

• INCENTIVES FOR REFORM IN THE NHS

**An assessment of current incentives in the south-east
London health economy**

Jenny Grant

As part of its continuing efforts to reform the NHS, the government has introduced a number of incentives to help the health sector meet national targets and objectives for improving care. This paper examines whether these incentives are helping or hindering progress. Its findings are based on interviews with health sector representatives in south-east London. The paper makes a number of recommendations for how incentives can be better aligned at a national level, and also highlights actions that local agencies – such as strategic health authorities – can take.

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About the author

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Jenny Grant
September 2005

Glossary

Care pathway

An approach to managing a specific disease or clinical condition that identifies what interventions are required, and sets out the various stages of care through which a patient passes and the expected outcome of treatment. The approach is designed to ease the journey of the patient through the health care system by co-ordinating their primary, secondary and tertiary care.

Commissioning

Commissioning relates to the purchasing and contracting of health care services. It is a broad term that covers a range of activities. A distinction can be drawn between two levels of commissioning: service planning and design, which involves identifying population need, determining priorities, understanding the market, and defining by whom, where and how services should be purchased; and the daily purchasing of services, which involves managing contracts and spending budgets.

Foundation trusts

NHS foundation trusts were first set up as a result of the Health and Social Care (Community Health and Standards) Act 2003, when ten top-performing hospitals were selected for foundation status by the Healthcare Commission. More hospitals have become foundation trusts since then. Although remaining part of the NHS, foundation trusts are subject to reduced control from central government. They differ from traditional NHS trusts in three main ways: they possess the freedom to decide locally how to meet their obligations; they are accountable, through (mainly elected) governors, to their members, who are drawn from local residents, patients and staff; and they are authorised and monitored by Monitor, the Independent Regulator of NHS Foundation Trusts.

GMS contract

On 20 June 2003, GPs accepted a new General Medical Services (GMS) contract, negotiated by the British Medical Association (BMA) and the NHS Confederation. The terms of this contract mean that payments to GPs are more closely related to the quantity and quality of the services they provide.

Health economy

A health economy refers to the totality of the providers and purchasers within a given geographical area.

Payment by Results

Payment by Results is a new funding system for care provided to NHS patients, which pays health care providers on the basis of the work they do adjusted for case-mix. It does this by paying a nationally set price or tariff for similar groups of patients, known as health care resource groups (HRGs), based on the historic national average cost of providing services to those HRGs. The fixed tariffs for specified HRGs are set by the Department of Health and are intended to avoid price differentials across providers that could otherwise distort

patient choice. Payment is on a per spell basis, where a spell is defined as a continuous period of time spent as a patient within a trust, and may include more than one episode.

The aim of Payment by Results is to provide a transparent, rules-based system for paying NHS trusts. It hopes to reward efficiency, support patient choice and diversity, and encourage strategies for achieving sustainable reductions in waiting times.

Purchaser

A budget-holding body that buys health or social care services from a provider on behalf of its resident population or service users.

Provider

An organisation that provides health or social care services under contract arrangements to a purchaser.

Unbundling and bundling

Under the Payment by Results system, trusts are reimbursed per spell, categorised by HRG. There are debates as to whether the HRG categories accurately reflect the cost of providing services, and whether they are flexible enough to incorporate varying treatment patterns.

When people refer to ‘unbundling’ the tariff, they mean making the cost of each component of the HRG transparent. This would allow different organisations to carry out different parts of the treatment. For example, unbundling the tariff for an HRG that includes a hospital procedure and after care, means that the after care can be administered in the community, with both the hospital and community provider accurately reimbursed for the work that they do.

Conversely, when people talk about ‘bundling’ the tariff, they mean budgeting for whole patient pathways or treatment programmes, which allows the individual components to be negotiated locally.

Introduction

The NHS has been subjected to continuous pressure to reform in recent years, in particular since publication of *The NHS Plan* in 2000 (Department of Health 2000a). Through this, and subsequent publications, the government has articulated its vision for the NHS. Recent policies have been accompanied by a cluster of incentives to drive change in the NHS. These include a mixture of top-down performance management and regulatory initiatives, along with stronger market-style incentives, such as:

- national targets, for example the four-hour wait target in accident and emergency (A&E) departments, supported by performance management, to guarantee rapid access
- a requirement for NHS trusts to achieve financial balance on an annual basis to facilitate system-wide accountability for local expenditure
- Payment by Results (PbR), which links hospital income with activity to create the basis for patient choice
- plurality of providers, in particular introducing competing providers from outside the NHS, to extend patient choice
- practice-based commissioning and the new General Medical Services (GMS) contract, to encourage services to be responsive to local needs
- foundation trusts, which have greater financial freedoms and new governance arrangements to encourage services to be locally responsive
- two regulators, Monitor and the Healthcare Commission, which have been set up to identify the need for action to counter poor performance and to maintain an element of central control
- the transfer of the NHS budget to primary care trusts (PCTs) to increase local purchasing power.

These individual elements of NHS reform have been designed to promote changes in service delivery in line with the vision for the NHS as set out in *The NHS Plan* (Department of Health 2000a) and subsequent policy initiatives. The Plan itself reflected the findings of earlier policy reviews, both for London and England as a whole, which argued for a rebalancing of the delivery of care away from acute hospitals in favour of a greater role for primary care and community-based services.

Simon Stevens (2004) – former health advisor to Number 10 Downing Street – has described the chronology of reform in three phases. According to Stevens, the first phase included a strong focus on top-down activities and setting national standards and targets to standardise care across providers. This required collaboration between the various service providers. The second phase was dominated by decentralisation, with attempts to shift the balance of power on to local organisations. The third phase has involved giving patients more choice and introducing market-style incentives to stimulate improvements in efficiency and quality – so-called ‘constructive discomfort’.

The present system of incentives comprises elements of all three phases. During phases two and three, the Department of Health has been modestly reducing command and control over the NHS through devolving the majority of the NHS budget to PCTs and introducing new freedoms for acute trusts (foundation status), individual practices (through practice-based commissioning) and individual patients (through patient choice). However, a significant element of central control has been maintained through national objectives, standards and targets, and through performance management.

This paper considers whether the current system of incentives is ‘fit for purpose’, that is, do the various elements combine effectively together to guide the local NHS as it attempts to meet national targets and promote the broad objectives set out in *The NHS Plan*, such as improved access and better quality care? Or, on the contrary, do they work against each other, making it harder for local organisations to meet all the targets and objectives they have been set?

