Summary: Intervention & Options

Department /Agency:	Title:	
Department of Health	**Impact Assessment of Currency and pricing development for community services**	
Stage: Final/Implementation	**Version:** 4	**Date: 25 November 2008**
Related Publications: High Quality Care for All; Our Vision for Primary and Community Care		

Available to view or download at:

http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialR

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What is the problem under consideration? Why is government intervention necessary?

Most community services are currently commissioned using block contracts but these are insufficient to support effective commissioning and choice. Block contracts disguise information about units of service provision leaving commissioners with difficulty determining whether they are obtaining value for money. An understanding about service units is also required to support strategic changes aiming to transfer activity from hospital to community settings.

Government intervention is necessary to help commissioners make sound financial investments, implement choice and reduce waits.

What are the policy objectives and the intended effects?

The objective is to develop new contract currencies and prices to increase transparency and enable a significant proportion of community services to be commissioned using cost and volume contracts from April 2011.

The intended effects are to provide services offering better quality and value for money to benefit patients and commissioners. In addition, movements towards cost and volume contracts will facilitate choice in the community both through the introduciton of currencies and anticipated increases in productivity and the greater potential to be able to offer care closer to home.

What policy options have been considered? Please justify any preferred option.

(1) Do nothing

(2) Locally and nationally lead development work for currency and pricing

Option 2 is the preferred option to achieve the objectives and effects most rapidly and provides a greater margin of benefits over costs.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

A review of current local work to develop currencies will be undertaken in mid 2009, a more comprehensive project review is scheduled for end of financial year 2011/12.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

..... Date:

Summary: Analysis & Evidence

Policy Option: Preferred	Description: Locally and nationally lead development work for currency and pricing

COSTS

ANNUAL COSTS	
One-off (Transition)	**Yrs**
£ 2.16m	2
Average Annual Cost (excluding one-off)	
£ 29.2m	

Description and scale of **key monetised costs** by 'main affected groups' Policy development by DH and PCTs, implementation costs fall upon commissioning PCTs and their community service providers.

Total Cost (PV) **£ 148m**

Other **key non-monetised costs** by 'main affected groups' Benefits to providers through efficiency gains from increased productivity and to commissioners through increased provider capacity to deliver more services.

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£ 0	
Average Annual Benefit (excluding one-off)	
£ 44.6m	

Description and scale of **key monetised benefits** by 'main affected groups' Benefits to providers through efficiency gains from increased productivity and to commissioners through increased provider capacity to deliver more services.

Total Benefit (PV) **£ 223m**

Other **key non-monetised benefits** by 'main affected groups' Productivity gains more rapidly realised under this policy option, facilitates moving care closer to home, benchmarking to demonstrate and implement best practice.

Key Assumptions/Sensitivities/Risks Assumed adoption of open book approach between commissioners and providers. Financial risk reduced through advice given by DH to all providers.

Price Base Year	Time Period Years	**Net Benefit Range** (NPV)	**NET BENEFIT** (NPV Best estimate)
		£ -7m - £149m	**£ 75.1m**

What is the geographic coverage of the policy/option?			NHS England	
On what date will the policy be implemented?			December 8th 2008	
Which organisation(s) will enforce the policy?			DH	
What is the total annual cost of enforcement for these organisations?			£ 100k	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			N/A	
What is the value of the proposed offsetting measure per year?			£ N/A	
What is the value of changes in greenhouse gas emissions?			£ N/A	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium **£100k**	Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ Decrease of £ **Net Impact** £

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

1. Intervention and options

Current contract mechanisms for community services are not sensitive enough to support and incentivise the strategic changes that form part of the vision put forward in High Quality Care for All1 and The Next Stage Review: Our Vision for Primary and Community Care2. These changes are to support the transfer of work out of hospital and treating more patients in a community setting where this can provide improved patient experience. In addition, commissioners are often not aware of whether they are obtaining value for money from their existing contract baseline with their own provider services and primary care due to the lack of transparency and paucity of data.

Without government intervention it is likely that commissioners will continue to struggle to make sound financial investments when commissioning community services. Patients and carers will continue to experience waits for services and will not be able to exercise choice of services to due to many providers' monopoly positions and lack of data to support choice.

The Options for the Future of Payment by Results: 2008/09 – 2010/113 consultation put forward proposals for future developments in Payment by Results (PbR) including expanding the scope of PbR to include new services, and using PbR to support policy objectives such as providing efficient care.

The consultation identified that whilst PbR had become synonymous with having a national currency and national price (i.e. everybody commissioned for the same units of activity and pays the same price); there were stages in moving to this goal from block contracts as used for community services. The consultation therefore outlined a three-tier model of PbR in extending the scope of the initiative and facilitates more local development:

- Local currency and local price
- National currency and local price
- National currency and national price

Respondents to the consultation highlighted community services as the second highest priority, after mental health, for inclusion in any expansion of the scope of PbR. As a result the PbR team have established a number of payment development sites for community services, working on local currencies that could potentially be used nationally. High Quality Care for All reaffirmed that community services should move away from being funded on a block contract basis, giving further impetus to local efforts to develop currencies and prices.

Summary of responses to consultation and impact on this impact assessment

The table below outlines the 281 respondents to the consultation by type of organisation they represented.

