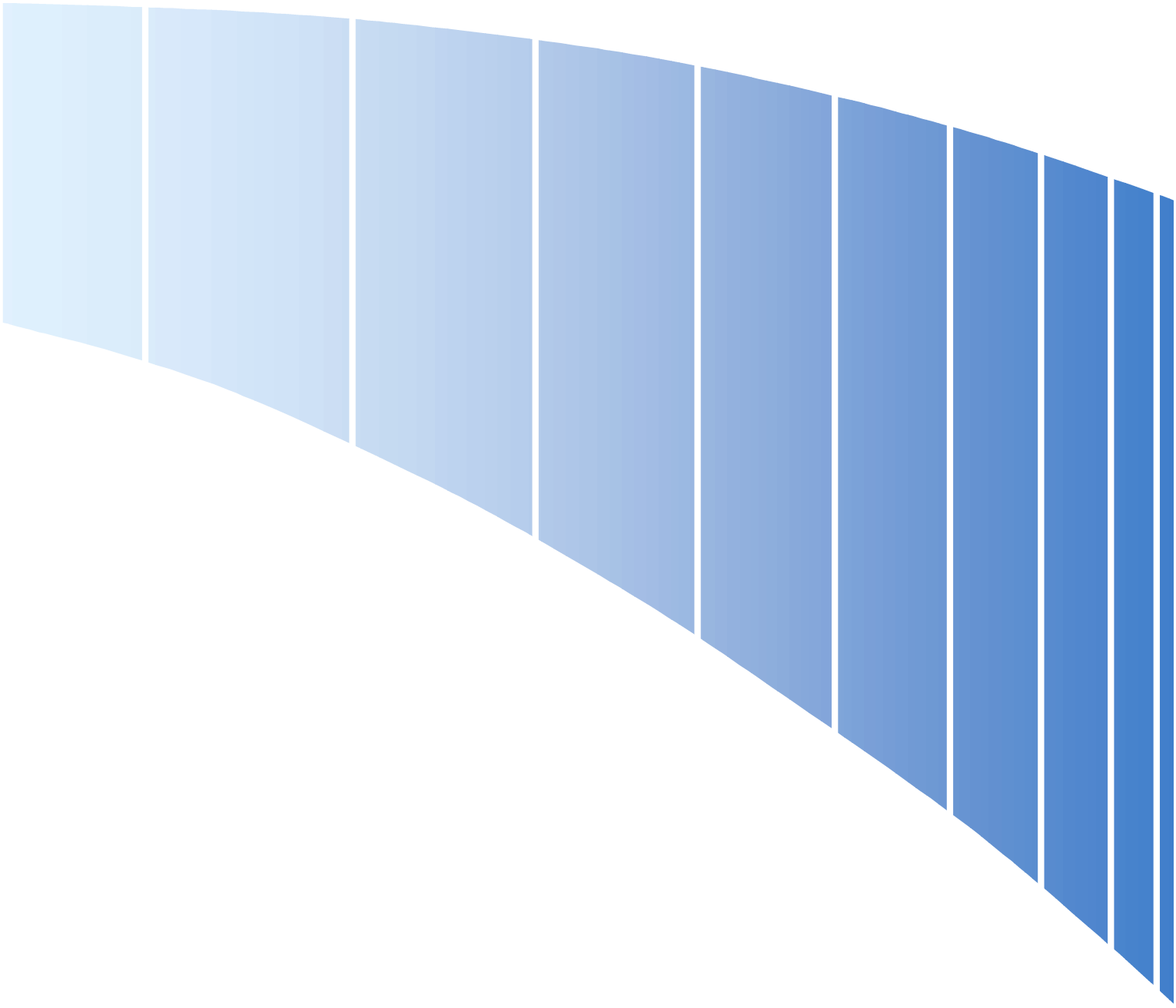
Summary of Responses to Consultation:

Options for the Future of Payment by Results: 2008/09 to 2010/11



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Contact Details	Richard Kelly Payment by Results - Development Branch 6th Floor New Kings Beam House 22 Upper Ground, London SE1 9BW 0207 633 7341		
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Contents

Executive summary

"In general the document was well received and appears to be well thought through" NHS Confederation

The consultation *Options for the Future of Payment by Results: 2008/09 to 2010/11* ran from March to June of 2007. This document outlines the key messages we received.

Who responded?

We received 281 representations, with over 80% coming from the National Health Service. Nine of the ten SHAs responded following co-ordinated discussion within their SHA, as well as 52 individual commissioners and 102 providers. We received 40 responses from clinical bodies. This document reflects the views of these groups where it is informative. We also received responses from individual clinicians, professional bodies, trade unions, and private companies.[1]

Strengthening the Building Blocks of PbR

Our proposed strategy for developing classifications of healthcare interventions involves looking abroad for 'off the shelf' replacements to our current classification systems (ICD and OPCS) whilst continually updating the current system. This was strongly supported, although there was no clear message on whether the updates should be annual or biennial. We encountered positive views on the feasibility of implementing the new system of currencies (HRG4) in 2009/10. Our approach to patient-level costing was particularly well received. The proposal to improve the timeliness of data flows was well received. The NHS Operating Framework for 2008/09 confirmed the move to 30 days and the NHS Standard Contract sets a more demanding target to be reached by April 2009.

Developing the National Tariff

There was notable support for the use of sampling as the basis of tariff calculation, and many useful suggestions for determining a representative sample that we will feed into our future work on this topic. Setting prices on a normative basis (as opposed to some form of 'averaging' of providers' reported costs) and further unbundling the tariff were both well supported, however significant minorities were opposed in both cases. We will take into consideration the concerns raised in our planning on these issues. We asked for examples of where the tariff acts as a barrier to commissioning care pathways and potential solutions to

[1] See Annex B for a full list of respondents

these problems, and received 138 responses that we will feed into our development work. Coding in community and outpatient settings was seen as very desirable, but its feasibility at present was questioned by a significant minority of respondents. Support for our proposals on developing PbR for specialised services outnumbered opposition by more than three to one. However, there were some mixed views from clinical bodies and single specialty hospitals, with whom we will continue to engage on the resolution of this issue.

The Future of Tariff Setting

A clear majority of those who commented were supportive of the new governance arrangements for tariff calculation, and the clinical bodies that commented were particularly in favour. Our proposal to introduce price signalling more than one year ahead received significant support, with more than 80% of respondents favouring the proposed approach.

Extending the Scope of Payment by Results

We proposed three incremental models of PbR as a basis for commissioning, namely '*Local Currency* + *Local Price*', '*National Currency* + *Local Price*', and '*National Currency* + *National Price*'. There was very substantial support for this concept. Mental Health emerged as a clear priority for future development of national currencies, and respondents identified Long Term Conditions as an area that would most benefit from a needs-based funding approach.

Specific Services

Annex B of the consultation document outlined proposals for seventeen specific services, and received strong support overall. Our proposals on four of the services received unanimous support (Adult Mental Health, Long Term Conditions, Preventative Services, and Outpatient attendances where a consultant is not clinically responsible, with more than 20 respondents commenting on each). Of the remaining 13 areas, all were supported by a factor of more than two to one, and the majority by much greater margins than this.

General Questions

Six themes emerged as clear priorities for respondents, namely: classifications, currencies, and casemix; expanding the scope of PbR; data quality; costing; tariff setting & governance; and prices that reflect quality and effectiveness. Over 120 respondents raised possibilities for piloting in PbR, and consequently over 50 PbR development sites are planning to run in 2008/09.

Key themes for Future Work

This document is a summary of consultation responses rather than a detailed work programme. However, we have highlighted some themes

for future work, including the need to ensure that PbR supports proposals emerging from the *Our NHS, Our Future* Review.

Impact Assessment

We sought respondents' views on the potential impact of PbR in terms of economic, social, environmental, and equality factors. There was particular interest in potential economic impacts, and potential impacts on some specific services were raised. Cabinet Office rules require formal equality screening to take place if significant issue are raised around the implementation of policy. We have concluded that it is not necessary at this stage. When each of the proposals is implemented, equality impact assessments will be undertaken taking into account the points made during the consultation process.

Introduction

This document provides a summary of responses received to the consultation *Options for the Future of Payment by Results 2008/09 to 2010/11*.

Payment by Results (PbR) was first introduced in 2003, and the consultation assessed how PbR could be further improved after its first few years of operation. The introduction of Payment by Results signalled a fundamental change in the funding of care commissioned by the National Health Service. For services under PbR, funding was now linked directly to activity. This necessitated a substantial cultural shift, not only in finance departments but for all professionals in the health service, with the aim of improving care for patients through improved utilisation of resources. PbR has grown over its four years of operation, and currently around 35% of PCT revenue allocations are subject to PbR. The consultation sought views from across the healthcare sector on how the Department should shape the next three years of PbR.

The consultation focused on five key areas:

- strengthening the 'building blocks' of PbR to ensure appropriate data underpin the transactions PbR enables
- refining the way the national tariff is constructed
- evaluating the governance arrangements that support tariff setting
- expanding PbR into new services
- considering proposals for PbR across seventeen specific services

A full list of questions asked in the consultation is available at Annex A.

We received almost three hundred substantive responses to our consultation and we are very grateful for such a high level of engagement.[2] Overall the response to our proposals has been positive.

In keeping with tariff timetables, some consultation topics relating directly to 2008/09 have been decided upon and were published as part of the 2008/09 tariff package in December 2007.[3] Where this is the case the

[2] For a full list of respondents, please see Annex B.

[3] For further details see: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081096

decisions took full account of the views heard in response to this consultation, and this document outlines what action has been taken.

PbR is not an end in itself, but a means of funding to support the objectives of the NHS. For this reason, many decisions regarding PbR for specific services will be taken in the context of ongoing policy work in these areas, and will be communicated as announcements are made in the coming year. A good example of this approach is the Cancer Reform Strategy[4], where development work on PbR was included to support the overall cancer policy objectives. The lessons from this consultation will inform this ongoing work across the Department.

[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

1. Analysing the responses

Who responded?

1.1 A total of 281 representations were received. For a full list of respondents please see Annex B. The table below gives a breakdown of those that responded across a variety of categories. Please be aware that the categories overlap, so the numbers will not sum.

Respondent Type	Number that responded
Strategic Health Authority	9
Primary Care Trust	31
Specialised Services Commissioner	11
Foundation Trust	28
Acute Trust	37
Mental Health / Learning Disability Trust	7
Other NHS	15
Independent Sector Provider	4
Individual - Clinical	20
Individual - Non Clinical	23
Royal College / Specialty Association / Other Clinical Body	40
Other Public Body	6
Company/Trade Association	12
Charity	19
Trade Union	2
Professional Body - Non Clinical	9
Other Non-NHS	9
NHS	172
Provider	102
Commissioner	55
Single Specialty Provider	14
Clinician View	62

1.2 Where relevant we have picked out specific groups in the analysis that follows. In particular, the views of the 40 clinical bodies are represented in the charts that accompany many of the questions below.

How We Analysed the Responses

1.3 Approximately 75% of the respondents used the structured proforma that accompanied the consultation. Across the questions, we employed a qualitative analysis of free-text comments with the aim of grouping the

responses in a way that would provide useful summary data. For instance, for many of the questions we sought to classify the 'General Impression' of the response from Strongly Positive to Strongly Negative, whilst also grouping particular points raised along common themes. Apart from three questions that particularly lent themselves to the method, we did not ask respondents to give their response along 'tick-box lines'.

1.4 Given the nature of the analysis, the percentages quoted through this document are almost all based on the interpretation of our analysts. They should therefore be used as a guide to the strength of respondents' views, rather than an absolute measure.

