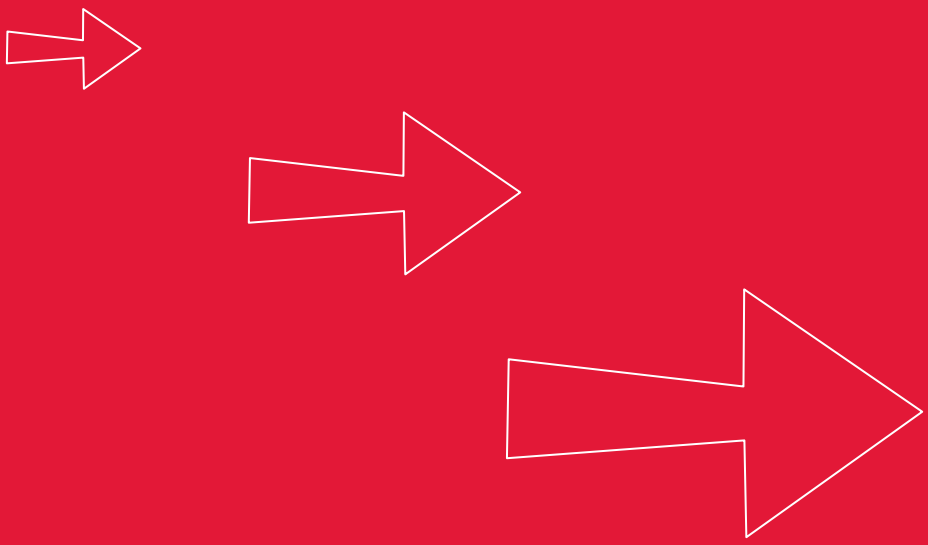
How to Guide No.3

Generating Economic Evidence for Innovation



THE YOUNG FOUNDATION

Contents

Introduction 4

Overview of the approach 6
- Structure 6
- The audience 10

1. Element A: Measuring the outcome 11
- Selecting the baseline: historical data 11
- Selecting the baseline: geographical data 12
- Selecting the baseline: control groups 12
- Bias within the data 13
- Statistical significance 14

2. Element B: Bridging assumptions 15

3. Element C: Cost assumptions 17
- Project costs 17
- Cashability 17

4. Calculation: Project savings ÷ Project costs = ROI 18
- Project savings 18

5. Further considerations: tailor to your audience 20

Conclusion 21

Annex – Commissioning in the NHS 22
- Current system 22
- PCT clusters 23
- New system – April 2013 24
- Other issues 25
- Payment by results, block and cost, and volume contracts 25
- Marginal tariffs 25
- Readmission payments 26
- CQUIN 27
- Best practice tariffs 27

Introduction

This is the third in a series of five *How to*[1] guides developed to help funders and project leads to set up and sustain innovative projects across the NHS. These *How to* guides draw together the material on supporting health innovation which the Young Foundation has been delivering and refining as part of its support for the Regional Innovation Funds (RIFs).

The 10 Strategic Health Authorities (SHAs) launched the RIFs in April 2009 to tackle the challenge of developing and mainstreaming innovation within the NHS. Fulfilling their mandate to lead service delivery innovation in the NHS, the SHAs have developed a portfolio of projects which attack some of the most urgent issues facing the NHS today by unleashing the imagination and knowledge of frontline staff. The SHAs have developed and refined a great deal of learning on how to promote and diffuse innovation across their areas, embedding innovative practice in day to day delivery.

The Young Foundation and NESTA have been supporting the SHAs in this enterprise, bringing deep experience of public sector innovation to bear. In this series of guides we collect much of the material that we have been using to perform this support role, refined by our participation in the RIFs, in order to contribute to the ongoing legacy of the RIFs.

This guide is set in the context of a likely period of flat budgets, despite rising demand. Against this backdrop, there is a real need for new ideas that can deliver both improved outcomes and reduced cost. Those that cannot demonstrate more for less may find ongoing funding hard to secure. The purpose of this guide is therefore to increase the ability of projects to create persuasive economic evidence.

This is not an invitation to exaggerate the cost savings, not least because this is unlikely to be effective. The health economy is full of promises that huge, long-term cost savings can be achieved by a given piece of equipment or a new service, if only the upfront cash can be found. Your likely audience will have acquired a hard-headed attitude to these sorts of promises.

Therefore, this guide is built around two key themes.

Building the economic case is dependent on being believable and persuasive.

Firstly, a **persuasive economic case is conservative**. Unlike an academic work, an economic case can be *more* persuasive when it is *less* accurate. Demonstrating that an investment of £1m will save at least £2m under the most conservative assumptions is far more likely to result in a positive decision than a return on investment (ROI) calculation that shows a larger saving under questionable assumptions. A lower number can have a greater persuasive force, due to more robust assumptions.

The second quality **of a persuasive economic case is simplicity**. Strong economic cases can usually be simply stated, and readily understood. Complexity can be seen as a sign of a weak case. As well as credibility, there are presentational advantages to a simple, overarching case. While there will often be considerable complexity in the details, a simple and straightforward explanation of the basic argument will be memorable to your audience. Further questioning will allow them to unpack the assumptions contained in this argument. Your audience must not get lost in the detail, but retain a sense of your achievements.