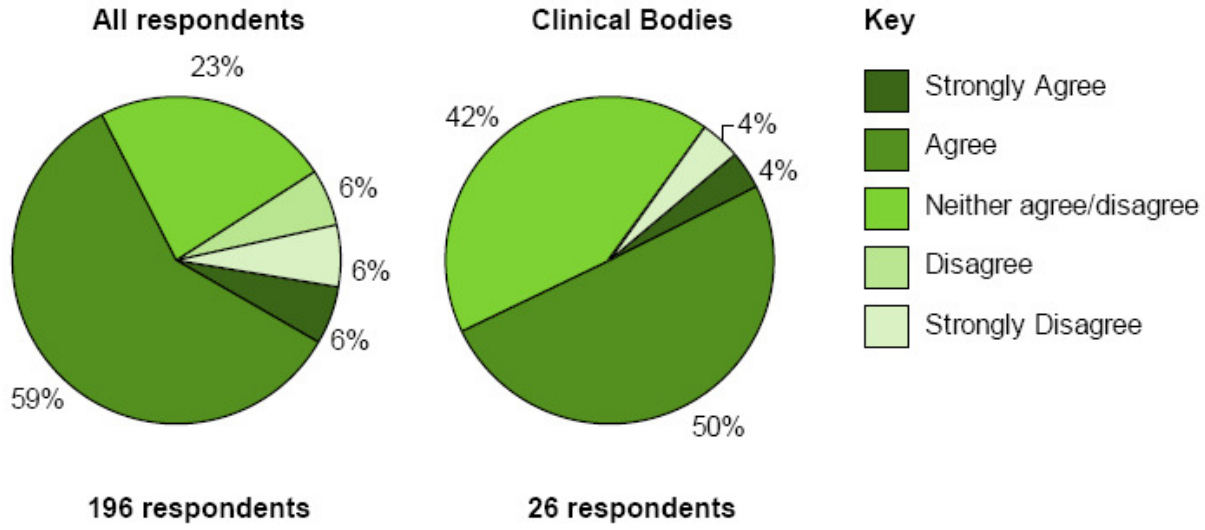
Respondent Type	Number that responded
Strategic Health Authority	9
Primary Care Trust	31
Specialised Services Commissioner	11
Foundation Trust	28
Acute Trust	37
Mental Health / Learning Disability Trust	7
Other NHS	15
Independent Sector Provider	4
Individual - Clinical	20
Individual - Non Clinical	23
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

The table below shows that Community based services was ranked second in terms of priority for expanding the scope of PbR after mental health services. Currency and pricing development is also under way for Mental health services as a result.

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

The chart below shows that 66% of the respondents to the consultation (agreed or strongly agreed that the approach to expanding PbR must be locally and nationally lead development work for currency and pricing. This is the prefferred approach outlineds in this impact assessment.

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



2. Links to other policy areas

The development of currencies and pricing is one of a number of products that constitute the Transforming Community Services (TCS) work programme. Several of these products help to establish the necessary knowledge and infrastructure for community services to support the development of currencies and pricing, see analysis and evidence for further details.

3. Policy Review

The DH PbR team have planned a review for mid 2009 to analyse the PbR development pilot sites progress given that much of this work is already happening locally. A more comprehensive review will be conducted at the end of the calendar year 2011.

4. Analysis and evidence

The policy proposal is to improve commissioning and provision of community services through the development and implementation of new contract currencies and prices rather than the current use of block contracts. This is to be done with in the existing financial envelope for each PCT. The need to move away from block contracts is emphasised by the fact that despite enabling providers to operate with tight control of their expenditure, the contracts provide little incentive to exceed contracted levels of activity.

Prior to implementation of currencies and pricing, infrastructure and knowledge is required to support development. Other products coming out of the TCS programme are precursors for development of currencies and must be adopted to facilitate change. As such, it is necessary to clarify the baseline from which it is intended currency and pricing development will be able to progress:

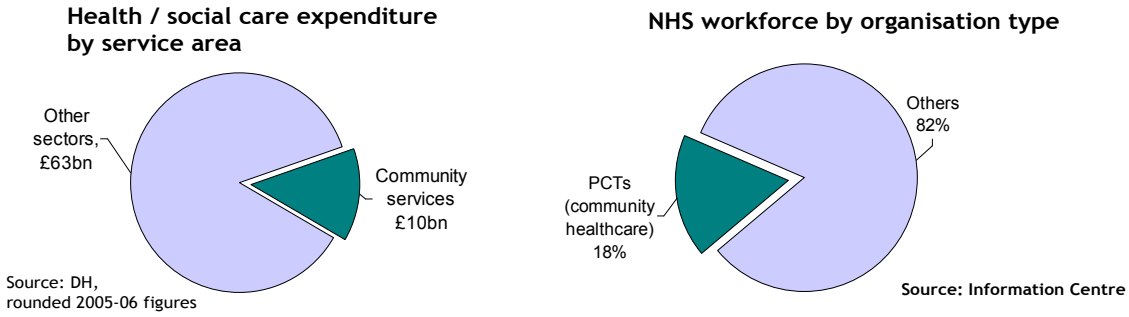
Underlying patient-level data is essential to develop currencies for service delivery although there is currently a recognised lack of data about community health care. Dataset development is progressing and support from DH is helping to ensure that the necessary data collection processes are in place to provide the baseline for currencies and pricing.

Currently the majority of PCTs undertake both commissioner and provider functions for community services. Given the Department's strategic direction to implement business

processes for community services, PCTs must implement separation between their commissioner and provider arms through SLAs and contractual arrangements. The Operating Framework 2008/09 highlighted that PCTs should formally separate their commissioner and provider functions by April 2009. For this IA, it is assumed that all PCTs have reached this stage prior to the policy of currency development.

For the purposes of evaluation, it is necessary to assume that all PCTs have the minimum requirements in place on which to build the currency and pricing framework. That is, PCTs are collecting and reporting patient-level data, appropriate information models are in place and they have forged separation between their commissioner and provider responsibilities.