2. Strengthening the building blocks of Payment by Results

Classifications
Qu 2.1 – page 29

Do you agree with the strategy outlined for the development of classifications to support PbR?
Strongly Agree / Agree / Neither / Disagree / Strongly Disagree

"The ability to attract tariff for outpatient activity would probably provide a good incentive to overcome the coding barrier, in due course."
Association of British Healthcare Industries

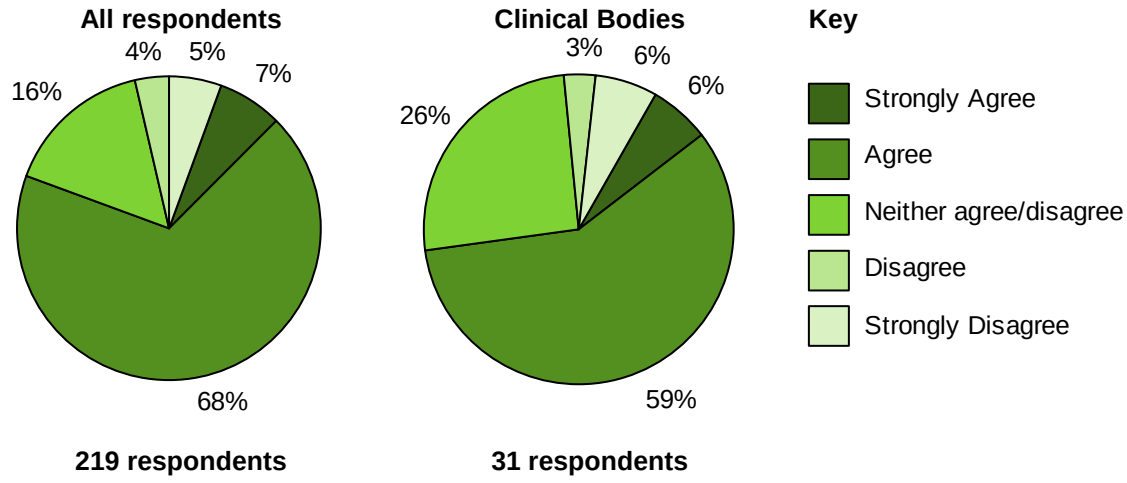
Proposals from the Consultation

2.1 With the involvement of NHS Connecting for Health and the Information Centre for Health and Social Care, the consultation proposed a review of options from extending OPCS beyond 2010/11, to replacing it with ICD-10-AM or another established system from abroad, including an examination of the implementation issues.

2.2 Whatever is decided, the future development of classifications will need to be compatible with our long-term strategy for integrated care records. This is likely to involve a mapping from READ and SNOMED CT clinical terminologies to standard classifications of diagnoses and interventions, at a more aggregate level.

Respondent Views

Do you agree with the strategy outlined for the development of classifications to support PbR? Strongly Agree / Agree / Neither / Disagree / Strongly Disagree



219 respondents **31 respondents**

2.3 Of 219 respondents, three quarters agreed or strongly agreed with our proposals, with less than ten percent opposed.

2.4 Prominent issues in the responses included the training and support available for clinical coders, and concerns around IT systems/suppliers. Over 40 respondents highlighted each.

Next Steps

2.5 We are continuing our work to review options beyond 2010/11.

Frequency of Classification Updates
Qu 2.2 – page 29

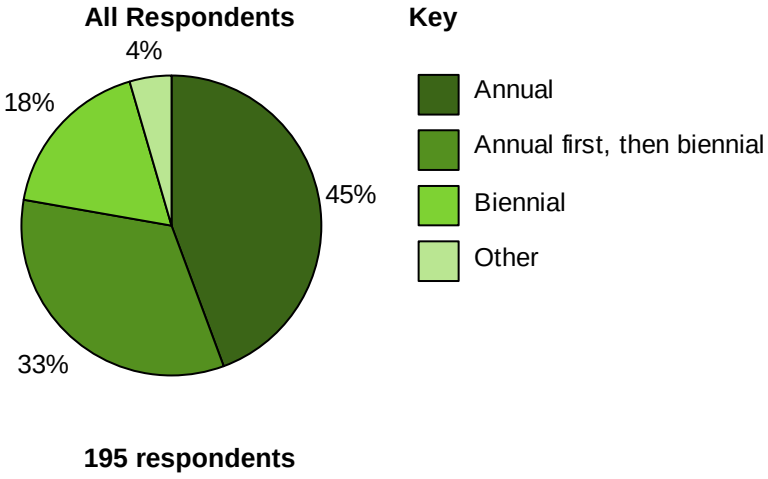
What is a reasonable frequency for implementing updates to the classification from 2008/09 onwards?
a) annual or b) biennial

Proposals from the Consultation

2.6 Until a replacement for OPCS can be implemented, annual updates to classifications will improve responsiveness of the system.

Respondent Views

Which approach did respondents prefer?



195 respondents

2.7 No clear consensus was evident, approximately half of the 195 respondents favoured annual updates, with one third favouring biennial.

2.8 Thirteen respondents preferred annual updates until the classification is more settled, and followed by biennial updates thereafter.

Currencies
Qu 2.3 – page 32

What steps should we take to ensure successful implementation of HRG4 in 2009/10?

"The implementation of HRG4 should assist in breaking down components of care within the tariff and more easily allow for elements of the care pathway to be provided by alternative providers." - Chartered Institute of Public Finance Accountancy

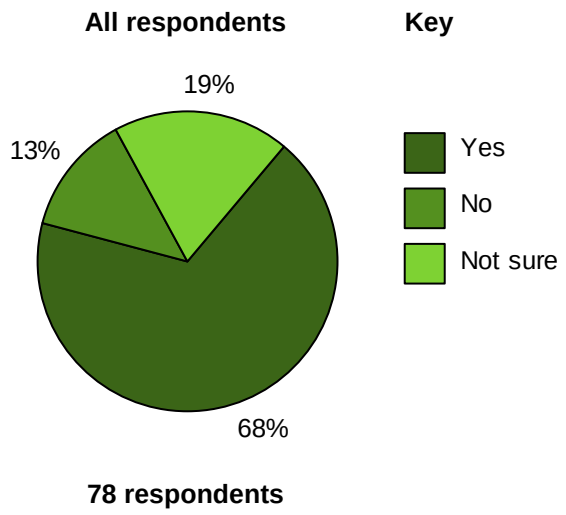
Proposals from the Consultation

2.9 A successor to HRG3.5 should, amongst other things, be 'setting independent' (focus on the service, irrespective of the location in which it is provided) and more granular (i.e. allow for greater differentiation between routine and complex work).

2.10 Our preference was to introduce HRG4 as an improvement on HRG3.5 and as a platform for the future development of currencies in acute care, rather than importing another system of currencies (for instance AR-DRGs). The introduction of HRG4 would take place from 09/10, and when evaluating further refinements we would specifically look at a potential hybridisation of the currency for PbR, reflecting the better aspects of the HRG and AR-DRG approaches.

Respondent Views

Do they think implementation by 2009/10 is feasible?



78 respondents

2.11 Of 78 respondents commenting, approximately two thirds were positive.

2.12 Only four clinical bodies commented, with three in favour and one undecided.

2.13 Significant issues raised include:

Issue	Number who highlighted
Timetable and process for 2009/10 tariff calculation and 'roadtesting' (i.e. full roadmap)	79
Risks associated with the quality of 2006/07 reference costs (the first to be based on HRG4)	55
Sufficient time to assess financial impact	48
Communications with clinicians on HRG4 must be improved	48
2007/08 reference costs data should inform 2009/10 tariff	26
Financial risk to organisation/services must be mitigated	24

Next Steps

2.14 We will continue to work towards the implementation of HRG4 from 2009/10 whilst taking into account the concerns of respondents. We remain committed to clearly communicating our timetables and carrying out road-testing to support the calculation of the tariff each year.

Costing
Qu 2.4 – page 34

Do you agree with our approach to implementing patient level costing?
Strongly Agree / Agree / Neither / Disagree / Strongly Disagree

"It is important that patient level costing is not seen as an academic exercise, solely for use at the centre, as accuracy of costing is clearly linked to its use for an organisation's own management purposes and so local ownership will be key."
The Audit Commission

Proposals from the Consultation

2.15 Linking patient-level information to costing presents an important opportunity to make a step change in the quality of cost data.

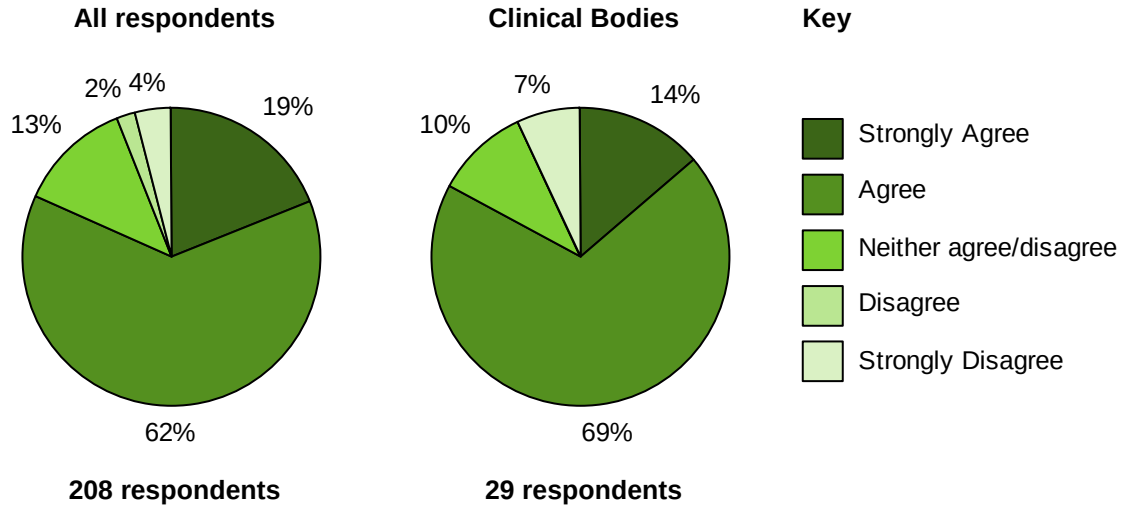
2.16 We would engage with suppliers of costing systems to the NHS to help ensure they are clear about what is required of their solutions.

2.17 We are establishing a clinical costing standards group to help in the production of guidance which will cover the costing standards and data sets (units of currency for each cost type, for example the number of minutes in theatre) needed to ensure some consistency of methodology between different providers.

2.18 We would set up a webpage to collate relevant information on patient-level costing in a single place. This is now available at: http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/NHScostingmanual/DH_080056

Respondent Views

Do you agree with our approach to implementing patient level costing?
Strongly Agree / Agree / Neither / Disagree / Strongly Disagree



2.19 Of 208 respondents, approximately eight in ten agreed or strongly agreed with our proposals. Twelve respondents disagreed or strongly disagreed.

2.20 More than 80% of providers that commented agreed or strongly agreed, including 30 out of 33 acute trusts.

2.21 27 respondents expressed support for national, mandatory collection of patient-level cost data, and nine expressed opposition.

2.22 50 respondents raised the importance of national clinical costing standards.

Next Steps

2.23 We will continue to work with the NHS and other stakeholders to support the implementation of patient-level information and costing systems.

Timeliness of data flows
Qu 2.5 – page 35

How realistic is it to deliver the proposed improvement in timeliness of data flows from 2008/09 and what issues need to be considered?

"There are a number of concerns about the performance of SUS that will need to be addressed because of its centrality to the operation of the system, if SUS is to become the single vehicle for defining PBR activity and transactions." – NHS Confederation

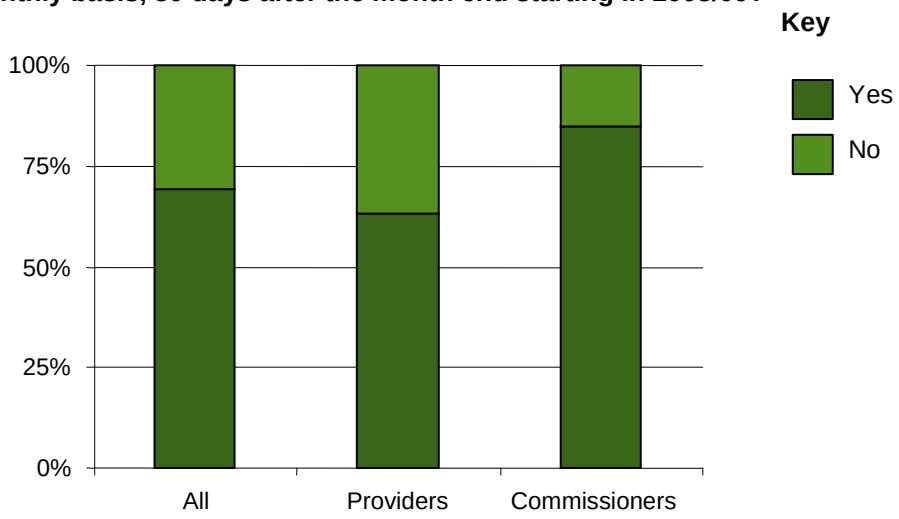
Proposals from the Consultation

2.24 Raise standards in relation to the timeliness of data from providers, whilst maintaining the requirement for prompt payment by commissioners:

2008/09	Proposal that providers' activity data finalised on a monthly basis, no later than 30 days in arrears of the month end
2009/10	Potential for continued improvement, e.g. provider activity data to be finalised within 14 days of the month end
2010/11	Potential for continued improvement, e.g. provider activity data to be finalised within 7 days of the month end

Respondent Views

On balance, is the respondent supportive of proposals to finalise activity data on a monthly basis, 30 days after the month end starting in 2008/09?