To answer this question the research has examined one health economy – south-east London – as a case study. It is at a local level that tensions between the various elements of the incentive system are likely to be most apparent, as individual organisations attempt to meet the targets and objectives they have been set. For example, local organisations need to collaborate to create patient-focused care for complex services, such as cancer care. But, at the same time, some incentives, such as payment reform and the increased emphasis on financial sustainability, are encouraging organisations to pursue their own agendas.

Some of the incentives create tensions between organisations. For example, PbR and other incentives encourage hospitals to protect income and maximise activity. However, if PCTs manage patients with chronic disease better, the result would be a loss of income for hospitals.

Other tensions are organisation-specific. For example, PCTs have purchased higher levels of hospital activity in order to meet the nationally imposed elective care targets, and have also needed to meet the cost of rising levels of emergency admissions. As a consequence, finance for other services, such as mental health, has been squeezed. Similarly, there is little residual budget for investment in public health initiatives aimed at preventing illnesses. Initiatives that receive central funding, for example smoking cessation, are exceptions.

The key questions that the research in south-east London investigated were:

- How do national policies impact at a local level?
- How far are tensions in the current policy framework, as outlined above, perceived to be important in the field by those responsible for implementation?
- What solutions are being pursued locally?

The research examined four areas.

- **Competition and collaboration** Can competition – encouraged by the financial regime, new payment systems and foundation status – and collaboration between trusts co-exist?
- **Managing demand for care** Do policies designed to create better access generate extra demand in the system and increase the pressure on services?

- **Transfer of services from hospitals to primary or community settings** Do current incentives enable PCTs to do this?
- **The role of the district general hospital (DGH)** Does the financial pressure on services and stronger market-style incentives challenge the sustainability of weaker organisations, especially smaller DGHs?

The project used three methods: a literature review, interviews and quantitative analysis. Most of this paper is based on the information generated by the interviews, as a key objective of the fieldwork was to identify the perceptions of people working in the health economy. The interviews were conducted with chief executives, chairs and finance directors from each trust in the South East London Strategic Health Authority. The research also included broader discussions with other organisations including the South East London Cancer Network, the Department of Health strategy team, and Matrix Research and Consultancy (for a list of interviewees, *see* Annexe 1, pp 25–6).

This report is divided into four sections:

- The health economy in south-east London
- Interviews
- Discussion
- Next steps.

The health economy in south-east London

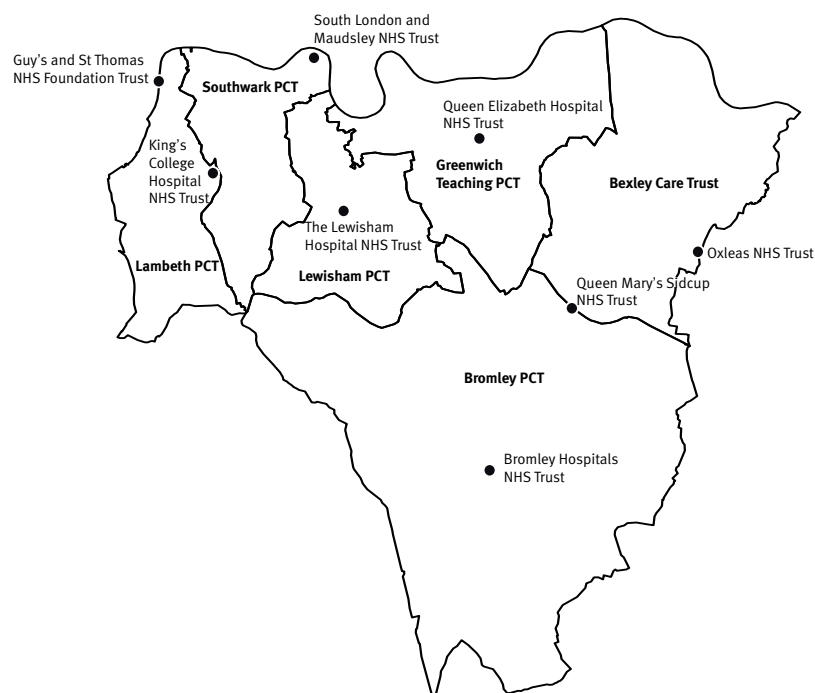
South-east London was chosen as the area for investigation as it exemplifies the key issues that the health sector is experiencing across London, and throughout the NHS as a whole.

Historically the sector has performed well relative to the rest of London. It has more general medical services of better quality, the lowest overall length of inpatient stay and the lowest overall hospitalisation rate in London. The pattern of finished consultant episodes is typical of London as a whole (King's Fund London Health Commission 1997).

Following the so-called Tomlinson Review (Department of Health and Department for Education 1992) and other London-specific reviews during the early 1990s, some rationalisation of services took place in this sector. This included a reduction in the number of beds, the merger of the Guy's and St Thomas' NHS Trusts, and a review of the distribution of specialised services.

There are now 14 trusts in this area: six primary care trusts (PCTs) and eight NHS trusts comprising two mental health trusts, two teaching hospitals and four district general hospitals (DGHS) (see Figure 1, below).