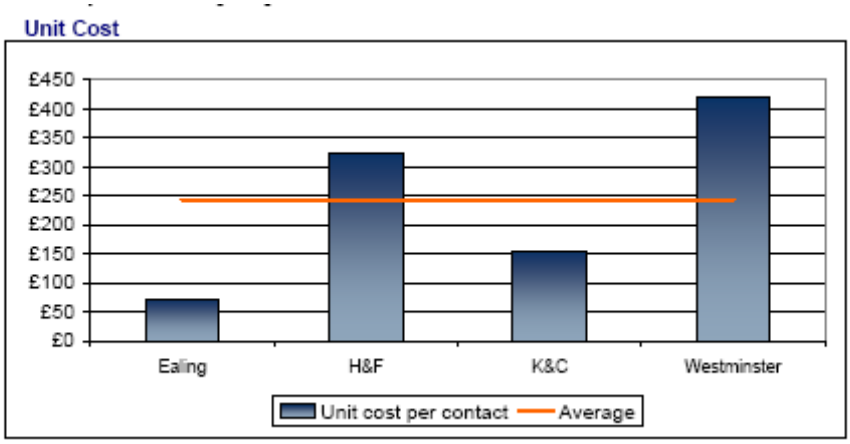
The current picture of community services across NHS England



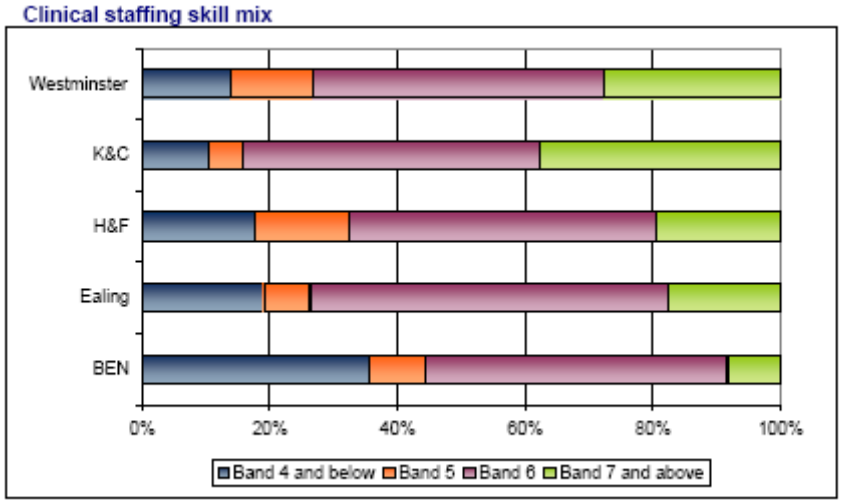
Approximately 14% of NHS spend, equating to over £10bn is spent annually on community services across England; almost one fifth of the NHS workforce is involved in delivery of these services. Despite this large volume of resources invested in community services, limited information is collected to evaluate the effectiveness of inputs in terms of the workforce, services, interventions or outcomes. This lack of information necessitates block contracting for the majority of community services, almost 90% of community contracts are set on this basis.

The NHS has recently commissioned research and analysis of community services to obtain more information about the services being provided. Investigation by several consultancies reveals a high level of variation in the cost, quality and method of service provision for community services.

The chart below illustrates the unit costs for delivering 'community children's services' in each of four neighbouring PCTs in and illustrates the four-fold variation in their costs.



The following chart illustrates the variation in skill mix as determined by the grade band of nurses used to deliver the same service across the four neighbouring PCTs. Kensington & Chelsea use almost 40% of band 7 staff and above to provide the same service that is considered to require less than 20% of band 7 and above staff in Ealing.



The reasons for this wide variation in costs and staffing skill mix is not yet understood, the underlying reasons need to be identified and managed by providers to ensure care delivered is in line with current good practice. Commissioners also need to understand the variation to ensure they are commissioning high quality, value for money services.

Assumptions

In assessing the costs and benefits of policy options it is assumed that all PCTs have adopted and adhered to guidance and requirements that form the TCS work programme. The time horizon of the policy is five years; implementation of the project will span three years.

Policy Option 2: Locally and nationally lead development work for currency and pricing

Option 2 is the preferred policy option and involves DH leading work to develop a currency and pricing framework in consultation with NHS organisations. In recognising the potential benefits of implementing such a framework for community services, there is evidence at local level of the NHS taking steps to move towards these methods of transaction.

Tower Hamlets PCT are an example of undertaking a local development to enable the move from block contracts to cost and volume contracts for community nursing services. Their decision was driven by the requirement to adhere to the World Class Commissioning competencies:

- Competency 4; Leading continuous meaningful clinical engagement can be enhanced through the significant clinical input into describing the services that make up a particular currency.
- Competency 7; Stimulating the market by seeking to commission tightly defined service offerings. Increased meaningful and comparable information will be available about the community services as a result of currency and pricing development, this can enhance both choice and competition for the services.
- Competency 8; Promoting improvement and innovation can be supported through the intelligent use of currencies and pricing to incentivise desirable service provider and system behaviours.
- Competency 11; making sound financial decisions through an understanding of the balance of financial risks associated with moving to new contracting currencies. The development and use of currencies will also lead to a clearer picture of the value for money that any particular service represents to a commissioner.

Costs

Tower Hamlets PCT is one example of several local initiatives designed to generate currencies for community services however there is great difficulty in disentangling the costs of developing currencies where this has been undertaken. The costs incurred by PCTs locally developing this framework vary depending on the starting point of the process. Where PCTs had better information quality and a more well suited management infrastructure the costs have been far less. This is especially true where PCTs have been able to utilise an existing, functioning Connecting for Health (CfH) solution as compared to Trusts working with paper based systems.