144 respondents, including 62 providers and 39 commissioners

2.25 Of 144 respondents, more than two thirds were supportive, although support was more pronounced amongst commissioners than providers.

2.26 Five out of seven SHAs that commented were supportive.

2.27 58 respondents raised the interaction with the PbR Secondary Uses Services (PbR SUS, the national reporting system for PbR implemented from 2006/07) as an issue for consideration.

2.28 66 respondents raised the resource implications involved in providing more timely data.

2.29 Proposals to finalise activity data at fourteen days in 09/10 and seven days in 10/11 were not supported. More than half the respondents opposed a fourteen day freeze, and approximately three quarters opposed a seven day freeze.

Action Taken for 2008/09

2.30 The NHS Operating Framework for 2008/09 confirmed that the information supplied 30 days after the end of each month will be the basis for payment reconciliation.

Next Steps

2.31 We are continuing our work to review options beyond 2010/11.

3. Developing the national tariff

Calculating the tariff using data from a sample of providers
Qu 3.1 – page 37

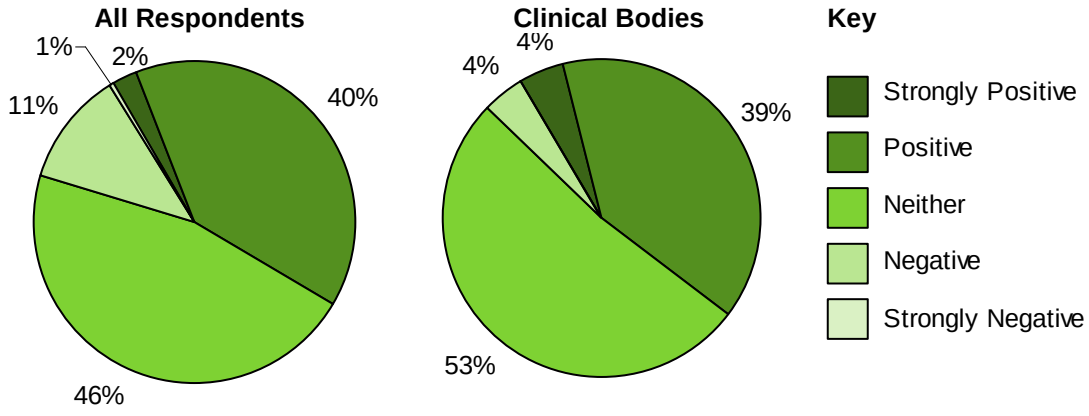
What particular issues do we need to consider in accrediting providers' data quality and in determining a 'representative' sample?

Proposals from the Consultation

3.1 We are currently examining the implications of using sampling techniques to calculate the tariff, with a view to their introduction to support the 2010/11 tariff calculation, which takes place in 2009/10. Thereafter, our expectation is that only data from accredited sites will feed into the tariff calculation.

Respondent Views

Do they have a general view towards the use of sampling?



167 respondents **23 respondents**

3.2 Of 167 respondents that expressed a general view, approximately four in ten were positive or strongly positive, and one in ten were negative or strongly negative.

3.3 Significant issues raised include:

Concern	Number who highlighted
Generic, or statistical concerns (e.g. sample size, spread in terms of geography, turnover, demography, audit commission ratings etc.)	143
Need for data accreditation (and hence close involvement of coders)	63
Criteria for selecting sample should emphasise quality/clinical outcome over efficiency/low cost	60
Continuing review and monitoring of accreditation standards and organisations	34
Avoiding skewing due to social/community care differences	22

Next Steps

3.4 We will continue to pursue options around calculating the tariff using data from a sample of providers, and are grateful for the comments that will help inform the most appropriate methods for sampling.

Prices that Reflect Quality and Effectiveness
Qu 3.2 – page 40

Does the approach outlined provide the right incentives for change that delivers quality care and value for money?

Proposals from the Consultation

3.5 There are instances where it is appropriate to take a more targeted approach to normative pricing, rather than simply using averages across all Trusts' reference costs.

3.6 We proposed working with our Clinical Advisory Panel to consider how PbR pricing can encourage a move to more efficient practice, especially in those areas where large gains can be made. We will therefore focus on high-volume healthcare resource groups (HRGs) in the first instance.

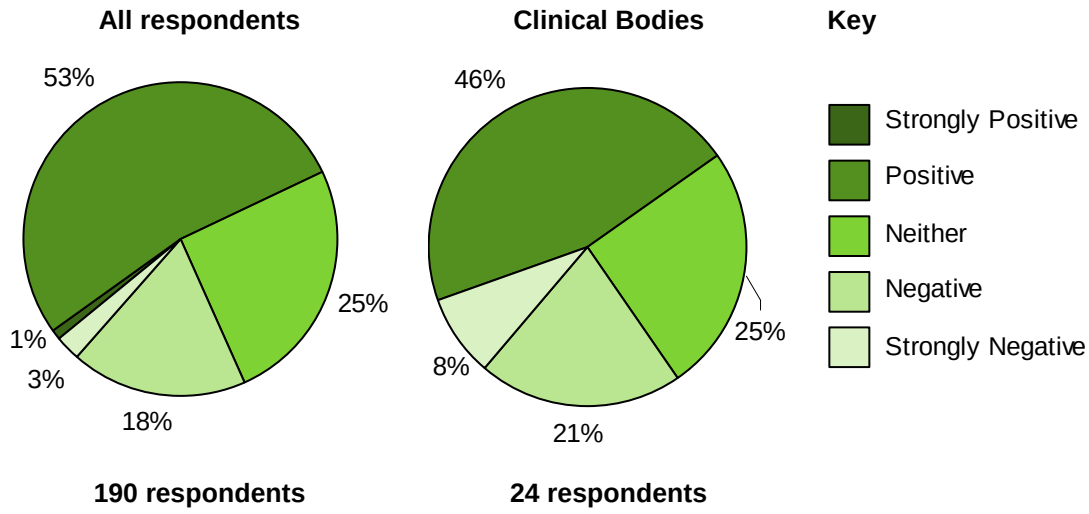
3.7 We stated an intention to ask the Clinical Advisory Panel to consider options on adjusting prices for six treatments, based on evidence from the NHS Institute for Innovation and Improvement's initial studies of efficiency in high-volume care:

- treatment of acute stroke
- caesarean section
- cholecystectomy
- primary hip replacements
- primary knee replacements
- treatment for fractured neck of femur

3.8 We propose that specific changes to tariff aimed at driving efficiency would be phased-in over a number of years, potentially to start in 08/09 and with the possibility of further expansion in subsequent years.

Respondent Views

What is their general view of normative pricing?



3.9 Of 190 respondents, just over half held positive or strongly positive views of normative pricing, whilst approximately one fifth were negative or strongly negative.

3.10 There was no significant variation between the views of commissioners and providers.

3.11 113 respondents highlighted the importance of quality & outcomes or clinical best practice, and 39 raised issues around clinical buy-in.

3.12 29 respondents expressed support for our targeted approach to normative pricing.

Action Taken for 2008/09

3.13 A number of normative adjustments were made to the 2008/09 tariff, including a new approach to supporting the implementation of NICE guidance. For 2008/09, a specific payment will be made when treating stroke patients with Alteplase, a NICE recommended drug.

Next Steps

3.14 Respondents' concerns centred around protecting and enhancing quality of care, and the need to provide incentives to do this. This suggests that our approach should focus on those areas where the use of the pricing mechanism can support improvements in the quality of patient care. We

propose to take forward the work outlined in the consultation document particularly focussing on the development of pathways and building on our approach to the NICE technical appraisal on the use of the drug Alteplase.

PbR Should Support Commissioning of Care Pathways
Qu 3.3 – page 43

Are there examples of where the tariff acts as a barrier to commissioning care pathways and, if so, what changes to the tariff structure would help overcome these problems (e.g. bundling or unbundling)?

Proposals from the Consultation

3.15 Our guiding principle is that PbR should support commissioning based on pathways by giving commissioners the flexibility to provide services closer to people's homes and to purchase acute and specialist care from the most appropriate provider.

Respondent Views

3.16 138 respondents gave an example of where the tariff acts as a barrier to commissioning of care pathways.

3.17 Issued raised included:

Issue	Number who highlighted
Perverse incentives (e.g. financial incentives to do more procedures; no incentive to provide support for self care; no incentive to provide rehabilitation; etc)	64
Partial coverage (e.g. Mental Health and Community Services excluded)	38
Need for more unbundling	33
Outpatient tariff structure (e.g. lack of granularity)	27
No recognition of support services (e.g. nutrition, therapies, genetics)	16

Next Steps

3.18 We will look into the potential conflicts raised in the responses, and scope possible solutions to the most pressing problems.

Unbundling the Tariff
Qu 3.4 – page 44

Given the approach outlined, what, if any, are the barriers remaining for unbundling tariffs?

Proposals from the Consultation

3.19 In 2008/09, we intend to fast track the 2006/07 reference cost data for a few HRGs as the basis for a wider range of indicative, unbundled tariffs than in 2007/08.

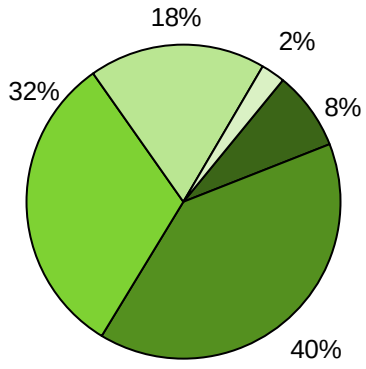
3.20 Introduction of HRG4 from 09/10 will alow unbundling of the national tariff for nine services: chemotherapy, radiotherapy, renal dialysis, rehabilitation, critical care, radiology, interventional radiology, high-cost drugs and specialist palliative care.

3.21 The overarching principle guiding our approach is that the acute tariff should be unbundled only for service items that are commissioned directly from primary care. By contrast, where secondary care clinicians are making the decisions on interventions, we propose to expand the use of casemix-based funding and to unbundle only high-cost, low-volume items. This does not, of course, constrain a provider's freedom to sub-contract where appropriate.

Respondent Views

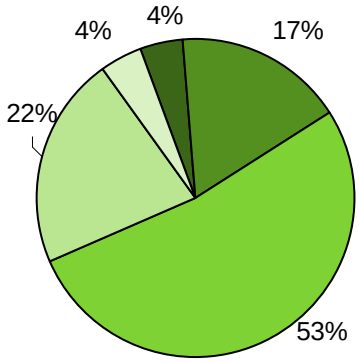
What is their general view towards unbundling?

All respondents



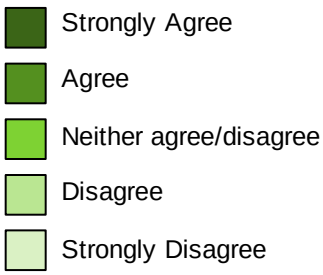
164 respondents

Clinical Bodies



23 respondents

Key



3.22 Of 164 respondents that expressed a general view towards unbundling, approximately half were positive or strongly positive and one fifth negative or strongly negative.

3.23 More commissioners than providers expressed positive or strongly positive views, with approximately two thirds in favour compared with just over one third of the providers.