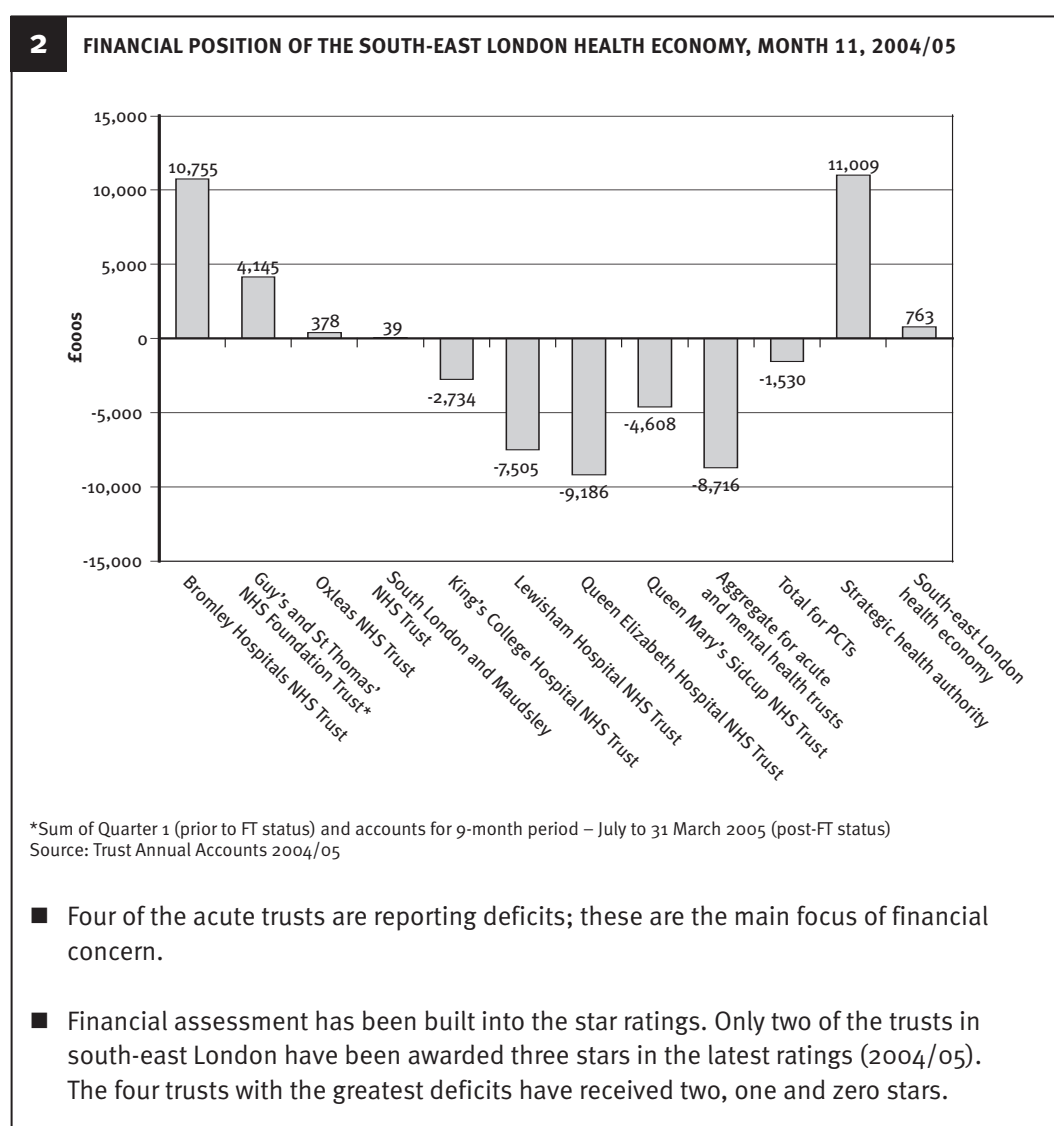
1 MAP OF THE SOUTH-EAST LONDON HEALTH SECTOR



Source: King's Fund 2005

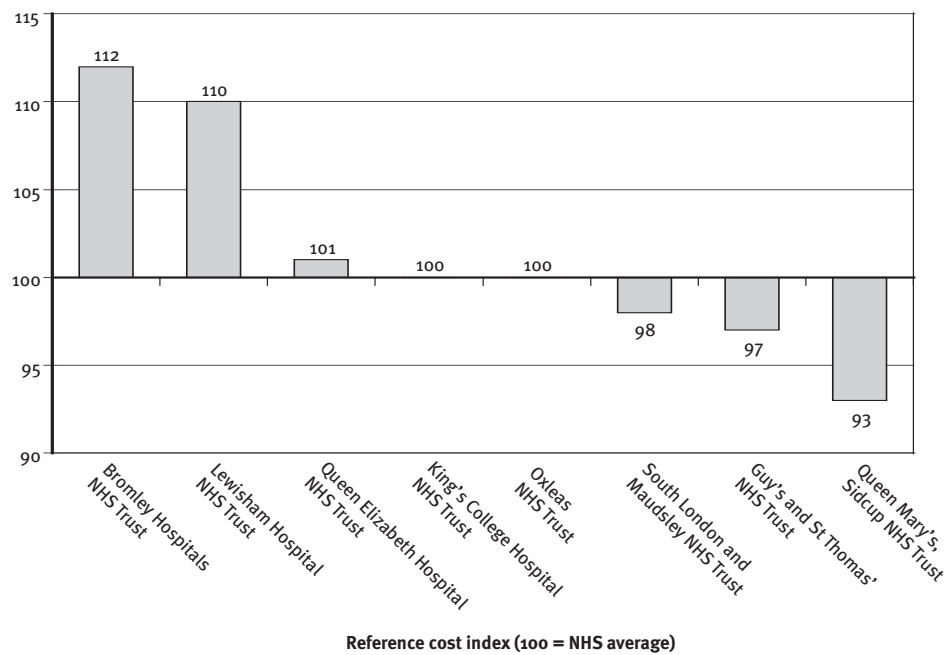
The financial situation of these organisations ranges from a deficit of £9.2 million to a surplus of £12.3 million (see Figure 2, below). The Reference Cost Index, which compares the actual cost of an organisation's activity with the same activity at national average costs (set to 100), ranges from 78 to 146 (see Figure 3, opposite).

Figures 4 and 5 (see p 8, 9) highlight that, as with the rest of the NHS, the use of health care has been rising, especially emergency admissions. This has contributed to the strain on organisations as the acute trusts are under pressure to deliver the rise in activity, and PCTs are under pressure to finance it. As Figure 6 (see p 10) shows, secondary care dominates PCT expenditure.