Given the lack of robust information about the costs of community tariff development, cost estimates for the implementation of PbR and the development of the national tariff for acute services provide a relevant indication of the implementation costs for community services. The key difference between the strategy for community services and that adopted for acute services under PbR is the timing of development: moving to a tariff for community services is expected to take three years; implementation for acute services was within a 12-month period.

Transition costs

Evidence from the Centre for Health Economics (CHE) from an analysis of the administrative costs of PbR showed that the majority of costs incurred by PCTs and providers in implementing PbR were due to the recruitment of additional staff, as such, the cost increases of the policy were not temporary. Given the similarities with community services currency development, it is assumed that commissioners and providers will face permanent annual increases in their resource commitments to implement currencies as was the case with PbR, see annual costs for further information.

As previously stated, the costs of acquiring the necessary infrastructure for currency and pricing development are exempt from this Impact Assessment (IA).

DH will provide the development framework for currencies and pricing and then support implementation of the project for the first two years. The costs of this will be £300k per year for 1 FTE from a policy lead and £50k per year for two technical advisory groups to support development. DH will also undertake clinical engagement with a Marie Curie nurse and representative from the Chief Nursing Officers Directorate within DH. This clinical input will be provided at a cost of £60k. Doubling these costs to allow for two years of central government support and discounting to reflect time preference totals £806k.

Central agencies still have a role in supporting local initiatives for the first two years of implementation. The NHS Information Centre (IC) will be called upon to provide support as part of PbR development at a cost of £50k per year and NHS implementation support will cost £50k per year. In addition, economic support will also be provided by the PbR pricing team in DH at an annual cost of £60k. Doubling these annual costs and discounting to cover the 2 year period of support generates costs to central agencies of £315k. The total transition costs to the Department for policy option 2 are **£1.12m**.

SHAs will incur transition costs as part of their oversight function, they will be required to review the policy and discuss the strategy with the board. The cost of board review of a nationally developed policy is expected to be £1,150 per SHA (assuming salary +oncosts of £170k and a 2 hour meeting), a total for all 10 SHAs of £11.5k. In addition, SHAs will oversee and advise

their PCTs regarding implementation of the policy. Given the national direction of the policy, SHAs will provide ½ day consultancy to each of their PCTs at a cost per SHA of £3520 per SHA (assuming £170k salary plus oncosts for 60 hours consultation). The total cost to SHAs is **£46.7k.**

In developing currencies and pricing with local input, PCTs will have a role in developing currencies in conjunction with DH. As commissioners, PCTs will incur costs through consideration and planning of policy development. It is anticipated that responsible officers for finance and community services will spend 1 WTE for 1 week developing the currency and pricing strategy for the PCT, these costs total £5.4k for both employees (assuming a cost of £140k and one full week each). Dedicated time for PCT board discussion will total £1,150 (based on 12 board members with salary + oncosts of £140k). Total transition costs per PCT are anticipated to cost each PCT £6,550. These costs reflect that data collection and the necessary infrastructure will already be in place on which to build currency and pricing development. Across the 152 PCTs in England, these figures equate to total PCT transition costs of **£995.6k.**

Service providers are also expected to obtain a full understanding of the cost of currency development. Given the prior assumptions of this assessment, the costs they face are for a finance lead to review the policy at a cost of £575 per provider (assuming salary + oncosts of £140k for 0.33 WTE for 1 week) and for a full board review at a cost of £1,150 (12 board members with salary and oncosts of £140k). Across 152 community service providers, transition costs equate to **£262k.**

Transition costs of option 2 total £2.16m

Annual costs

The DH will incur annual costs once the policy has been implemented to monitor and report on activity and outcomes of currency development for community services. These costs are estimated to be £100k per year after the second year of development. Considering the 5 year horizon of this assessment, DH costs for these activities will total **£271k** accounting for the 3.5% discount rate.

Annual costs to SHAs will also be absorbed as business as usual in their roles as system managers.

As previously stated, it is assumed that, in line with PbR development, the majority of costs associated with the project will permanently accrue to the NHS. The analysis by CHE suggested that the direct costs to PCTs of establishing PbR within their organisation was been between £90k and £190k, the mean value of this range is £140k. However, these estimates of PbR implementation include collecting and coding patient-level clinical information, these costs will not accrue to PCTs for community services currency development as this work forms part of the infrastructure. As such, for this assessment, the costs estimated by CHE have been reduced to reflect the advanced status of community data prior to the currency development work programme. The range of costs, halving the contribution for information administration lies between £70k and £140k for PCTs, the central estimate is £105k. The mean value of these costs across all 152 PCTs is £15.96m within a range of £10.64m to £21.28m.

Considering the 5 year time horizon of the policy and discounting accordingly, the total average cost to PCTs as commissioners is **£74.6m**, £490k per PCT. Given the uncertainty around this central cost estimate, the anticipated minimum costs to all PCTs are expected to be £49.7m with a maximum of £99m over 5 years.

Permanent costs of a similar nature will also accrue annually to providers. CHE estimated the costs to Trusts providing acute services that implemented PbR to be between £100k and £180k. Deflating these costs to reflect the established community dataset prior to currency development yield estimates of between £50k and £150k, the mean value is £100k. The total average cost across all community providers is £15.2m with a range of £7.6m to £22.8m.