3.24 59 respondents identified the need for greater transparency as to what is in and what is out of tariff as a prerequisite of unbundling.

3.25 59 respondents identified current information/IT systems as a barrier to unbundling.

3.26 Eleven gave examples of where more bundling up in the tariff would be useful.

Next Steps

3.27 We will continue to review the information and IT system requirements necessary for any further unbundling of the tariff.

Applying the Tariff to the Same Service in Different Settings
Qu 3.5 – page 47

Extending the use of HRGs to outpatient and community settings would require coding of activity in the same way as for admitted patient care where a procedure is undertaken. Is this a feasible proposition?

"It is not clear what the implications for coding would be. There is a shortage of coders in the NHS now. The practical ability to facilitate robust coding in primary care would need to be adequately thought through and planned for."
Chartered Institute of Public Finance Accountancy

Proposals from the Consultation

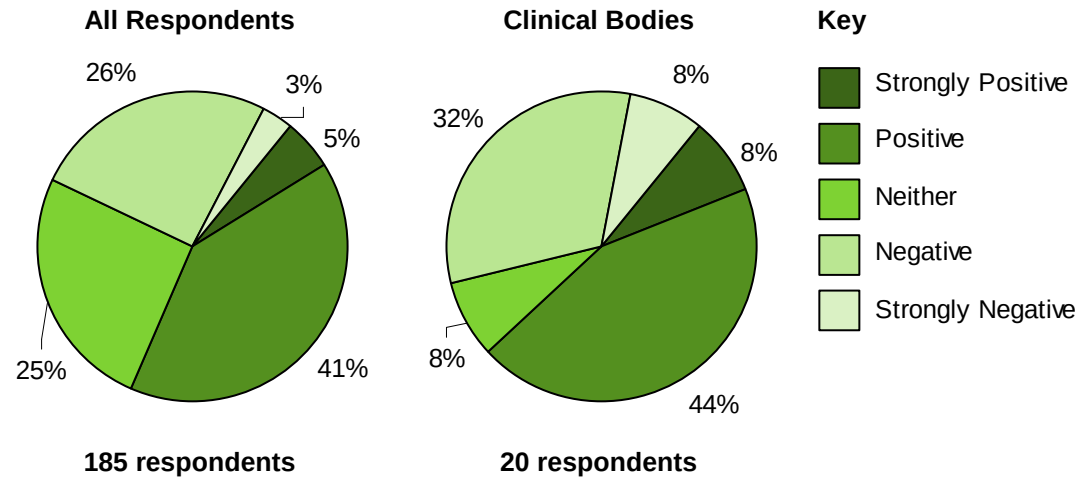
3.28 08/09 - HRG3.5 tariffs will continue to apply only to admitted patient care, day cases and services provided in community settings that are 'the same as' these.[5] There will be separate tariffs for a limited range of outpatient procedures and local flexibilities to support commissioning of additional procedures delivered in outpatient settings.

3.29 09/10 - Opportunity to apply HRG4 tariffs to activity delivered in outpatient and community settings, subject to coding of this activity in the same way as for admitted patient care. HRG4 has been developed with the principle of 'setting independence' in mind.

[5] For further details see paragraph 3.46 of 'Practice based commissioning: practical implementation', available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062703

Respondent Views

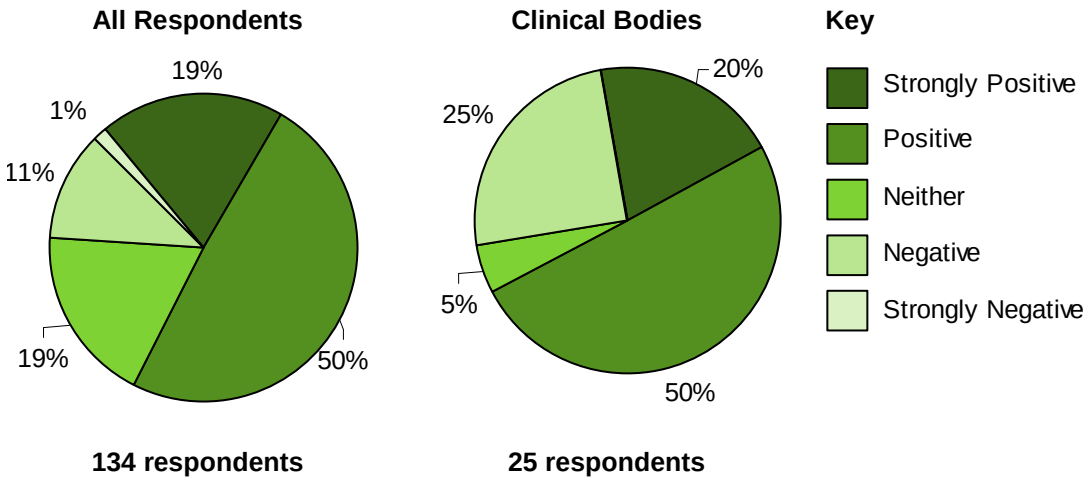
Do they consider coding in outpatient & community settings feasible?



3.30 Of 185 respondents, almost half were positive or very positive as to the feasibility of coding in outpatient and community settings, and approximately 30% were negative or strongly negative.

3.31 There was minimal variation between the opinions of commissioners and providers.

Do they consider coding in outpatient & community settings desirable?



3.32 Of 134 respondents, over two thirds were positive or very positive as to the desirability of coding in outpatient and community settings.

3.33 There was more support amongst providers than commissioners.

3.34 Six SHAs considered such coding desirable with none opposed.

3.35 Significant issues raised:

Issue	Number who highlighted
Problems with IT infrastructure or information systems	82
Clinical coding capacity	62
Need to consider appropriateness of setting independent tariffs on a case by case basis	40
Need for different prices to reflect differences in casemix across settings	38

Specialised Services
Qu 3.6 – page 50

What is the best way to refine the approach to funding specialised services in 2008/09 under HRG3.5, and in the future under HRG4, in a way that funds services not institutions?

Proposals from the Consultation

3.36 With HRG4 to be introduced for payment in 2009/10, we needed to take additional steps in 2008/09 to ensure specialised services are fairly rewarded. We considered the following measures:

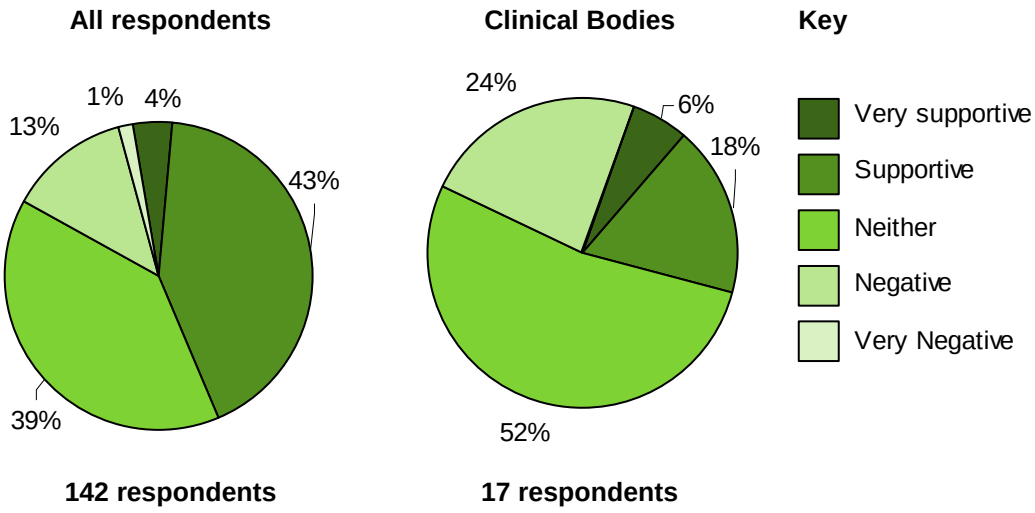
- further refinement of the relative weights of the specialised top-up payments
- basing prices for certain HRGs on the costs submitted from a sample of providers who deliver the highest volumes of activity in those HRGs
- better targeting of the specialised top-up payments: we could require in future that top-ups can be paid only where the provider is designated by specialised services commissioners, or we could replace top-ups altogether, replacing them with payments direct to providers designated by commissioners
- further exclusions from tariff
- where our work on 2008/09 identifies specific pricing issues – for example an HRG whose price appears anomalous – we will consider setting the price normatively with the advice of our Clinical Advisory Panel

3.37 Beyond 2008/09, we will continue to refine the scope and structure of the tariff to better reward specialist services. Current proposals include:

- the introduction of HRG4, which includes a number of more detailed HRGs that should better identify complex cases
- an improved approach for low-volume services with varying demand, and which have dedicated staff and/or facilities that cannot be put to alternative uses, for example infectious disease centres
- continued review of specialised top-ups
- continued review of exclusions from tariff

Respondent Views

On balance, are they supportive of DH proposals on developing PbR for specialised services?



3.38 Of 142 respondents, almost half were supportive or very supportive of our proposals on specialised services, less than 15% were negative or strongly negative.

3.39 61 providers commented, with 26 in positive and nine negative.

3.40 33 commissioners commented, with nineteen positive and three negative.

3.41 Five of eleven single specialty hospitals were supportive and three negative.

3.42 Respondents were 2:1 in favour of restricting eligibility for 'top-ups' to designated centres, with 42 commenting on this aspect.

3.43 40 respondents highlighted the importance of the roles of both specialist centres and local hospitals in clinical networks.

3.44 42 expressed a preference that top-ups be kept in HRG4, whereas nine said they should be removed.

3.45 23 asked for a review of exclusions.

3.46 14 expressed a desire for normative costing of specialist services (eg: using only costs from accredited centres to set the tariff).

Action Taken for 2008/09

3.47 2008/09 sees a refinement to the way in which top-ups for specialised activities are paid. The PbR specialist top-up percentages have been revised and in 2008/09 these top-ups will only be payable to a list of eligible organisations. As with 2007/08 top-ups will be triggered using primary diagnosis.

4. The future of tariff setting

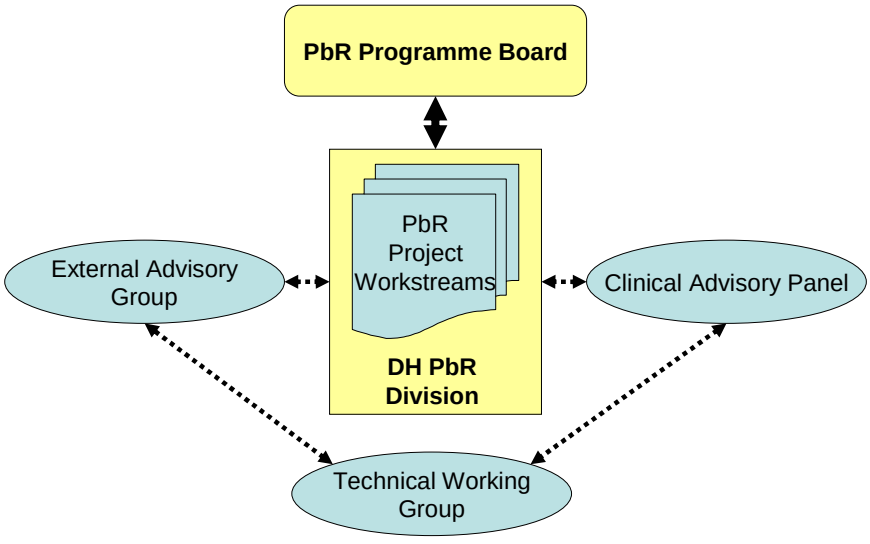
Governance
Qu 4.1 – page 56

Do our new arrangements for tariff setting provide the transparency that stakeholders want in a way that is consistent with the Secretary of State's responsibilities to operate within a fixed cash limit?

"We consider that these new arrangements for tariff setting do provide the transparency that stakeholders want and that they are in line with the Lawlor report."
The Association of Chartered Certified Accountants

Proposals from the Consultation

Payment by Results Governance Groups



4.1 **The Programme Board** is a small, focused group which meets monthly and is tasked with ensuring that the PbR team has an appropriate work plan and delivers the outputs of that programme on time and to budget. The Board has representatives from DH, the Information Centre, Connecting for Health and the NHS.