3

REFERENCE COSTS FOR SOUTH-EAST LONDON, 2004

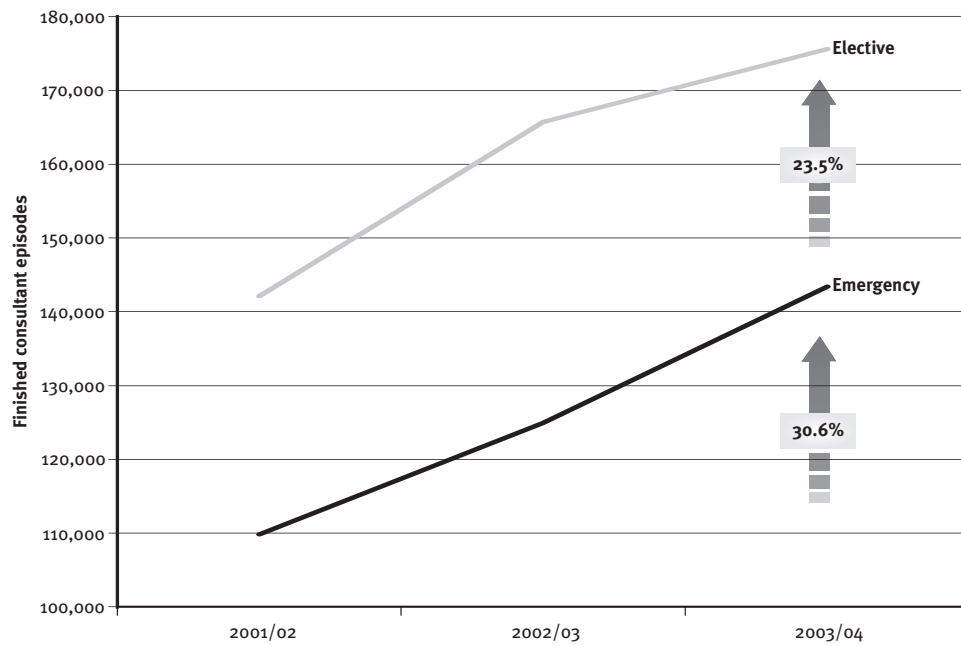


Source: Department of Health (2005a)

- Trusts with higher than average costs on aggregate (scoring over 100) will make losses under Payment by Results (PbR) as reimbursement levels will be less than costs.
- The tariff is recalculated every year, placing constant pressure on trusts to secure cost efficiencies.
- High-cost trusts need to make greater than average cost savings in order to improve their position.
- Two of the trusts in south-east London are in particularly unfavourable positions.

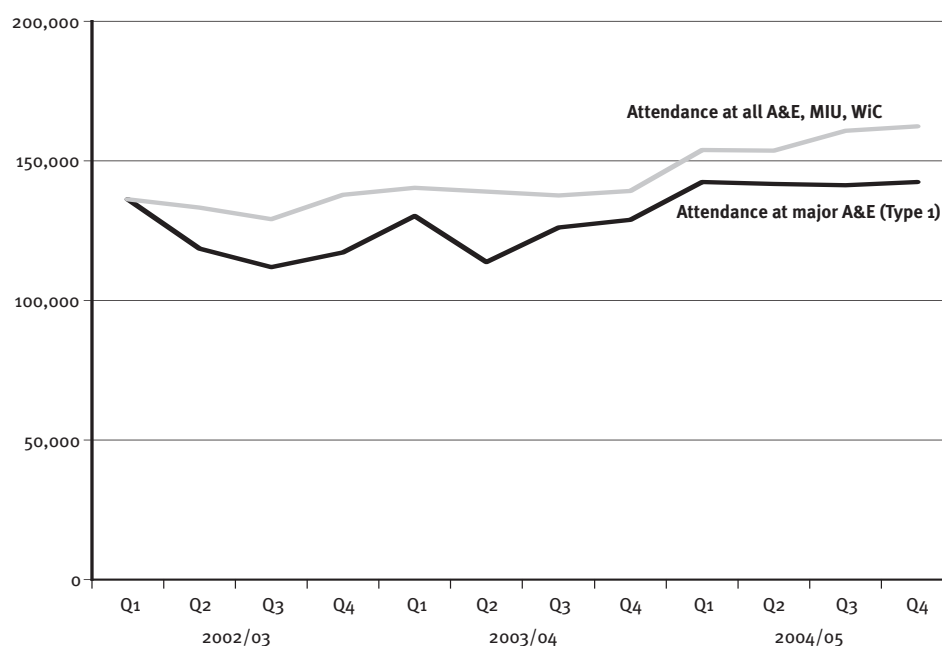
4

EMERGENCY AND ELECTIVE ADMISSIONS IN SOUTH-EAST LONDON, 2001/02 TO 2003/04



Source: Department of Health (various)

- Total admissions have been increasing over the past three years.
- Emergency admissions have increased at a greater rate (30.6 per cent) than elective admissions (23.5 per cent). Organisations need to manage increases in demand, particularly in emergency services, to maintain financial health.

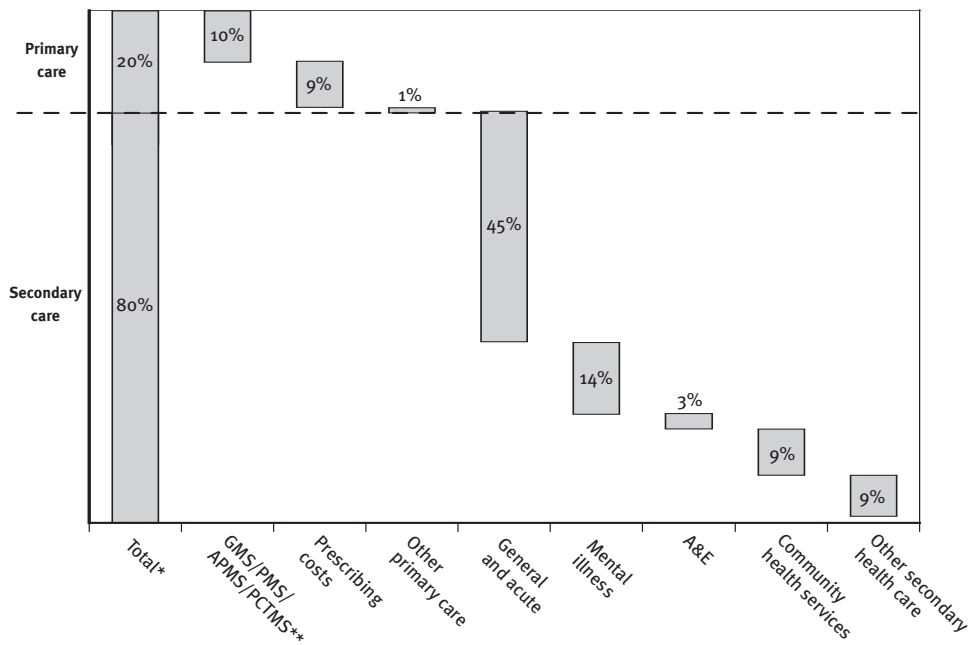


Source: Department of Health (2005b)

- Total attendance at all accident and emergency (A&E) facilities – which includes walk-in centres (WiCs) and minor injuries units (MIUs) – has increased by 19 per cent since 2002/03. This is a higher rate of growth than attendance at major A&E facilities (Type 1), which increased by 4 per cent over the same period.