For the 5 year time horizon under consideration, annual costs to community service providers will total **£71m** when discounted for time preference. The range within which these costs may lie when accounting for uncertainty is £35.5m to £106.5m

These annual costs total £29.18m, discounted over the 5 year time horizon they total £146m. The range of costs accruing to commissioners and providers is likely to vary, the band widths are consistent with the variance in costs outlined by the Centre for Health Economics in their assessment of administration costs of PbR. As such, the minimum annual costs are expected to be £85.5m and maximum costs are anticipated at £206.26m

With transition costs of £2.16m and total annual costs of £146m, the total cost of option 2 for the full 5 years is £148m with a range of £87.7m to £208m.

Non-monetised costs

Following a review of PbR by the Audit Commission, a three-tier model of the principles for pricing was outlined (see intervention and options). It is likely that different community services will be best suited to different currency and pricing strategies, national or local. As local areas develop currencies preferred pricing principles for services will be identified. It is not yet known which model is best suited to different services. As such, the costs of implementing full pricing strategies for services cannot yet be identified. These issues will be reviewed as DH produces further documentation and provides additional support for community services.

Benefits

In undertaking local development of currencies and pricing there are likely to be significant benefits at PCT level in undergoing the process of creating currencies for commissioned services. However these benefits are likely to be unevenly distributed amongst local commissioners and populations depending upon the approach taken and the capability and systems in place to support the initiative.

In developing the community nursing service tariff in Tower Hamlets PCT almost £2m of cash releasing savings were identified through restructuring provision using new case management and skill mix arrangements. The redesign of the care pathway for LTCs as a result of tariff development also has a value estimated by the PCT of £2m. The process of tariff development requires a service review and as such the development process provided benefit to the PCT in highlighting where savings could be made. Additional work commissioned by the PCT identified a ‘gap’ equating to £12m between expected and reported prevalence of a set of disease groups within their population, the cash savings identified through tariff development will fund 25% of the nursing posts required to meet this need.

Potential benefits from developing a currency for community services are indicated by work commissioned by the service highlighting areas of excess capacity and as such where productivity could be increased. Currency development can contribute to this work by the requirement to have a close understanding of the services delivered in developing service units. This work entails reviewing current service arrangements where datasets are in place to highlight inefficiencies.

Meridian Productivity Ltd is an organisation focussed on the core principles of productivity, which specialises in working within the Healthcare Sector. They have worked with a large number NHS community services provider arms and consistently identified productivity opportunities. For example, NHS community clinics were identified that have utilisation of only 8% and a review of community service lines identified potential savings of up to £1.5 million per service line.

Meridian Productivity Ltd worked initially with 9 PCTs in the north of England. Results from this work and subsequent studies identified that there is the potential for productivity gain of up to 25% in community services:

- District nurses spend around 50% of their time with patients. 75% is realistic.
- Health visitors spend around 40% of their time with patients. 65% is realistic.

Another consultancy firm, McKinsey, have worked with a number of PCTs and found the potential for productivity gains of up to 27% within these PCTs. Large variation in productivity across all staff groups were identified such as a variation of between 11 and 34 district nursing visits per WTE per week. McKinsey also found evidence to suggest that 10%-15% of admission to community hospitals for rehab were inappropriate.

Partnerships UK worked with PCTs in NHS London on a variety of issues, including provider performance. They also found wide variation in productivity in community service delivery. The number of contacts per WTE for community nursing varied from less than 200 per year to over 800.

Although this evidence suggests large savings and productivity gains for PCTs, they are difficult to realise within the current commissioning framework. Service providers do not currently have a detailed understanding of the services they run and employees do not have a sufficient framework of standards and goals to work towards. The requirement to have an acute awareness of the services provided in order to develop currencies and pricing will allow providers to review their current operations and restructure, as experienced by Tower Hamlets PCT in order to realise these productivity gains.

The benefit of undertaking a service review is already being recognised as individual PCT provider arms undertake detailed analysis of their services, (costs and methods of provision) as part of the expansion of PbR tariff to cover some community services. PCTs not formally involved in this development work have recognised the benefit and are continually joining the programme.

Using the evidence from the consultancies as outlined above, the value of benefits to be gained through developing currencies and pricing can be estimated. The analysis by Partnerships UK

suggests that there is significant potential for improvement by increasing the number of contacts annually per WTE. Their evidence suggests that providers can make more contacts annually given the high end value of the reported range. Whilst not assuming that every provider would immediately be able to achieve the capacity of the most efficient, with 800 contacts per WTE per year, it is reasonable to assume that providers will take steps towards productivity improvements.

The mean value of the variation in contacts reported by Partnerships UK is 500 contacts per WTE per year, this is taken to be the assumed number of contacts per provider for this analysis. Conservative estimates suggest that a minimum of 10% productivity gains can be realised through service redesign, with an upper limit of over 25%. As a result of identifying current service provision and associated costs to develop currencies it is likely that large productivity increases will be realised in year 2 after service reviews have been undertaken and productivity improvements identified.

The average cost of community staff as derived from the Unit costs of health and social care 20075 published by PSSRU is approximately £45 per contact. Using this information and the evidence and assumptions outlined above, values can be placed on productivity savings derived from the process of tariff development. These estimates generate total estimated benefits of £186m over the 5 year period of this assessment. These savings work out to be approximately £1.22m per PCT over 5 years.

Based on the evidence from productivity studies with different groups of PCTs, the average number of contacts per WTE per year for community services is 500 and there is the potential for maximum productivity gains of up to 25%. For the purposes of this analysis, a conservative estimate of 10% productivity gains are expected over the 5 year time horizon of this analysis. It is assumed that service reviews in year 1 will highlight significant opportunities for productivity improvements in subsequent years, there will be a one year delay in the realisation of benefits to allow for service review. Gains will then follow at rates of 2%, 3%, 3% and 2% in subsequent years.