The act of producing an effective economic case also brings benefits. It codifies in a simple way the economic theory of change that underlies the project rationale, and forces the project lead to understand the core principles of the intervention. It can feed into the ongoing monitoring of the project and bring into focus its potential effectiveness.

[1] *How to find and select the best innovations*
How to contract, monitor and evaluate innovations
How to generate economic evidence for innovations
How to design and deliver support to innovations
How to diffuse innovation

Overview of the approach

In order to produce a convincing economic case, it helps to use a simple structure. This section provides a brief overview of the approach. The subsequent sections outline a more detailed breakdown of each element.

Structure

Figure 1 highlights the core elements of a persuasive economic case.

In the first instance it is important to explain the **outcome** that you are measuring, together with the reasons why that measurement is robust and accurate.

Next, outline any **bridging assumptions** that you make. Nearly all calculations of ROI will need to make assumptions about facts that are not absolutely known, either because they are forecasts of the future, or because the precise fact about the world is not known exactly. Bridging assumptions are those that are necessary to translate the variable that is being measured into a resource that can have a cost attached to it. For example, consider a project that allows paramedics to treat more cases at the roadside rather taking them to A&E. A necessary bridging assumption would be the number of A&E journeys that the average ambulance makes in the relevant area. You will need to explain why they are well sourced and conservative.

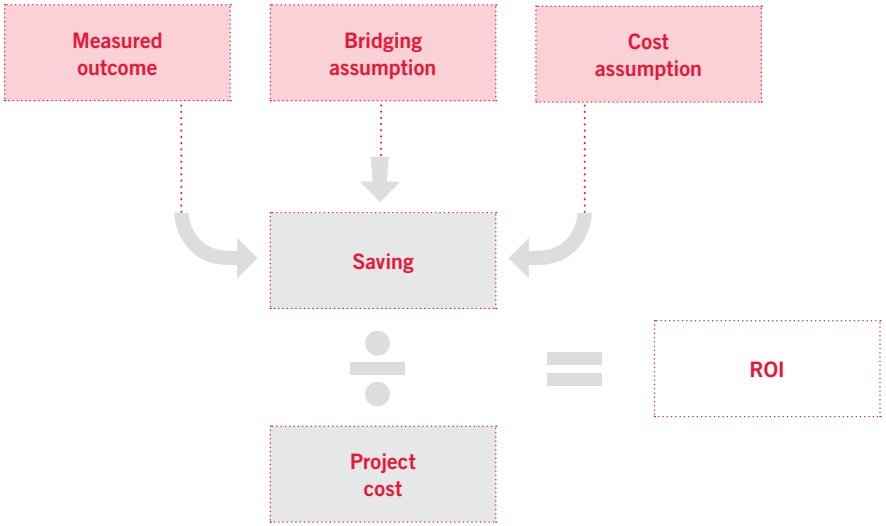


Figure 1: Basic structure of an economic case

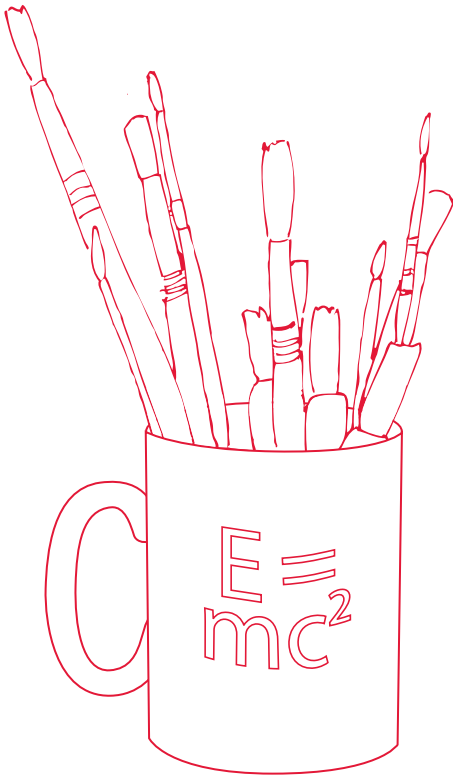
The final element looks at the **expected cost** of the expense that you are reducing, and an explanation of the extent to which this is cashable[2].

These three together will give an indication of the **saving** generated by the project.

Once the three elements are brought together the **cost of the project** you are running is included. This must include not only the direct costs of the project, but any costs that the system incurs as a result of the project. For example, working with a hard to reach group may make them more likely to use other NHS services (for example, a GP), despite a fall in their total costs (fewer A&E visits, and fewer long-term health problems). Sometimes, calculating these costs and establishing causation can be challenging. Including additional information on the rationale for these types of additional costs can be helpful.

The **ROI** will be the ratio between this and the cost of the project.

Understanding and developing useable, effective ROI figures is both an art and a science.