4.2 **The External Advisory Group** is a large, stakeholder body which meets at roughly six-weekly intervals and gives advice to ministers on the full range of PbR policy development. It has representatives from DH, the Information Centre, Connecting for Health, the NHS (organisations and workforce), the independent sector, social services, academics, other government departments and regulatory bodies such as Monitor, the Healthcare Commission and the Audit Commission.

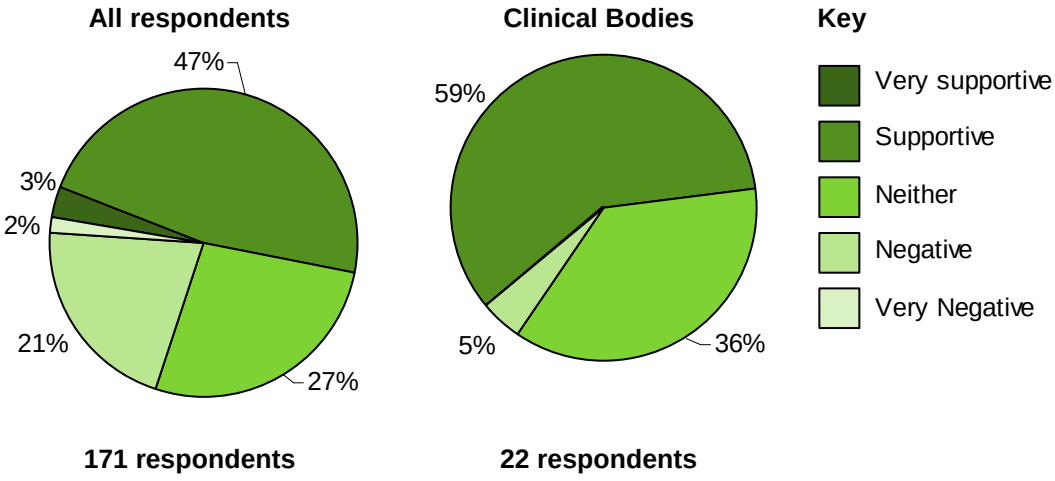
4.3 **The Clinical Advisory Panel** consists entirely of clinicians (doctors, nurses and allied health professionals) and meets quarterly to offer clinical advice, at a strategic level, on all aspects of PbR policy. The group will be supported by ad hoc sub-groups of relevant clinicians brought together as necessary by DH's clinical leads (the National Clinical Directors) throughout the year.

4.4 We proposed to keep open the option of contracting out tariff calculation, but first consider the impact of changes already made in light of the recent independent review.

4.5 We stated that for the time being price setting would remain within DH and subject to the final agreement of government ministers. PbR is not a sufficiently mature policy at this time to support a move to a more independent model akin to that used by the Bank of England Monetary Policy Committee.

Respondent Views

What is their general impression of our new arrangements with respect to transparency?



4.6 Of 171 respondents, half were positive or very positive regarding the transparency afforded by our governance arrangements. Just under a quarter were negative or very negative

4.7 Thirteen clinical bodies were positive towards the proposals, with only one negative response

4.8 21 respondents favoured an independent ‘Bank of England’ model for tariff setting

4.9 Nineteen favoured the introduction of independent reviews of tariff setting

4.10 44 requested full details be published of how tariff is calculated from reference costs

Multi-year Price Signalling
Qu 4.2 – page 57

Will the proposed arrangements for multi year price signalling (2008/09 – 2010/11) support better service planning, and what additional information would help improve this?

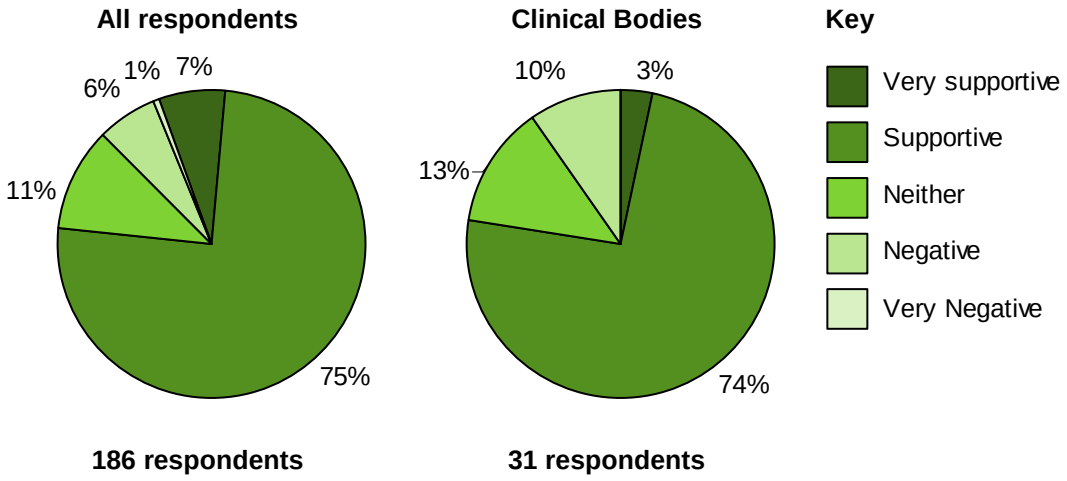
Proposals from the Consultation

4.11 Our expectations about the overall tariff increase, or at least some of the key variables, would be published over a multi-year period. For example, we might state our expectations about the overall annual uplift (which covers pay, prices and reform) for each of the next three years, and/or the corresponding efficiency assumptions. These could be expressed as a range.

4.12 Predicting individual HRG prices over multiple years would not be feasible given the extensive revisions to the 'Building Blocks' of PbR outlined in previous chapters.

Respondent Views

What is their overall view of multi-year price signalling?



4.13 Of 186 respondents, more than four fifths were positive of very positive towards multi-year price signalling, with only thirteen respondents opposed or strongly opposed.

4.14 71 respondents highlighted the benefits of multi-year planning assumptions such as pay and price inflation.

4.15 29 highlighted the benefits of multi-year efficiency requirements.

4.16 23 favoured some form of price stability, such as a multi-year fixed tariff.

Next Steps

4.17 There is clear support for price signalling beyond 2008/09. However, PCT allocations - which need to be taken into account in any future tariff uplift assumptions - have been set for 2008/09 only. Therefore, we will reconsider the publication of a set of pricing assumptions when PCT allocations are announced for 2009/10 and 2010/11 in summer 2008.

5. Extending the scope of Payment by Results

Three Generic Models of PbR
Qu 5.1 – page 59

Do the three proposed models of PbR offer a sound basis for expanding the scope of PbR in the future?
Strongly Agree / Agree / Neither / Disagree / Strongly Disagree

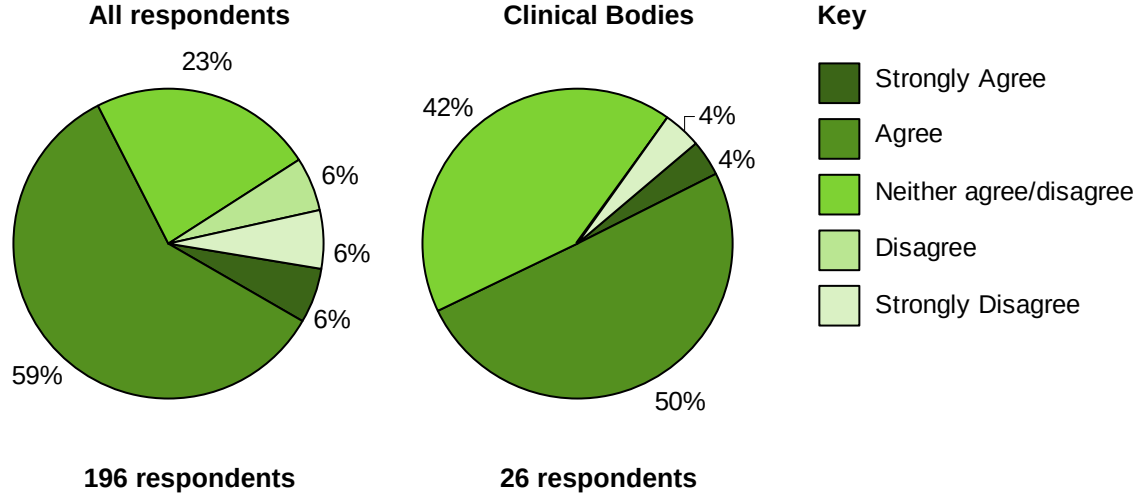
Proposals from the Consultation

5.1 We proposed to introduce three generic models of PbR based on the principle of linking funding to patient care. Our basic assumption is that nearly all services should be commissioned under one of the three models of PbR:

- Local Currency + Local Price
- National Currency + Local Price
- National Currency + National Price

Respondent Views

Do the three proposed models of PbR offer a sound basis for expanding the scope of PbR in the future? Strongly Agree / Agree / Neither / Disagree / Strongly Disagree



5.2 Of 196 respondents, approximately two thirds agreed or strongly agreed that the three models represent a sound basis for expanding the scope of PbR, and just over a tenth disagreed or strongly disagreed.

5.3 79 respondents acknowledged a need for local flexibility.

5.4 62 called for an expansion of PbR beyond acute services.

5.5 55 acknowledged the need to strengthen the building blocks of PbR as a prerequisite to expanding the scope of national tariff.

5.6 31 emphasised that 'national currency, national price' should be the direction of travel for all services.

5.7 27 called for a rules-based framework to cover 'local currency/local price'.

5.8 22 highlighted the need for clear criteria for any departures from the national tariff.

5.9 Seven respondents highlighted a further option to the three models proposed, that being a 'National indicative price', which could be used as a benchmark in preparation for a possible mandatory national price.

Next Steps

5.10 We will use the models above to provide the context for our planning as we evaluate proposals for expanding the scope of PbR, and will continue to use national indicative prices as a benchmark to aid local negotiations.

Criteria for applying PbR to different services
Qu 5.2 – page 62

How could the proposed criteria for applying the three models of PbR to different services be improved?

Proposals from the Consultation

5.11 As a minimum, contracts would need to include a requirement for providers to collect and report information to commissioners about the people who are accessing their services and the care provided, even where services are being funded on a block basis

5.12 To go further and develop national currencies and prices, we suggested applying a series of criteria underpinning 3 critical questions:

- Is a national currency appropriate?
- Is national pricing appropriate?
- Are conditions right for applying national prices, given where we are now?

Respondent Views

5.13 Overall, respondents were supportive of these criteria:

"The proposed criteria are comprehensive, clear and logical."
Newcastle upon Tyne Hospitals Foundation Trust

"The criteria are sensible."
Chartered Institute of Management Accountants (CIMA)

"The criteria are helpful in terms of deciding whether a service can be subject to national currency and pricing."
Allied Health Professionals Federation

5.14 A number of good suggestions were made for how the criteria should work in practice. It was proposed that "local" needed to cover a whole health economy and not just specific sites. Several respondents highlighted that as new national currencies were developed they should support patient pathways.

5.15 Others identified that whilst lack of information might in the short-term mean that 'Local Currency + Local Price' was appropriate, this should be the spur for national work to address data inadequacies. The "chicken and egg" scenario was also mentioned by some respondents i.e. that data would only improve once people think it will be used for a national tariff.

Priorities for Developing National Currencies
Qu 5.3 – page 62

Based on the proposed criteria, what are the priorities for developing national currencies?

"Current HRG development understandably focuses on larger volume episodes and specialities – there is a lack of clarity within smaller clinical specialities whether the HRG process will extend to them or whether the mechanisms to support costing are appropriate for small specialities with low patient numbers, diverse service configurations and dealing with expensive low-volume long-term care for conditions." Royal College of Physicians

Proposals from the Consultation

5.16 See Qu 5.2 on previous page.

Respondent Views

5.17 17 service areas were raised as possible candidates for future development of national currencies.