Using these assumptions each PCT will realise benefits of £1.47m over the 5 year time period. Across all PCTs for 5 years, these gains will total **£223m.** The service is not expected to use this cash release to generate savings for local organisations but to re-invest in primary care services to improve the service offered. This use of funds will be valuable in moving care closer to home by transferring activity from hospitals to the community setting where appropriate.

Given the uncertainty around the potential for 10% productivity gains to be realised by all PCTs, further assumptions about expected patterns of behaviour can be used to generate confidence intervals around the benefits. A useful approach is to assume that a proportion of PCTs do not realise the full potential gains of the policy or realise them sooner than anticipated. Assuming that 1/2 of PCTs reach 8% productivity improvement in 5 years, a lower level of benefits of £201m will be realised. If however, 1/2 of PCTs are able to realise benefits within 4 years of policy introduction, benefits will be £237m.

Non-monetised benefits

Many of the benefits identified as a result of PbR implementation are expected to be realised for community services once the programme begins to be implemented, development of currencies and pricing at the national level will bring substantial benefits through the speed at which the policy can be implemented and benefits realised.

The steps involved in the process will give commissioners experience towards achieving the competencies required of World Class Commissioning and thus meeting one of the key requirements of DH. In working towards becoming World Class Commissioners and developing currencies for community nursing services, Tower Hamlets PCT were able to redesign the nursing service offered in the community to target unmet need following a service review necessary to support tariff development.

Once developed, the use of innovative currencies can incentivise desirable organisational systems, individual behaviours and lower barriers to integrated care delivery. Currencies can also help to manage variation in quality and outcomes in community services by benchmarking. There is also the potential to reduce variation in costs by highlighting those where the current prices charged do not reflect the cost to the provider of service delivery.

Recent strategic changes to the NHS with direction from DH are moving towards a 'patient led NHS'. An important step in this movement is investigating methods by which patients can play a more active role in determining service provision. The DH will be piloting personal health budgets beginning in 2009. Developing currencies and prices will bring significant advantages to this project by being able to identify the costs of different units of service. This information will help patients and clinicians to trade-off options of care pathways to choose the most appropriate for the patient and their budget.

National development of currencies and then prices will create NHS wide consistency supporting benchmarking and the choice agenda. A report from the National Audit Commission (NAO), which is still in draft but due to be released this calendar year, calls for:

- National guidance on funding for end of Life care services as the historic grant making system has produced funding inequities. It should provide the basis for setting tariffs but leave enough room for local circumstances.

The same draft report also estimates that expected benefits such as improved quality of care, patient experience and outcome as well as potential cost savings through reduced hospital admissions- thought to be £104million per year are achievable in the medium term. This saving can only be realised if many of these services and patients are provided for in the community. The proposed national development of currencies and pricing can help expedite this progress.

Earlier this year the Audit Commission released a paper into the benefits of the existing PbR work: The Right Result? PbR 2003-20076.

Chairman of the Audit Commission Michael O'Higgins said:

'Now that the NHS has implemented Payment by Results, it should start to deliver the significant increases in productivity and efficiency across the NHS that the policy was designed to achieve.'

Key findings by the Audit Commission:

- PbR has encouraged a better understanding of costs
- Interest in information and information quality has improved as a result of PbR
- PbR has encouraged PCTs to strengthen commissioning and focus on demand management

- South West Essex PCT believes use of tariff biggest single impact on provider behaviour of any reforms
- Use of tariff has undoubtedly played apart in improved financial standing of NHS organisations

Key recommendations by the Audit Commission;

- DH should invest in development appropriate payment mechanisms for community services
- DH/NHS should explore the use of separate payment mechanisms- i.e. not just tariff PbR

There are significant advantages in national, departmental led development of options for currency and prices. In the absence of DH provision of this information PCTs may either invest in identifying this information for themselves such as the qualities required for an appropriate currency or may proceed in the absence of this information.

Net Benefit

Given costs of £146m and benefits of £223m, the anticipated net benefit of option 2 is **£75.1m.** The range of anticipated benefits for option 2 is from within the range lying between -£7m and £149m.

Although the range of benefits includes negative net benefits this reflects the time horizon of this analysis. The continual accrual of gains over subsequent policy years means that positive net benefits will be realised from the worst case scenario of maximum anticipated costs and minimum anticipated benefits in year 6. The maximum costs over a 6 year period would total £246m but the minimum benefit over 6 years will be £284m generating a net benefit of £38.6m. In all subsequent years, whilst annual costs will remain at around £100k per organisation, annual benefits once 10% productivity gains are realised will remain at around £1.47m year on year per commissioner and provider.

Key assumptions/sensitivities/risks

There is financial risk involved in implementing currencies and cost and volume contracts. With block contracting the commissioner faces a fixed price for the provision of community services by a particular profession for their population. With cost and volume contracts there is an incentive for providers to increase their productivity thereby increasing revenue. Analysis of the options to mitigate this risk need to be identified by local commissioners.

It is assumed that whilst development is underway, providers and commissioners will adopt an open book approach to facilitate identifying costs and units of currency for community services. If this does not occur there may be more difficulty in achieving accurate currencies and prices and the full intended benefits may only partially be realised.

5. Conclusion

Analysis of the preferred policy option relative to no intervention from the Department of Health clearly demonstrates that intervention has the most significant net benefits and is the preferred method of achieving the objectives set out in this paper.

Policy option 2, local and nationally led currency and pricing development reflects the NHS's preferred way forward for community services currency development that has been expressed

in the latest PbR consultation work. This is a mixture of national and local work. Further more the complexity of community end of life care services and the mixture of non-NHS organisations involved there provision would place a large burden on local NHS organisations to tackle. The DH is better placed to complete this piece of currency work. Finally option 2 moves towards achieving policy aims quicker than option 1 as development is happening not just locally but also nationally.