6

THE PROPORTION OF PCT EXPENDITURE USED TO PURCHASE PRIMARY AND SECONDARY CARE IN SOUTH-EAST LONDON, 2004/05



Source: Trust Annual Accounts 2004/05

*PCT expenditure for south-east London, 100% = £2,100 million

**General Medical Services/Personal Medical Services/Alternative Provider Medical Services/Primary Care Trust Medical Services

- Eighty per cent of PCT budgets are used to purchase secondary care, with general and acute spend alone making up nearly half.

Interviews

Scope for local action

Most interviewees were positive about some elements of reform, in particular:

- Payment by Results (PbR) as a funding model that follows the patient and encourages efficient provision of services
- foundation trusts that are delivering locally responsive services
- targets that are bringing improvements in the speed and convenience of access to care.

Interviewees considered that the aims of reform and their design were broadly appropriate. However, they acknowledged that, in practice, some incentives work against each other and make progress towards policy objectives harder to achieve.

Interviewees perceived problems in four key areas:

- competition and collaboration
- managing demand for care
- transfer of services from hospitals to primary or community settings
- the role of the district general hospital (DGH).

This chapter includes a section on each of these problems, including the main points from the interviews and a brief commentary.

Competition and collaboration

Can competition – encouraged by the financial regime, new payment systems and foundation status – and collaboration between trusts co-exist?

What the interviewees said

- Within the health economy in south-east London not all organisations are ready to respond to the new incentives appropriately, in particular choice and PbR. This increases the potential for a wider gulf to develop between strong and weak providers.
- There are many examples of organisations collaborating over specific services, partly in response to national policies such as the national service frameworks. However, new policies, especially PbR and the establishment of foundation trusts, are seen to be reinforcing the boundaries between institutions and hindering the collaboration needed for seamless patient care.

Comment

There is an inherent tension between competition and collaboration. This can be managed differently for different services. For those services that are time-limited, non-complex,

predictable events, competition between providers can increase efficiency and quality of services. However, for services that require proactive case management across providers, the priority ought to be collaboration between service providers. (For more details, see Annexe 2: Cancer care, available at: www.kingsfund.org.uk/resources/publications/incentives_for.html)

Local leadership can encourage collaboration where appropriate and minimise the risk of fragmented care in key service areas. The strategic health authority (SHA) has a key role in encouraging these collaborative efforts.

Managing demand for care

Do policies designed to create better access generate extra demand in the system and increase the pressure on services?

What the interviewees said

- The majority of initiatives to improve access have encouraged greater service use. It is important to understand why, how and where demand is initiated to ensure that initiatives to manage demand are appropriately targeted, designed and implemented.
- Targets are driving improvements in operational efficiency and succeeding in improving access to care. But they have reinforced the hospital as the place in which to receive care. Demand management initiatives need to recognise this.
- The government is supporting self-care, for example through NHS Direct and the expert patient programme. However, there is only limited evidence that this has led to a reduction in demand for existing services. The expectations patients have of what services will deliver need to be managed to ensure that demands can be met within the constraints of a national health service that is free at the point of access.

Comment

In line with other research (National Audit Office 2004a), this fieldwork found that pressure on services is increasing. New services are meeting previously unmet areas of demand that have arisen as a result of new and different ways for patients to access care. This is most dominant in emergency care. For example, initiatives to facilitate a patient-focused system (such as NHS Direct, out-of-hours GP services, minor injury clinics and walk-in centres), while well received by patients, have been largely unsuccessful in reducing the pressure on current emergency services and have not addressed the escalation in demand. (For more details, see Annexe 3: Emergency care, available at: www.kingsfund.org.uk/resources/publications/incentives_for.html)

The onus is on primary care trusts (PCTs) and, to a lesser extent, practices to manage demand better. Yet the current incentives for each to do so are relatively weak. Nevertheless, there is scope for initiatives such as:

- GP triage in accident and emergency (A&E)
- better access to good quality primary care (in particular out-of-hours)
- managing referrals on to the waiting list to ensure that waiting times targets are met
- more action on practice-based commissioning and stronger incentives for practices to take it up
- identification of patients at high risk of emergency admission

- better case and disease management
- support to provide self-management by patients.

Transfer of services from hospitals to primary or community settings

Do current incentives enable PCTs to do this?

What the interviewees said

- PCTs seeking to transfer services into a community setting find that resource and physical constraints present real barriers to success. Initiatives to transfer care must be preceded by investment to expand local services, stronger incentives to manage demand in the community, and agreements with hospitals not to fill any spare beds inappropriately with other patients. Current funding constraints, which include inflexible budgets once commissioned activities are accounted for and the need to achieve annual financial balance, make this difficult to achieve.
- PCTs need stronger incentives to drive change and the transfer of services.
- The transfer of activities from hospitals into community-based care needs to be addressed from the patient perspective to establish where, and by whom, services are best performed, and what the consequential skill requirements are. Much of the activity is carried out in hospitals because that is where the physical and human resources are at present.

Comment

The transfer of services from hospitals to primary or community settings has been on the policy agenda for well over a decade. Current initiatives to encourage better management of people with long-term conditions is encouraging this transfer. However, other more powerful incentives in the system run counter to this objective. For example, PbR and foundation status encourage hospitals to maximise activity levels in order to maximise income, thereby encouraging retention of activity in hospitals. Similarly, private finance initiative (PFI) commitments have significantly increased the overheads of participating hospitals, making maximisation of revenue a priority and the release of capacity expensive to achieve.

Practice-based commissioning may offer incentives to GPs to manage demand more effectively in the community, but so far take-up has been poor.

Nevertheless, financial pressures mean that most NHS organisations will have to scrutinise where costs can be taken out of the system. The role of an SHA is to ensure that any closure of or reduction in services does not result in a less comprehensive service to patients and that no population groups are being significantly disadvantaged with respect to access to good quality care.

The role of the district general hospital (DGH)

Does the financial pressure on services and stronger market-style incentives challenge the sustainability of weaker organisations, especially smaller DGHs?