5.18 Mental Health emerged as clearly favoured, with 48 respondents highlighting it as a priority.

5.19 The table below outlines the numbers of respondents who suggested each area as a priority:

Area	Number who suggested
Mental health	48
Community Based Services	35
Critical Care	33
Urgent / Emergency Care	25
Long Term Conditions	24
Telephone Services	18
Maternity (inc: Midwifery)	17
Cancer (inc: Palliative care, Chemotherapy)	16
Rehabilitation	14
New HRG 4 Areas	13
Learning Disabilities	13
Pathology	9
Renal Services	8
Primary Care	8
Health Promotion/screening	6
Burns	4
Nutrition	4

Next Steps

5.20 Mental Health emerges as a clear priority for expanding the scope of PbR, and we will take this forward as part of our core agenda for the coming year. We will also continue to work on the potential expansion of PbR to the other priority areas highlighted, especially Community Services, Critical Care, Urgent and Emergency Care (including Ambulances), and Long Term Conditions.

Needs-based Funding
Qu. 5.4 – page 67

Which areas of healthcare could most benefit from a needs-based funding approach?

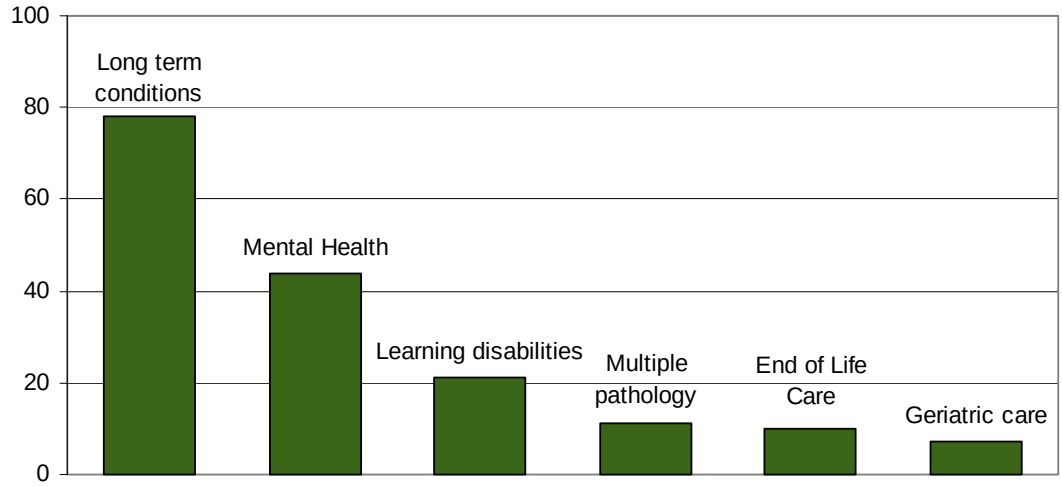
Proposals from the Consultation

5.21 Needs-based funding may be most appropriate as a tool for allocating budgets to primary care or other 'principal providers' that have a role in commissioning services for particular client groups as well as provision. However, this is very much emerging thinking and we need to wait for progress on defining concepts such as a 'Year of Care' for conditions such as diabetes before we can properly consider the implications for national currencies and tariffs.

5.22 A further extension of this concept would be to introduce a person-specific element to capitation-based funding. We have asked the Advisory Committee on Resource Allocation to consider and recommend new ways of allocating resources down to practice level, based on actual patient characteristics, to deliver fairer shares. Our aim is for the research to inform an approach to allocating budgets for practice based commissioning that would take greater account of the needs of people registered with particular practices.

Respondent Views

Number of respondents who support candidates for needs based funding:



5.23 Six areas were raised by respondents as candidates for a needs-based funding approach, with Long Term Conditions the most popular candidate.

Next Steps

5.24 As findings from the ongoing work on a ‘Year of Care’ approach for diabetes become apparent, we will evaluate options around implementing a needs-based funding approach for these services.

6. Specific Services

Annex B – Specific Services
Qu. B.1

If you have any comments on the extension of PbR to the services outlined in Annex B, please list them below, specifying which services your comments relate to.

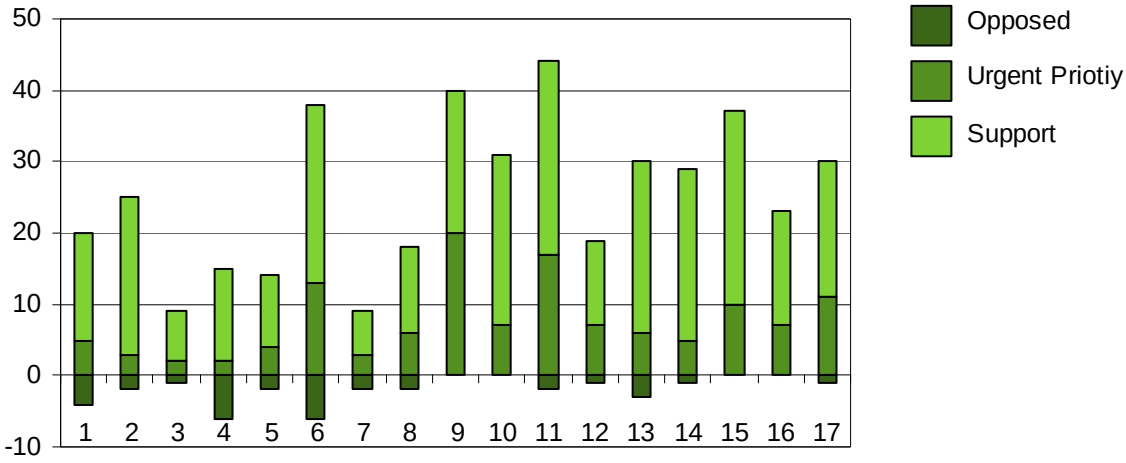
Proposals from the Consultation

6.1 This document was an annex to the consultation. It contained more detailed information on plans to develop PbR for a number of specific service areas, as follows:

1. Urgent and emergency care
2. Attendances at A&E, minor injury units, urgent care centres and NHS walk-in centres
3. Primary care 'out of hours' services
4. Emergency admissions
5. Observation / assessment or similar units – paying for very short stays
6. Critical care
7. Emergency ambulance services
8. Patient transport services and hospital travel cost scheme
9. Adult mental health services
10. Outpatient attendances where a consultant is not clinically responsible
11. Telephone consultations
12. Maternity services
13. Community-based alternatives to hospital care
14. Community services
15. Long-term conditions care
16. Preventative services
17. Sexual health services

6.2 For further detail on each of the proposals individually, please refer to the consultation document. The graph below outlines the level of support encountered for each proposal (using the reference numbers from the list above):

Number of respondents who supported/opposed our proposals on specific services



6.3 Support was unanimous on four of the proposals:

- Adult Mental Health
- Long Term Conditions
- Preventative Services
- Outpatient attendances where a consultant is not clinically responsible

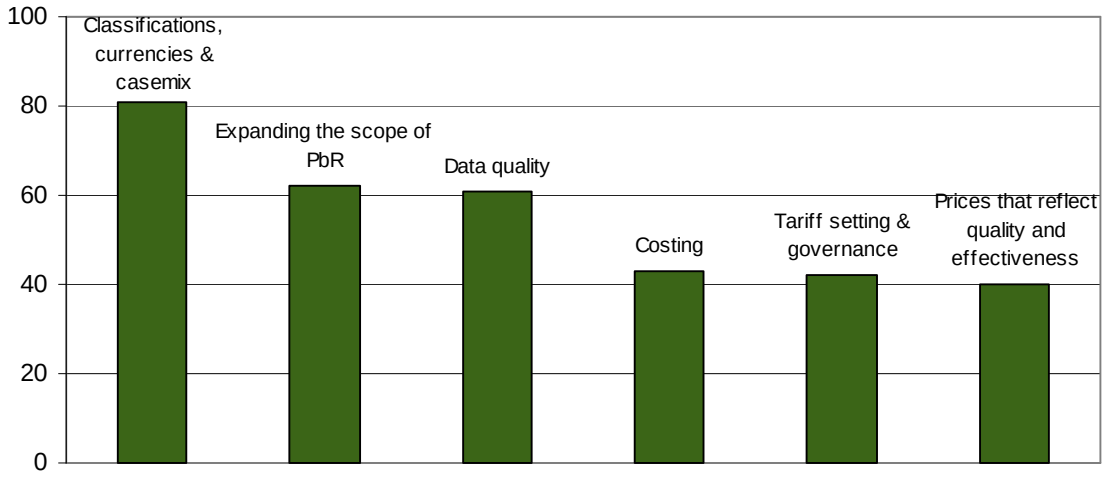
6.4 Of the remaining thirteen areas, all were supported by a factor of more than two to one.

6.5 There was particularly high support for proposals on telephone services, critical care, sexual health, community alternatives to hospital care, and community services.

7. General questions

Qu. G.1

Of the issues discussed in this document, which are the three most important and should therefore be prioritised?



7.1 Respondents' comments were grouped into broad categories. The chart above shows the six categories that were the most prominent, namely:

- Classifications, currencies, and casemix
- Expanding the scope of PbR
- Data quality – Including clinical coding and guidance
- Costing – Including patient-level costing, and reference costs
- Tariff setting & governance – Including timetabling and clarity of national standards
- Prices that reflect quality and effectiveness

7.2 The response echoes the prominence given to the 'building blocks' of PbR in the original consultation document, ie: classifications, currencies, casemix and costing. With appropriate focus on these building blocks it is possible to have increasing confidence in the allocation of funds that PbR brings about, and we will continue to pursue improvements in this fundamental area.

Qu.G.2

Do you have any ideas for developing PbR that you would wish to pilot? If so, please express your interest here to allow us to pass on to the relevant SHA or to the FT Network as appropriate.

7.3 We received over 120 expressions of interest in piloting under our 'Development Sites' project. The sites fall into two broad categories. For services currently outside the scope of tariff, sites will be testing new currencies, datasets, etc that might form the basis of tariff in the future. For services currently within the scope of tariff, sites will be investigating alternative currencies or funding models that might form the basis of improved tariffs nationally.[6]

7.4 Since the consultation closed, we have been working closely with SHAs to develop the initial ideas into operational pilots for 2008/09. More than 50 sites are now entering the final planning stages. A full list of pilots will be available on the PbR website early in 2008: www.dh.gov.uk/pbr

Qu.G.3
If you have any additional comments on any aspect of the consultation document, please list here.

7.5 The comments in response to this question have been fed into specific topic areas addressed through this document. Below are some more general observations:

"We believe that the introduction of Payment by Results has been effective in providing transparency and promoting efficiency, as it was designed to do. However, we believe that the government needs to acknowledge the limitations of PbR and that it cannot rely on PbR to improve quality." - The Health Foundation

"It has been a useful exercise to go through the document which appears to have been carefully thought out." – The British Pain Society

"Whilst such a system will require development over time to resolve the issues that emerge, even in its present state as a somewhat blunt tool, [PbR] has been used successfully as a catalyst for change, with the organisation, and wider health community seeing significant benefits from the financial transparency PbR brings." The Rotherham NHS Foundation Trust

"Overall we were encouraged by the consultation document; the process appears genuine and numerous options are given."
Association of Chartered Certified Accountants (ACCA)

[6] Projects will not involve changes to price alone

"We… remain concerned that the complexity of many services is not adequately incorporated into the principles of PbR – the multidisciplinary nature of services, the lack of distinct interventions, the lack of clarity of outcomes in mental health, the need to develop networks of care." - Royal College of Paediatrics and Child Health

"For the future an outcome based PbR should be an urgent consideration, leading to more cost effective and efficient patient care." - Southampton City PCT

"As PbR becomes more complex care should be taken not to divert a disproportionate amount of NHS resources into administrative and payment systems rather than delivery of patient care." - North West London Hospitals NHS Trust

"It is reassuring that this document identifies a good understanding of a number of problems faced at ground level. The recommendations generally appear achievable and are not overly ambitious." - Milton Keynes PCT

8. Key themes for future work

8.1 This document outlines the responses we received to the consultation *Options for the Future of Payment by Results: 2008/09 to 2010/11*. It does not outline a full programme of future work. Many of the decisions that need to be taken on specific questions and for specific services are part of ongoing work that will be resolved over the coming months. This document is one vital part of that process. Further announcements on PbR can be expected as policy directions are set in specific areas (for example as part of the Cancer Reform Strategy published in December 2007), and in light of broader directions for the Department and service as a whole (such as those contained within the *Our NHS, Our Future* review led by Lord Darzi).