6. Impact on the private sector

The preferred policy option is not considered to have any impact upon the private sector relative to no intervention. Community services are currently provided by PCT provider arms, although they will become increasingly separated from PCTs as a result of the Transforming Community Services programme, they are currently public sector agents and as such, the cost of developing currencies and prices will be accrued by the public sector.

Transforming Community Services aims to generate a competitive market for the provision of community services and as such new providers to the market may be from the private sector. Currencies and prices are a necessary step to the development of a competitive market to create a unit of transaction with which to trade services. As such, costs outlined in this document accruing to the providers of community services will not be considered as additional costs to any potential private sector providers. These costs are part of the cost of entry to the market that any potential provider will account for them in their marginal decision of whether to enter the market.

7. New Burdens on Local Government

A new burden is defined as any new policy or initiative which increases the cost of providing local authority services. This policy does not result in local authorities incurring additional costs. Although there are close links between the provision of social care through community services the local authority, as a joint commissioner, will not incur additional costs. Joint commissioning strategies are PCT led and as such, any costs that arise through the requirement to use currencies and pricing for jointly commissioned services will be incurred by the responsible PCT.

8. Sustainability

Sustainable development ensures that the needs of the present are met without compromising the ability of future generations to meet their own needs. The policy outlined in this IA helps to ensure that this condition is satisfied. The implementation of currencies and prices that reflect the costs incurred in service provision ensure that services are provided in optimal quantities within the resource constraint. Bulk contracts, as currently used for 90% of community services lead to disincentives for providers to deliver more services than their contracted amount and the price negotiated for the contract may not accurately reflect the cost of factors used in service delivery. Developing cost and volume contracts create incentives for services to be provided efficiently thereby increasing the quantity of services delivered within the same constrained budget. Implementing this market mechanism creates a sustainable service within the scope of this policy.

9. References:

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Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	*Results in Evidence Base?*	*Results annexed?*
Competition Assessment	No	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	No	Yes
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	Yes
Rural Proofing	No	No

Annexes

Screening template

Title and short description

Title: Currency and Pricing Options for Community Services

Current contract mechanisms for community services are not sensitive enough to support and incentivise the strategic changes that form part of the vision put forward in High Quality Care for All and The Next Stage Review: Our Vision for Primary and Community Care. These are to support the transferring of work out of hospital and treating more patients in a community setting. In addition, commissioners are often not aware of whether they are obtaining value for money from their existing contract baseline with their own provider services and primary care due to the lack of transparency and paucity of data.

In the past, community services have not been a major focus of developments in information systems. Earlier initiatives have failed because of the difficulty in capturing data in the community. Consequently, while there is a broad understanding of what community services are, there is very little robust information about service volumes, costs, quality or outcomes.

Without government intervention it is likely that commissioners will continue to struggle to make sound financial investments when commissioning community services. Patients and carers will continue to experience waits for services and will not be able to exercise choice of services to due to many providers monopoly positions and lack of data to support choice.

The aim is to have a significant proportion of all community services moved from block contracts to cost and volume contracts using new contract currencies and prices from April 2011 onwards. The intended effects of this is to improve the value for money that commissioners can get from providers. It is also intended to drive up the quality of services to benefits patients and increase the choice that patients and carers have when access community services. The use of new currencies with accurate pricing should lead to more services being available in the community, closer to home for patients.

For example:

Transformational Change

Local needs as highlighted in Joint Strategic Needs Assessments and Regional Next Stage Review plans should increasingly be addressed in a more integrated manner of working than is currently the case. This helps commissioners and providers understand the scale of the financial risk they may be exposed to as a result of moving away from block contracts.

The innovative use of currencies can incentivise desirable organisational, systems, individual behaviours, and lower barriers to integrated care delivery.

World Class Commissioning

The World Class Commissioning Assurance Framework sets out eleven core commissioning competencies that a World Class Commissioner would demonstrate. Attainment of four of the competencies can be strongly linked to the use of new commissioning currencies and pricing mechanisms. These are:

•Competency 4; Leading continuous meaningful clinical engagement can be enhanced through the significant clinical input into describing the services that make up a particular currency.

•Competency 7; Stimulating the market by seeking to commission tightly defined service offerings. Increased meaningful and comparable information will be available about the community services as a result of currency and pricing development, this can enhance both choice and competition for the services.

•Competency 8; Promoting improvement and innovation can be supported through the intelligent use of currencies and pricing to incentivise desirable service provider and system behaviours.

•Competency 11; Making sound financial decisions through an understanding of the balance of financial risks associated with moving to new contracting currencies. The development and use of currencies will also lead to a clearer picture of the value for money that any particular service represents to a commissioner.

Shifting Care

The Next Stage Review: Our Vision Primary and Community Care reiterated the message of the Our health, our care, our say White Paper, that care needs to shift as close to home as is safe and effective. This will improve choice and access for patients.

To support this shift in care we need to be able to identify and pay for this activity. This may require the development of currencies to describe new ways of delivering care.

Managing Variation

Community health services vary in the quality of service they provide and the outcomes they achieve for their patients. Without comparable commissioning currencies it is difficult to identify this variation and hence it is impossible to tackle. The use of consistent currencies will facilitate benchmarking and help commissioners to choose high quality providers.

The process of developing currencies will also highlight variation in the cost and quality of service delivery. This process includes building a much more detailed understanding of existing services costs, delivery methods and outcomes than currently exists for most community services.