What the interviewees said

- The need to address the viability of south-east London DGHs as stand-alone institutions is becoming more urgent. Where possible, it is in the interests of all members of the health economy to keep services convenient and accessible to patients.
- The financial pressure on DGHs is heightened by the budgetary difficulties PCTs are experiencing. DGHs have focused on improving operational efficiency. However, this is unlikely to be enough to solve the financial problems.
- DGHs can only be sustained as truly general, local providers if they work with other providers – including PCTs, GP practices and other hospitals – rather than trying to continue as standalone providers of their current range of services.

Comment

Clinical safety, the need to centralise specialist services, shortages of staff and competing demands on NHS budgets are all affecting DGHs. These are heightened by the current financial pressures described by interviewees.

There needs to be a realistic assessment within individual hospitals of what is clinically and economically viable at a local level. In the most extreme cases, this may result in a radical revision of the portfolio of services a hospital provides. The solution may be specific to London, as the proximity of service providers and the apparent degree of excess capacity gives scope for more flexible solutions and rationalisation of services than would be available in areas where the DGH is in a smaller urban area.

If service rationalisation is the way forward, the PFI contracts that some hospitals have in place could prove problematic. They not only heighten financial pressures by creating a high fixed-cost base, but also make disposal of fixed assets more difficult.

Without national revision to the current incentives – trusts, PCTs and the SHA can take steps to manage demand and improve services. The following four case examples demonstrate the kinds of initiatives that are possible.

Collaboration: case example

The area of Lambeth and Southwark is one of four pilot locations for Pursuing Perfection in the NHS. There are three projects:

- improving care for patients with chronic obstructive pulmonary disease
- improving care for those needing total knee replacements
- promoting the health of older people.

Each project has developed collaborative working across health services, the hospital and the community to improve communication between service providers and to assess patients jointly. The underlying objective is to offer proactive rather than reactive care by identifying problems at an early stage.

The pilot involves the Lambeth and Southwark PCTs, Guy's and St Thomas' hospitals, Lambeth and Southwark local authorities, the South East London Strategic Health Authority and King's College Hospital.

Improving demand management in A&E: case example

Lewisham Primary Care Trust is attempting to improve the system for unplanned and unscheduled care (Matrix Research and Consultancy 2005). This has involved:

- redesigning A&E to allow better triage of self-referring patients as they arrive so as to direct demand appropriately
- identifying the most resource-intensive patients to help design more effective interventions that reduce avoidable use
- improving the management in the community of patients with long-term conditions and older people to reduce avoidable use of emergency care through active case management and better intermediate care.

Transfer of a service from the hospital into primary care: case example

Greenwich Primary Care Trust carried out an audit within the Queen Elizabeth Hospital to identify inappropriate admissions, and designed interventions in primary and community services to minimise their occurrence. The audit highlighted two main causes.

- The absence of services that could prevent admission: the hospital has been working with the other organisations in the health economy as part of the Greenwich Urgent Care Network to ensure required services are available and accessible.
- Inefficient hospital procedures: the hospital and PCT have been working together to reduce the length of inpatient stay, reduce the number of patients that are admitted but could be treated in the community, and improve the 'care pathway' for patients with long-term conditions.

Sustaining services at a district general hospital (DGH): case example

In order to sustain a financial and clinical future for the Queen Elizabeth Hospital in Woolwich, Guy's and St Thomas' NHS Foundation Trust entered into a formal arrangement. There were two key elements.

- Guy's and St Thomas' NHS Foundation Trust provided managerial support, including the secondment of the Chief Operating Officer to the Queen Elizabeth Hospital.
- There was collaborative working to address issues of common concern including implementation of the Working Time Directive, improvement of staff recruitment and retention, delivery of targets and agreement about common approaches to improving clinical governance.

The two organisations are in the process of establishing in more detail the benefits and specific initiatives relating to the alliance before confirming long-term arrangements.

Summary of case examples

Initiatives such as these can and should be built on. But the effort to do this will be undermined as long as incentives continue to work against these kinds of initiatives. For example:

- incentives are generally geared towards reducing waiting rather than managing demand better for patients with long-term conditions or patients needing emergency care
- because of the requirements of the financial regime, trusts are reluctant, and in some cases unable, to engage in initiatives where they cannot realise the benefits within the year to meet financial balancing requirements
- the payment system provides little incentive for secondary and tertiary providers to help with initiatives to manage demand more appropriately – that is, to reduce admissions to hospital
- considerable financial deficits exist that are unlikely to be recovered by local providers or commissioners.

Regarding this last point, the extent to which overspends should be supported is unclear. To date SHAs have applied for support for areas of planned overspend. However, once the NHS has moved away from brokerage and operates in a market-style environment where trusts can retain their surplus, the extent to which planned overspend should be continued to be supported by the NHS needs to be addressed nationally.

The current powers of the SHA are insufficient to solve these problems. So, while there is scope for many more local initiatives such as those illustrated above, there need to be changes to the current incentive structure that can be made only at a national level.

Discussion

There are three main areas where revision of the current arrangements could be beneficial:

- financial arrangements
- commissioning
- service configuration.

Before describing each of these in more detail, it is important to make a distinction between different areas of care. To date, some elements of reform have been targeted at elective care. Questions are now arising about how to extend this reform appropriately into other areas of care, in particular services for patients with long-term conditions and other services requiring collaboration between primary, secondary and other providers.

It is evident that the nature of service provision for elective care is very different to that of other services. Therefore, it is important to distinguish between three different categories of care:

- elective care: a planned response to needs that have already been identified by the health and social care system
- emergency care: care provided for needs that arise in an unplanned way and require urgent attention – these needs require an integrated response from primary care through to specialist hospital facilities
- care for patients with long-term conditions: services for people with a wide range of physical disabilities, learning disabilities, enduring mental health problems and chronic disease as well as people who need ongoing support to live independently. We include in this both those conditions that patients have for life, such as diabetes, and those conditions, such as cancer, where care can extend over years, if not life.

In the following commentary, the first two sections (see Financial arrangements and Commissioning) will use these categories of care to help structure the discussion.

Financial arrangements

There are two areas that need review.