8.2 That said, we are able to give some broad thinking on the way ahead:

8.3 **Getting the Building Blocks Right:** One of our key priorities must be to ensure that the building blocks for PbR – classifications, coding, casemix, costing and currencies – are as robust as possible. Improving these will be an iterative process to give us a more clinically meaningful and patient-focused payment system.

8.4 **Fit With the *Our NHS, Our Future* Review**: The future development of PbR must support the findings emerging from Lord Darzi's *Our NHS, Our Future* review. This will mean developing a tariff that supports the localising of care where possible and the centralising of treatment where necessary. We need to examine the effect on casemix of shifting care out of hospitals. We also need to consider how PbR can better support the functioning of clinical networks and co-operation between providers.

8.5 **Expanding the Scope:** Based on the consultation response, we have been given a clear mandate to progress work in a number of areas. Our five priority areas will be:

- Mental health services
- Community services
- Critical care
- Urgent and emergency care (including Ambulances)
- Long term conditions care

8.6 Whilst these service areas are the priorities for PbR development work, this does not preclude work in other areas if resources are available.

8.7 **Locally driven:** We want to encourage local involvement in the development of PbR. PbR must not be a reform done to the NHS, but one developed by, and with, hospitals, PCTs and SHAs. This local involvement is at the heart of our use of development sites and the encouragement of local innovation. We will be seeking to foster dialogue and share learning across the NHS.

8.8 **Clinically led:** For PbR to have the greatest impact it has to involve clinicians. We are trying to involve clinicians at every level from the specific currency development work done by the Information Centre's Expert Working Groups to the overall clinical scrutiny provided by the Clinical Advisory Panel. To truly gain clinicians' support for PbR, more thought will need to be given to how PbR supports the goals of quality and safety.

9. Impact assessment

9.1 All Government departments are required to subject new policy initiatives to a process known as Impact Assessment, including equality screening. This is to ensure that proposals that are chosen from a range of options are those that best achieve their objectives while minimising costs and burdens. Impact assessments ensure that those who are interested in a policy can understand and challenge:

- why the Government is proposing to intervene
- how and to what extent new policies may impact on them
- the estimated costs and benefits of proposed and actual measures

9.2 The impact assessment for this consultation has been undertaken to the policy development stage, and we have concluded that final assessments should take place, and be published, as and when each strand of the policy is taken forward.

9.3 Below is a short summary of the responses we received to our questions regarding the impact of the proposals in the consultation document.

Economic, Social or Environmental Impacts
Qu I.1

Would any of our proposals lead to economic, social or environmental impacts on you or your organisation?

9.4 73 respondents commented on this question. A substantial proportion gave general comments around PbR being a system of funding, and hence having the capacity by its nature to have an economic effect. Some fleshed this out further to discuss the possible impact on jobs if Trusts faced financial hardship because of PbR. Others raised the fact that HRG4 and the expansion of unbundling will bring many financial unknowns.

9.5 There were a few services where respondents raised specific concerns about the current funding situation, with paediatrics and specialised services receiving multiple mentions. Also some respondents were worried that services outside PbR might be disadvantaged by a potential knock on effect of budgets being devoted to services provided under

tariff. Mental Health and Preventative Care were both highlighted as examples.

9.6 Expenditure on IT and coding requirements to support PbR was raised as an economic impact. The potential for coding to distract clinicians, or increase workplace stress, was raised as a social impact with the potential to affect quality of care. However, other respondents highlighted the fact that the improved data provided by PbR can help to make better care decisions.

9.7 Queries were also raised as to the methodology underpinning Market Forces Factor (MFF) payments, as incorrect payment could disadvantage one community over another.

9.8 The potential for PbR to improve resource utilisation was raised as the main positive economic impact. Possible social benefits included the potential for PbR to support the provision of more localised services.

Equality Impact Assessment
Qu E.1

Please outline any ways in which the PbR policy described in this document may impinge on human rights.

9.9 33 respondents chose to address this issue. Some were not critical of the proposals and had chosen to comment on things which would, in their view, support human rights eg care pathway and packages approaches. Others raised issues which were not specifically associated with the proposals in the consultation but were general points such as concerns that the existing tariffs were insufficient to support particular services or that services currently outside the scope of PbR were being disadvantaged.

Equality Impact Assessment
Qu E.2

Please outline any way in which the PbR policy described in this document may discriminate or cause inequality relating to groups covered by equality legislation: race, disability, gender, age, sexual orientation and religion and belief.

9.10 43 respondents commented. Many of the issues raised were generic and not specific to PbR eg people from socially disadvantaged backgrounds finding it more difficult to access care. A number of respondents were particularly concerned with how the tariff currently

reimburses services for children with disabilities and a number of others were concerned that “high cost” patients could be discriminated against. Again these are points which do not appear to apply in particular to the proposals which were contained in the consultation but could be considered to apply to the current operation of PbR.

Equality Impact Assessment
Qu E.3

Please outline any way in which the PbR policy described in this document may discriminate or cause inequality relating to groups covered by equality legislation: race, disability, gender, age, sexual orientation and religion and belief.

9.11 27 respondents chose to answer this question. Amongst the points made were that a needs-based approach to tariff development should enable the tariff to be more closely aligned with the needs of different groups; that the proposals should lead to more equitable distribution of reimbursement; that the proposals should help to better target reimbursement and that normative pricing could be an incentive to improve clinical quality.

Conclusion

9.12 In the light of the responses to the equality impact assessment questions we considered, at a meeting with representatives of other policy areas, if there was a need to engage in formal equality screening of the proposals contained in the consultation document. We have concluded that this is not necessary – at this stage - but that as and when each of the proposals is taken forward, equality impact assessments will be undertaken, taking into account the points made during the consultation process.

Annex A:What We Asked

Strengthening the building blocks of PbR

Classifications
Do you agree with the strategy outlined for the development of classifications to support PbR?
Strong agree / Agree / Neither / Disagree / Strongly Disagree

Frequency of classification updates
What is a reasonable frequency for implementing updates to the classification from 2008/09 onwards; a) annual; or b) biennial?

Currencies
What steps should we take to ensure successful implementation of HRG4 in 2009/10?

Costing
Do you agree with our approach to implementing patient level costing?
Strong agree / Agree / Neither / Disagree / Strongly Disagree

Timeliness of data flows
How realistic is it to deliver the proposed improvement in timeliness of data flows from 2008/09 and what issues need to be considered?

Developing the national tariff

Calculating the tariff using data from a sample of providers
What particular issues do we need to consider in accrediting providers' data quality and in determining a 'representative' sample?

Prices that reflect quality and effectiveness
Does the approach outlined provide the right incentives for change that delivers quality care and value for money?

PbR should support commissioning of care pathways
Are there examples of where the tariff acts as a barrier to commissioning care pathways and, if so, what changes to the tariff structure would help overcome these problems (e.g. bundling or unbundling)?

Unbundling the tariff
Given the approach outlined, what, if any, are the barriers remaining for unbundling tariffs?

Applying the tariff to the same service in different settings
Extending the use of HRGs to outpatient and community settings would require coding of activity in the same way as for admitted patient care where a procedure is undertaken. Is this a feasible proposition?

Specialised services

What is the best way to refine the approach to funding specialised services in 2008/09 under HRG3.5, and in the future under HRG4, in a way that funds services not institutions?

Future of tariff setting

Governance
Do our new arrangements for tariff setting provide the transparency that stakeholders want in a way that is consistent with the Secretary of State's responsibilities to operate within a fixed cash limit?

Multi-year price signalling
Will the proposed arrangements for multi year price signalling (2008/09 – 2010/11) support better service planning, and what additional information would help improve this?

Extending the scope of payment by results

Three generic models of PbR
Do the three proposed models of PbR offer a sound basis for expanding the scope of PbR in the future?
Strong agree / Agree / Neither / Disagree / Strongly Disagree

Criteria for applying PbR to different services
How could the proposed criteria for applying the three models of PbR to different services be improved?

Priorities for developing national currencies
Based on the proposed criteria, what are the priorities for developing national currencies?

Needs-based funding
Which areas of healthcare could most benefit from a needs-based funding approach?

General

Of the issues discussed in this document, which are the three most important and should therefore be prioritised?

Do you have any ideas for developing PbR that you would wish to pilot? If so, please express your interest here to allow us to pass on to the relevant SHA or to the FT Network as appropriate.

If you have any additional comments on any aspect of the consultation document, please list here.

Annex B

If you have any comments on the extension of PbR to the services outlined in Annex B, please list them below, specifying which services your comments relate to.

Economic, social or environmental impacts

Would any of our proposals lead to economic, social or environmental impacts on you or your organisation?

Equality Impact Assessment

Please outline any ways in which the PbR policy described in this document may impinge on human rights.

Please outline any way in which the PbR policy described in this document may discriminate or cause inequality relating to groups covered by equality legislation: race, disability, gender, age, sexual orientation and religion and belief.

Please outline any way in which the PbR policy described in this document may protect human rights and promote equality (within race, disability, gender, age, sexual orientation and religion and belief) and prevent inequality.

Annex B:Who Responded?

This section lists all respondents to the consultation. An asterisk denotes that the respondent was used to form the 'Clinical Bodies' graphs in the main document.

- Advanced Medical Technology Association
- Age Concern
- Allied Health Professions Federation, representing: Society and College of Radiographers, Society of Chiropodists and Podiatrists, Chartered Society of Physiotherapists, British and Irish Orthoptic Society, British Association of Art Therapists, British Association of Dramatherapists, College of Occupational Therapists, Royal College of Speech and Language Therapists, British Association of Prosthetists and Orthotists, Association for Professional Music Therapists *
- Ashford & St Peter's Hospitals NHS Trust
- ASSIST - The National Association for Health Information Professionals
- ASSISTA Ltd
- Association for Clinical Biochemistry
- Association of British Clinical Diabetologists *
- Association of British Dispensing Optician (ABDO), Association of Optometrists (AOP), the College of Optometrists, and the Federation of Ophthalmic & Dispensing Opticians (FODO) *
- Association of British Healthcare Industries (ABHI)
- Association of British Neurologists *
- Association of Chartered Certified Accountants (ACCA)
- Association of UK University Hospitals
- Assura
- Audit Commission
- Barnet PCT
- Barts & The London NHS Trust
- Berkshire Healthcare NHS Foundation Trust
- Bexley Care Trust
- Birmingham Children's Hospital NHS Foundation Trust
- Birmingham East & North Birmingham PCT
- BLISS
- Boston Scientific UK & Ireland
- Bradford & Airedale Teaching PCT
- Breakthrough Breast Cancer
- British Academy of Childhood Disability *
- British Association for Community Child Health (BACCH) *
- British Association for Paediatric Nephrology *
- British Association for Sexual Health and HIV (BASHH) *
- British Dietetic Association
- British Elbow & Shoulder Society *
- British Geriatrics Society *
- British In Vitro Diagnostics Association (BIVDA)
- British Infection Society
- British Medical Association - Health Policy & Economic Research Unit *
- British Paediatric Mental Health Group *