Improving the quality and outcomes of community services across the board may not reduce health inequalities. Population groups identified in local Joint Strategic Needs Assessment as suffering from health inequalities may need a special focus to close the gaps with the rest of population. Currencies and pricing mechanisms can be developed to incentivise providers to focus on these groups.

The greater transparency should also lead to higher productivity from community services.

Negative impact

This policy will not have a significant negative impact on equality in relation to:

Disability

Some community services are specifically designed to meet the needs of disabled people, for example community equipment services, speech and language therapy etc. Due to the current lack of understanding of how these services are organised, what exactly they provide and how much this costs a it is not possible to benchmark the existing level of quality of these services or to improve the current service offering.

The DH has recently completed a review and a publication based on the review is due shortly entitled Information Models for Community Health Services. The review found that there are many emerging models of good practice, but very poor levels of consistency and no national best practice or minimum data set for community services.

The development and implementation of new contract currencies and prices is a tool to help commissioners and providers address this issue by providing a transparent and increasingly consistent understanding of what a quality service is.

Ethnicity

It is well known that people from some black and minority ethnic groups have a greater prevalence of some long-term conditions such as diabetes and coronary heart disease. Many community services are particularly focused on these conditions, but it is not currently possible to assess whether service provision is appropriately matched to need or local circumstance. Through the development of contract currencies for community services, it will be possible understand current service provision and reconfigure service delivery to best meet local needs.

For example the head of policy at Diabetes UK, Bridget Turner, commented in September 2008 that Middle-aged Asian women are at higher risk of diabetes and cardiovascular disease than other woman and are probably not getting enough exercise because the mechanisms for the delivery of care are not in place at PCT level.

New contracting currencies are designed to support the development and implementation of the mechanisms that Bridget refers to.

Gender

It is not currently possible to assess whether community services equally meet the needs of both males and females. As the common dataset for community services becomes embedded this information will be more readily available to support the development of contract currencies and prices that can improve access to services for both genders.

Sexual orientation

It is not currently possible to assess whether community services adequately meets the needs for people of any sexual orientation. As the common dataset for community services becomes embedded this information will be more readily available to support the development of contract currencies and prices that can improve access to services for both genders.

Age

In many PCTs, older people are the largest population group who use community services. Children are also a significant group and some services, such as health visiting and school nursing, only cater for children and young people. There are currently a number of performance indicators for social care for both older people and for children, but the range of measures for healthcare is much more limited. The development and implementation of contract currencies and prices and an associated understanding of best practice models of care will help to reduce inequalities and improve outcomes for both groups. In particular, contract currencies which support greater integration of care should lead to fewer older people being admitted to hospital and will therefore increase their independence.

For example currently only about 55% of general nurses and a third of doctors reported being trained in the use of at least one of the three main end of life care tools. (NAO, 2008) New contract currencies could provide a lever for commissioners to require providers to provide end of life care services using one or more of these three tools.

Religion or belief

It is unlikely that development and implementation of new contract currencies and prices will have any effect on a cohort of service users or carers defined by religion or belief.

Positive impact

The aim of this work is to improve the commissioning and productivity of community services. It will provide the tools for commissioners an providers to improve the productivity of community services provision.

It is expected that this work will lead to a better understanding of community services and issues relating to equality such as access and health outcomes by different patient cohorts. As a result of implementing this policy commissioners and providers will be in abetter position to address the equality issues they face.

Evidence

Very little quality evidence about community services currently exists. This is due to a traditional focus on the acute sector for service development, a lack o meaningful national data collections and a historic underinvestment in data collecting and reporting infrastructure. However the Operating Framework for the NHS for 2008/09 requires PCTs to “create an internal separation of their operational provider services, and agree Service Level Agreements for these, based on the same business and financial rules as applied to all other providers.” This will require the creation of a robust business platform for community service providers, based on a new

standard contract with activity and outcome measures, contract currencies and performance indicators.

Further evidence for implementing this policy is the fact that PCTs annually commission circa £10b worth of community services, 90% of which is on block contract with little or no meaningful contract or performance management.

Work produced by private consultancies analysing the productivity opportunity in community services further adds weight to the need for this policy on productivity and economic/financial grounds.

Example:

Meridian Productivity Ltd is an organisation, focussed on the core principles of productivity, which specialises in working within the Healthcare Sector. They have worked with a large number NHS community services provider arms and consistently identified productivity opportunities, for example NHS community clinics that have utilisation of only 8% or and savings of up to £1.5 million per community service line. Realising this savings and productivity gains is proving difficult because:

Most provider arms have not currently got a detailed enough understanding of the business they run

Individuals need to be convinced there are better ways of working, and are assisted in setting real goals and standards to work towards, the situation will never change, and significant opportunities to improve patient service and focus will go unmet.

Screening assessment

The policy does not require a full EqIA. This policy directly targets commissioners and providers to better understand the businesses they run. For example the costs of service provision including apportionment of overheads and treatment of VAT for community services.

The 2010 or 2011 evaluations highlighted in the 'next steps' box below may conclude that a full EqIA is needed at that time and accordingly one will be carried out.

Next steps

A formal evaluation of work to date is being undertaken in Mid 2009, with further reviews May 2010 and 2011 to ensure that the policy promotes equality and helps to eliminate discrimination. These reviews will be lead by the DH to also help monitor the situation as the policy making proceeds and the policy is implemented.

The 2009 evaluation will consider focus on the technical implementation issues. However, it will also look at how implementation of currencies is likely to affect equality. The subsequent

reviews will have an increasing focus on equality issues as the new contract currencies will be increasingly embedded for a greater range of community services across NHS community services.

Get the document signed off by a Director, have it published, and keep it on file as your partial EqIA. Copy it to the EHRG.