- **The financial regime** The requirement to operate within budgetary limits on an annual basis has proved a disincentive for primary care trusts (PCTs) to invest in initiatives that will not yield benefits within that time. Most initiatives take time to recover the costs of initial investment and to begin to be beneficial. For example, one managed care organisation in the United States estimated that it would take seven years to demonstrate the impacts of investments in care for patients with diabetes (Dixon, Lewis *et al* 2004). To make a bigger impact, the health economy, or central government, should pilot more radical innovations and evaluate their impact.

- **Payment by Results (PbR)** There is strong support, in principle, for a prospective payment system. PbR reimburses providers for each ‘spell’ of activity. It was originally designed for elective care to promote patient choice and competition between providers, as well as to improve productivity. However, this research suggests that PbR is more ‘fit for purpose’ for some areas of care than others. It is important to note that the payment system alone cannot be expected to achieve wider policy goals. In reality, PbR is but one set of incentives in a wider range that needs to be developed to encourage appropriate treatment and demand management.

The issues discussed with regards to the financial regime could be addressed by giving PCTs a similar regime to foundation trusts, allowing for internal or external borrowing, and flexibility in accounting for financial balance. The payment system requires more detailed review, with a different solution for each category of care.

Analysis by category of care

ELECTIVE CARE

Elective care consists mainly of predictable, time-limited episodes. A tariff that reimburses by spell is therefore appropriate. PbR is likely to develop into a more sophisticated model over time, overcoming the current debates regarding ‘unbundling’, and in other cases ‘bundling’, of the tariff. With the current need to increase activity there is a good chance that existing incentives will produce the results that the government is aiming for, that is, effective competition, higher productivity and a reduction in national average costs.

EMERGENCY CARE

Applying payment by spell to emergency care, as the government currently intends, will create an incentive for providers to increase admissions inappropriately. PCTs and practices are currently too weak to counter this trend effectively. Effective demand management is therefore at risk.

Some PCTs are making arrangements with NHS trusts to share the financial benefits of reduced avoidable admissions. This could be developed further. But what is needed more fundamentally are much stronger incentives for commissioning bodies to reduce avoidable admissions through better out-of-hospital care.

CARE OF PEOPLE WITH LONG-TERM CONDITIONS

For some patient groups the focus is on managing the demand for hospital services more appropriately, for example, by increasing the amount of care administered at home and in community settings, and by minimising the number of interactions with the system an individual needs through preventive and proactive care. The reform of services for other patient groups, such as cancer, is dominated by redesign of the patient pathway and improvements in delivery modes.

For managing demand, a key question is whether the system of paying providers could be designed to encourage appropriate demand management and/or whether the incentives for demand management should primarily be focused on commissioning organisations (for example, to ‘keep’ any surpluses from reduced expenditure). Given the volume of work that needs to be undertaken to develop an accurate payment system under PbR, it may be more pragmatic and logical to load the incentives for demand management

on commissioners rather than through the payment system. This way, an appropriate national price for different aspects of treatment can be developed in the care pathway, but thought should be given to the incentives that commissioners would need to bear down on costs constantly and in an appropriate manner. Clearly it would help if the incentives on providers (in particular secondary providers) were also aligned to support commissioners wanting to manage demand. How this might best be done is worth further consideration, for example, allowing secondary providers to provide community services that could substitute for more expensive hospital care. The door to this approach has been opened in the recent Department of Health document *Commissioning a Patient-led NHS* (Department of Health 2005c).

For redesign of service provision, the payment system needs to be compatible with these changes, and able to support and complement them. Tariffs will need to be carefully reviewed and are likely to require unbundling to ensure that the different elements of care can be administered by the appropriate institution. For example, aftercare and follow up can often be well placed in community settings but, unless the tariff allows for such movement, it will continue to be provided in the hospital.

Some (including some of our interviewees) have mooted the idea of developing a different payment system especially for people with long-term conditions. For example, an annual payment to providers for a 'patient pathway' or a 'patient with a given condition'. Under this system the whole budget of a care group could be handed over to particular providers (as is the case for mental health), a voluntary sector group or potentially to patient groups acting as purchasers to meet their own needs. The incentive on the providers would be to supply the care as cost effectively as possible each year. But for providers to be active in this respect there may need to be further incentives, for example, the threat of competition from another provider. A pragmatic approach would therefore be to develop tariffs for different elements of a care pathway (treating the payment of care for patients with chronic conditions in this respect no differently from that of patients with other conditions) and to strengthen the incentives for commissioners as noted above. In the longer term it might be possible to develop annual payments based on pathways, once knowledge of the relevant cost and use patterns is more established.

Commissioning

Several of those interviewed saw commissioning, and particularly practice-based commissioning, as part of the solution to maintaining collaboration, encouraging demand management and shifting services from hospitals into the community. However, at present commissioning by PCTs remains weak, with little influence on what care services are delivered and where. There has been a very slow uptake in practice-based commissioning, probably because the extra financial rewards to GPs from the new General Medical Services (GMS) contract decrease the motivation for GPs to take a lead. The new direction set by the Department of Health (2005c), *Commissioning a Patient-Led NHS*, may accelerate take-up of practice-based commissioning or encourage PCTs to utilise 'commissioning services' from non-NHS providers. This may help to strengthen commissioning, particularly in critical areas such as the management of emergency admissions and the care of people with long-term conditions. It may be that more radical solutions need to be sought in future to provide a counterweight to a more aggressively competitive provider market.

Analysis by category of care

ELECTIVE CARE

PCTs are currently in a good position to commission elective care, but local autonomy is being undermined by contracts set nationally with the independent sector. This should be a temporary problem for PCTs as more non-NHS providers enter the market and the need to let national contracts decreases.

EMERGENCY CARE

Changes are needed in emergency care to ensure that the service is affordable and sustainable. Commissioners will need to change the balance of services, including managing demand more appropriately through better access to good quality primary care, case management and disease management. There may be a case for larger commissioners, which can have bigger purchasing clout with providers (see Department of Health 2005c). Fewer purchasers would mean that it would be necessary for them to work with more than one major provider. This would be a better way to spread risk and move the purchaser into the lead influencing role, determining how and where services should be delivered.

CARE OF PEOPLE WITH LONG-TERM CONDITIONS

For some chronic conditions, commissioning at local level may be appropriate whether by GP practices or by new kinds of commissioner, such as voluntary organisations concerned with a particular patient group. However, for other conditions that are rare or complex and require specialist facilities that can be found only in a tertiary hospital, a commissioner with a wider remit may be necessary. This could involve national planning and design of services, like that undertaken for national service frameworks, or local planning and design of services by a local consortia of PCTs.