- British Paediatric Neurology Association*
- British Pain Society *
- British Sleep Society *
- British Society of Paediatric and Adolescent Rheumatology *
- British Society of Rehabilitation Medicine (BSRM)
- British Thoracic Society *
- Brook Advisory Centre
- Buckinghamshire Hospitals NHS Trust
- Buckinghamshire PCT
- BUPA
- Cambridge University Hospitals NHS Foundation Trust
- Camden PCT
- Central Surrey Health
- Chartered Institute of Management Accountants (CIMA)
- Chelsea & Westminster Hospital NHS Foundation Trust
- Cheshire & Merseyside Data Quality & Clinical Coding Team
- Chesterfield Royal Hospital NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- Clinician, A Birmingham PCT
- Clinician, Mayday NHS Trust
- Clinician, Medical School, University of Nottingham Queen's Medical Centre
- Clinician, Nutrition & Dietetic Services, Parkside Community Health Centre, Leeds PCT
- Clinicians, Leeds Teaching Hospital Trust, Senior Medical Staff Committee, Leeds Local Medical Committee and Leeds PCT PEC
- College of Emergency Medicine *
- College of Occupational Therapists *
- Commissioning & Costing & Business Planning Department, Gateshead Health NHS Foundation Trust
- Consultant in Contraception & Sexual Health, Derbyshire County PCT
- Consultant in Paediatric Neurodisability at Great Ormond Street Hospital
- Consultant in Public Health Medicine, Dorset Primary Care Trust
- Consultant Orthopaedic Surgeon, Southampton University Hospitals NHS Trust
- Consultant Paediatrician, Barnsley Hospital NHS Foundation Trust
- Consultant Paediatrician, Bradford Teaching Hospitals NHS Foundation Trust
- Consultant Paediatrician, Calderdale & Huddersfield NHS Foundation Trust
- Consultant Paediatrician, Countess of Chester NHS Foundation Trust
- Consultant Paediatrician, East Lancashire Hospitals NHS Trust
- Consultant Paediatrician, Hinchingbrooke Health Care NHS Trust
- Consultant Paediatrician, St George's Healthcare Trust
- Consultant Paediatrician, West Sussex PCT
- Consultant Physician (diabetes), Newcastle PCT and Newcastle Upon Tyne Hospitals Foundation Trust
- Consultant Psychiatrist, Coventry & Warwickshire Partnership Trust
- Countess Mountbatten House Specialist Palliative Care Service (part of Southampton University Hospitals NHS Trust
- Countess of Chester Hospital NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- Croydon PCT
- Cumbria Partnerships NHS Trust
- Cystic Fibrosis Trust
- Derby City PCT
- Derby Hospitals NHS Foundation Trust

- Derbyshire County PCT
- Devon PCT
- Devonshire Partnership Trust
- Doctors.net.uk
- Doncaster & Bassetlaw Hospitals NHS Foundation Trust
- Dorset Healthcare NHS Foundation Trust
- East Kent Hospital Trust
- East of England Specialised Commissioning Group & the 14 EoE PCTs on behalf of whom they commission specialised services
- Equalities & Human Rights Group
- Faculty of Family Planning & Reproductive Health Care *
- Family Planning Association
- Finance Department, Royal Marsden NHS Foundation Trust
- Finance Manager, Telford & Wrekin PCT
- Foundation Trust Network (NHS Confederation)
- Gateshead Health NHS Foundation Trust
- General Surgery Directorate, Sheffield Teaching Hospitals NHS Foundation Trust
- Genetics Consortium and South East England Genetics Clinical Network
- Great Ormond Street Hospital for Children NHS Trust
- Guy's & St. Thomas' NHS Foundation Trust
- Hammersmith Hospitals NHS Trust, London
- Hampshire Partnership NHS Trust
- Hampshire PCT
- Healthcare Financial Management Association (HFMA)
- Healthlogistics.co.uk Limited
- Heart of Birmingham Teaching PCT
- Help the Hospices
- Hemina Ltd
- Herefordshire PCT
- Heywood, Middleton & Rochdale PCT on behalf on commissioning PCTs in the Pennine Care NHS Trust
- Hill & Knowlton Ltd
- Hillingdon PCT
- Hull Teaching PCT (including specific response from Hull & East Yorkshire Hospitals NHS Trust)
- Improvement Foundation Ltd
- Independent Advisory Group on Sexual Health & HIV (SHIAG)
- Independent Midwives Association (IMA) *
- Individual - Anonymous
- Individual Clinical Coder
- Individual Clinical Coding Manager, A Community Hospital in South East England
- Individual, Centre for Sexual Health & HIV Research, Royal Free & University College Medical School
- Individual, Dermatology Department, Great Ormond Street Hospital
- Individual, Dietetic Services, Northern Lincolnshire & Goole NHS Trust
- Individual, East Riding of Yorkshire PCT & NHS Yorkshire & The Humber
- Individual, Finance and Information, Kingston Hospital NHS Trust
- Individual, Information, Poole Hospital NHS Trust
- Individual, Occupational Therapy Services, St Marys NHS Trust
- Individual, Paediatrics, Stockport NHS Foundation Trust
- Individual, Performance Review, Milton Keynes General NHS Trust
- Individual, Physiotherapy, South Devon Healthcare NHS Foundation Trust
- Individual, Radiology, Southampton University Hospitals NHS Trust

- Individual, Sexual Health, Camden PCT
- Individual, Southampton University Hospitals NHS Trust
- Individual, Therapy Services, Manchester PCT
- Individual, Women's Services, Arrowe Park NHS Trust
- Institute of Biomedical Science
- Isle of Wight PCT
- Johnson & Johnson
- Joint Epilepsy Council of the UK & Ireland - representing: Brainwave – The Irish Epilepsy Association, David Lewis Centre for Epilepsy, Enlighten – Tackling Epilepsy, Epilepsy Action, Epilepsy Bereaved, Epilepsy Connections, Epilepsy Research UK, Epilepsy Scotland, Epilepsy Specialist Nurses Association, Epilepsy Wales, Epilepsy West Lothian, Gravesend Epilepsy Network, Gwent Epilepsy Association, International League against Epilepsy (British Branch), The Meath Epilepsy Trust, Mersey Region Epilepsy Association, National Centre for Young People with Epilepsy, National Society for Epilepsy, Organisation for Anti-Convulsant Syndrome, Quarriers, St. Elizabeth's Centre
- Kettering General Hospital
- King's Fund
- Kyphon UK
- Leeds General Infirmary
- London Ambulance Service NHS Trust
- London Levy Review Group
- London Network of Nurses & Midwives Sexual Health Working Group *
- London Provider Group
- London Sexual Health Commissioning Network (Commissioners from 31 PCTs in London)
- London Specialised Commissioning Group
- Mayday University Hospital & St Helier Hospital - on behalf of the GUM Service Delivery Subgroup of SWAGNET (South West London HIV & Gum Clinical Services Network)
- Member of Parliament
- Mental Health Executive Working Group for the NHS Information Centre, Casemix Service *
- Mental Health Foundation
- Mental Health Network (NHS Confederation)
- Mid Trent Critical Care Network
- Milton Keynes PCT
- Monitor
- Multiple Sclerosis Society
- National Association for Colitis & Crohn's Disease (NACC)
- National Childbirth Trust
- National Haemoglobinopathy Screening and Services Development Group *
- National Institute for Health and Clinical Excellence (NICE)
- National Institute for Mental Health in England
- New Ways of Working for Primary Care Mental Health, Peninsula Medical School
- Newcastle Upon Tyne Hospitals Foundation Trust
- NHS Confederation (excluding FTs)
- NHS Counter Fraud & Security Management Service
- NHS Direct
- NHS East Midlands
- NHS East of England
- NHS North West
- NHS Sickle Cell & Thalassaemia Screening Programme

- NHS South Central
- NHS South West
- Norfolk Suffolk and Cambridgeshire Neonatal Network / East of England Specialised Commissioning Group
- North East Essex PCT
- North East London Specialised Commissioning Group (in their role as management leads for the London & South East Coast Burns Consortium)
- North East SHA
- North Lincolnshire PCT
- North Tees and Hartlepool NHS Trust
- North West London Hospitals NHS Trust
- Northern Devon Healthcare NHS Trust
- Northern Specialised Commissioning Core Team
- Northumberland Tyne & Wear NHS Trust
- Nottinghamshire Healthcare NHS Trust
- Nuffield Orthopaedic Centre NHS Trust
- Oxfordshire & Buckinghamshire Mental Health Partnership Trust
- Oxfordshire Learning Disability NHS Trust
- Oxfordshire PCT
- Pan Thames Paediatric BMT Consortium
- Papworth Hospital NHS Foundation Trust
- Parkinson's Disease Society
- Partnerships for Children, Families & Maternity (Department of Health)
- Physiotherapist, Gateshead Health NHS Foundation Trust
- Physiotherapist, North Staffordshire Primary Care Trust
- Physiotherapist, St George's Healthcare NHS Trust
- PIAG
- Plymouth Hospitals NHS Trust
- Portsmouth City Teaching PCT
- Portsmouth Hospitals NHS Trust
- Renal Community Response initiated by the National Clinical Director for Renal Care *
- Roche Products Limited
- Rotherham NHS Foundation Trust
- Rotherham PCT
- Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
- Royal College of General Practitioners*
- Royal College of Paediatrics & Child Health *
- Royal College of Physicians *
- Royal College of Psychiatrists *
- Royal Free Hampstead NHS Trust
- Royal Liverpool Children's NHS Trust
- Royal Marsden NHS Foundation Trust
- Royal National Orthopaedic Hospital
- Royal Wolverhampton Hospitals NHS Trust
- Salford Royal NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- Sandwell and West Birmingham Hospitals NHS Trust-The Birmingham and Midland Eye Centre
- Severe Acute Pulmonary Failure (SAPF) Consortium, North West London Specialised Commissioning

- Sexual Health National Support Team, Health Improvement Directorate, Department of Health
- Sheffield Teaching Hospitals NHS Foundation Trust
- Shropshire County PCT
- SNOMED in the Structured electronic Record Programme (SSeRP)
- Society & College of Radiographers - Radiotherapy Advisory Group *
- Somerset PCT
- South Birmingham PCT
- South Devon Healthcare NHS Foundation Trust
- South East Coast SCG & the 8 SEC PCTs that they commission specialised services on behalf of: Brighton & Hove City PCT, Eastern & Coastal Kent PCT, East Sussex Downs & Weald PCT, Hastings & Rother PCT, Medway PCT, Surrey PCT, West Kent PCT & West Sussex PCT
- South East Coast SHA
- South Tyneside NHS Foundation Trust
- South Warwickshire General Hospitals NHS Trust
- Southampton City PCT
- Southampton University Hospitals NHS Trust
- Southend University Hospital Foundation Trust
- Specialised Commissioning Team West Midlands
- Specialised Healthcare Alliance
- Specialist in Diabetes and Endocrinology, North Cheshire Hospitals NHS Trust
- Specialist Orthopaedic Alliance, Royal National Orthopaedic Hospital NHS Trust, Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust, Nuffield Orthopaedic Centre NHS Trust, Wrighton, Wigan and Leigh NHS Trust, Royal Orthopaedic Hospital NHS Foundation Trust
- St George's Healthcare NHS Trust
- Stockport NHS Foundation Trust
- Stockport Primary Care Trust
- Sussex Acute Commissioning Service
- SWL Specialised Commissioning Team
- Tees Esk and Wear Valleys NHS Trust
- Tees Valley & South Durham Critical Care Network
- Terence Higgins Trust
- The Association of the British Pharmaceutical Industry (ABPI)
- The British Psychological Society *
- The British Society for Rheumatology *
- The Cardiothoracic Centre - Liverpool NHS Trust
- The Chartered Institute of Public Finance & Accountancy (CIPFA) Health Panel
- The Health Foundation & leaders from various NHS organisations (not specified)
- The London HIV Consortium (commissioning HIV treatment & care on behalf of the 31 London PCTs)
- The National Council for Palliative Care
- The Professional Association of Clinical Coders (PACC-UK)
- The Royal College of Midwives *
- The Royal College of Pathologists *
- The Royal College of Surgeons of England *
- The Royal Liverpool and Broadgreen University Hospitals NHS Trust
- The Walton Centre for Neurology & Neurosurgery NHS Trust
- Trust Health Limited
- UNISON
- Unite - Amicus Section
- United Kingdom Genetic Testing Network (UKGTN)

- United Lincolnshire Hospitals NHS Trust
- University College London Hospitals NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust/ SUS PbR User Assurance Group
- University Hospital Birmingham NHS Foundation Trust
- University Hospital of North Staffordshire NHS Trust
- University Hospitals Coventry & Warwickshire NHS Trust
- Walsall Hospitals NHS Trust
- West Middlesex University Hospitals NHS Trust
- West Midlands SHA
- Yeovil District Hospital NHS Foundation Trust
- Yorkshire & Humber SHA & the response is the feedback from an SHA wide consultation event hosted by the SHA

Summary of Responses to Consultation: Options for the Future of Payment by Results: 2008/09 to 2010/11 is available to view or download from www.dh.gov.uk/publications.

We may also provide *Summary of Responses to Consultation: Options for the Future of Payment by Results: 2008/09 to 2010/11* in braille, on audio-cassette tape, on disk and in large print, on request.