Service configuration

District general hospitals (DGHs) were originally expected to serve the majority of the needs of local populations of less than 150,000. In the decades since their introduction, the balance has shifted in favour of larger units. This has been stimulated by financial pressure, market forces, issues about quality of care and staffing (including the impact of the European Working Time Directive), and diversity in treatment options. Experiences in south-east London suggest that it may not be desirable to maintain a single 'general' solution that attempts to meet nearly all patient needs locally. It is important to consider the critical mass of activity required to keep high quality services and specialised skills.

There are several alternatives available. These could include:

- a reduction of the portfolio of services of DGHs to those local functions that are still clinically and economically viable, for example outpatients and simple elective care
- configuring services in relation to the teaching hospitals, akin to a hub and spoke model
- carrying out local activity under the direction of a teaching hospital.

All of these options involve reconfiguring the role of the hospital as a site where services are delivered rather than being an individual organisation in itself, confined by its physical resources. It is the service, not the hospital building, for which the provider is accountable.

The potential service models could include outreach clinics in each community service area and provision of outpatient assessment clinics at the specialist centre. There could be a rotation of staff from community services and outpatient centres into the specialist centre for training purposes, shared in-service education and ongoing professional development. These all require working across community and specialist services.

Next steps

The main question raised in this paper is whether the system of incentives is ‘fit for purpose’. The fieldwork conducted within the NHS suggests the answer is not yet. This is because existing incentives can work against each other, making it hard for local organisations to meet all the targets and objectives they have been set.

National steps

Without doubt, further action at a national level is required in two areas to align the incentives more appropriately.

- **Financial arrangements** Policy-makers need to review the financial regime for primary care trusts (PCTs) to allow them to be more flexible in their investments, as well as the current and planned arrangements for the payment system for emergency care and care of patients with long-term conditions.
- **Commissioning** This includes revising the scale and expertise of commissioning bodies for emergency care and care of patients with long-term conditions. National policy-makers should also consider how commissioning might be strengthened through much stronger incentives than those outlined in the recent Department of Health (2005c) publication *Commissioning a Patient-led NHS*, in particular, incentives to encourage appropriate demand management.

Local steps

There are actions that can be taken locally by a variety of different agencies.

- **Acute trusts** For smaller acute trusts the key activities in the short term will be to identify services that are financially and clinically viable – as well as those that are not – and manage the relocation of staff and services while ensuring continuity of care for patients. Larger acute trusts will need to work with the smaller trusts to manage the transition for patients and expand services to accommodate the extra demand that will flow to them as a result.
- **PCTs** For PCTs the priority is appropriate demand management in order to control expenditure better and provide better value for money. The main focus of this needs to be on better management of patients who are at greatest risk of unplanned admission to hospital through accurately identifying these people, and on better provision of case and disease management. Until these cost pressures are addressed, other policy areas, including mental health and public health in particular, risk being neglected.
- **Strategic health authorities (SHAs)** The SHA perspective across the entire health economy will be invaluable for identifying where costs and/or capacity can be taken

out of the system, while maintaining a comprehensive and good quality service that is accessible to patients. There needs to be a clearer identification of what services should look like, where services should be and who should deliver them to ensure both cost effectiveness and the desired level of quality. SHAs will need to ensure that changes in service configuration are co-ordinated across the health economy.

Annexe 1: List of interviewees

Kevin Barton, Chief Executive, Lambeth Primary Care Trust

Stuart Bell, Chief Executive, South London and Maudsley NHS Trust

Tom Breen, Finance Director, Lewisham Primary Care Trust

Chris Bull, Chief Executive, Southwark Primary Care Trust

Susan Cottingham, Director of Service Strategy and Commissioning, Lambeth Primary Care Trust

Peter Dixon, Chairman, University College London Hospitals NHS Foundation Trust

Yvonne Doyle, Director of Public Health and Medical Director, South East London Strategic Health Authority

Andrew Eyres, Director of Finance and Information, Lambeth Primary Care Trust

Stephen Firn, Chief Executive, Oxleas NHS Trust

Bala Gnanapragasam, Chairman, The Lewisham Hospital NHS Trust

Lucy Hadfield, Chief Executive, Lewisham Primary Care Trust

Tim Higginson, Director of Strategy, Guy's and St Thomas' Hospital NHS Trust

Simon Leftley, Chief Executive, Bexley Care Trust

Malcolm Lowe-Lauri, Chief Executive, King's College Hospital NHS Trust

Jim Lusby, Performance Director, South East London Strategic Health Authority

Jane Maher, Chief Medical Officer and Consultant Clinical Oncologist, Macmillan Cancer Relief

Jacque Mallender, Managing Director, Matrix Research and Consultancy

David Mellish, Chairman, Oxleas NHS Trust

Jonathan Michael, Chief Executive, Guy's and St Thomas' Hospital NHS Trust

Helen Moffat, Chief Executive, Queen Mary's Sidcup NHS Trust

Lis Nixon, National Lead for Emergency Care, Department of Health

Amanda O'Brien, Director of Modernisation, Greenwich Teaching Primary Care Trust

Stephen O'Brien, Finance Director, Croydon Primary Care Trust

Richard Page, Finance Director, Oxleas NHS Trust

Keith Palmer, Non-executive Director, Guy's and St Thomas' Hospital NHS Trust

John Pelly, Chief Executive, Queen Elizabeth Hospital NHS Trust

Claire Perry, Chief Executive, The Lewisham Hospital NHS Trust

Hilary Pickles, Public Health Director, Hillingdon Primary Care Trust

Bridget Riches, Chief Executive, Bromley Primary Care Trust

Lynn Saunders, Director of Service Improvement, Queen Elizabeth Hospital NHS Trust

Jane Schofield, Chief Executive, Greenwich Teaching Primary Care Trust
Graham Simpson, Planning Director, South East London Strategic Health Authority
Ann Smart, Finance Director, North East London Strategic Health Authority
Michael Walsh, Chief Executive, South East London Strategic Health Authority
John Watkinson, Chief Executive, Bromley Hospitals NHS Trust
Alistair Whittington, Lead Manager, South East London Cancer Network
Janet Williamson, National Director, NHS Cancer Services Collaborative

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