[2] Cashability relates to the ability to realise a saving. Ie if an intervention saves a resource, can you withdraw it from the system, or will it be taken over by another part of the system?

Simplified ROI case study[3]

Nineteen per cent of all 999 calls in this area are fall-related, totalling 1,000 calls a year at the beginning of the RIF project. These calls are attended by an ambulance with 50% resulting in conveyance to A&E and 30% of those patients are admitted to A&E. This RIF project proposes responding to those calls with a rapid response falls car that has an emergency care practitioner and a social care practitioner with direct commissioning rights on board.

The project hopes to deliver a range of outcomes including reduction in the number of patients that need to be conveyed to A&E (because the falls car is able to respond to immediate and longer term social care and preventative needs of patients), a resulting fall in the number of admissions to A&E and in the longer term a reduction in the number of falls overall by modifying and improving the domestic environment for people at risk of falling.

Some information to compile an initial projected ROI is available and includes:

Measured outcomes:
Change in number of falls overall

—

Change in number of patients conveyed to hospital

—

Change in the costs of falls car vs ambulance

Bridging assumptions:
The falls car will result in a reduction in the number of falls calls to the ambulance service

—

The falls car will result in fewer patients being conveyed to A&E

—

Of those that are conveyed to hospital, fewer will be admitted

—

Average cost of falls car is less than £245 per response

Cost assumptions:
Average cost of £245 per ambulance response

—

£90 per A&E spell

—

£800 non-elective short stay admission per fall

Therefore, saving:
Reduce (from 50% to 10%) number of conveyance to A&E

Before
(500 patients x 90 = 45k) +
(150 patients x 800 = 120k) = 165k
After
(100 x 90 = 9k) +
(30 x 800 = 24k) = 33k
Saving = £132,000 per year

—

Reduced cost in running a car vs ambulance
Saving = £10,000 per year

—

Reduce (by 5%) number of falls calls
50 fewer patients x £245 = £12,250 per year
Saving £12,250

—

Total saving = £154,250 first year

Cost of the project:
1 Car + Staff + Time =
Total Cost = £100,000 first year

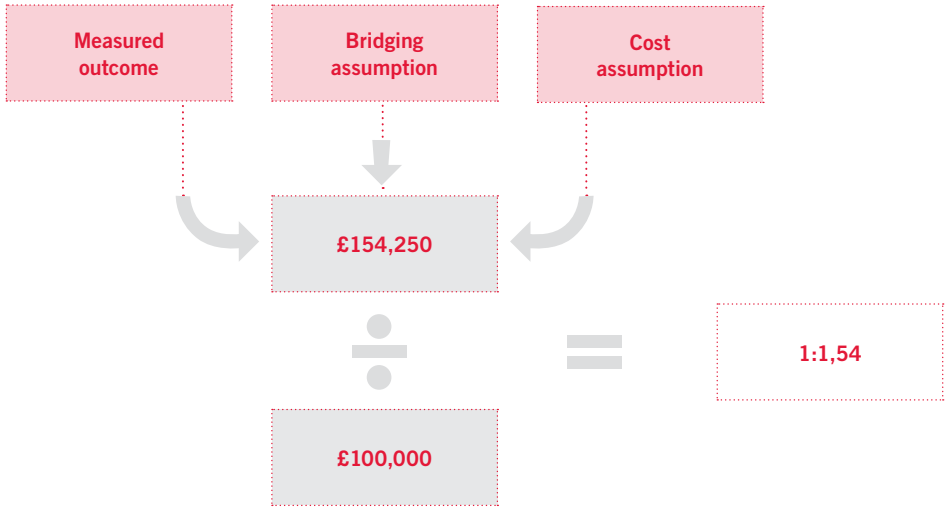


Figure 2: Example ROI (simple, conservative)[3]

[3] Based on a simplified RIF case study

The audience

One of the most important principles that should be kept in mind is the audience to whom the case will be made and who, when and how they benefit (or not) from savings. This will have three main impacts on the way the case is presented.

— 1

Certain savings will be accessible to certain parts of the health service. A reduction in length of stay for a given patient group will be a saving to the acute trust, but will be hard for commissioners to access. A reduction in admission rates, on the other hand, will be a saving for the commissioner, but a cost for an acute trust. For a basic introduction to the structure of NHS payments, see Annex.

— 2

It is important to consider if and **how savings might be cashed**. For a provider, it will be necessary to close beds or wards to realise savings, which, in turn, requires a certain scale. For a commissioner, a reduction in admissions for a given illness will result in a cash benefit, but other patients may come to fill the beds, offsetting the cash benefit.

— 3

Different audiences will have different concerns and require different standards of proof. Certain audiences may accept assumptions that another would question. What seems reasonable in terms of the cost of a resource like a bed day will vary. Where possible, it is extremely helpful to have a conversation with your key stakeholders early and to build their particular view into your case.

Key points

Make **conservative** assumptions, including on costs

—

Be as **simple** as possible

—

Show **robust** and accurate measurement of the chosen outcome

—

Be **tailored** to the specific audience for whom it is intended

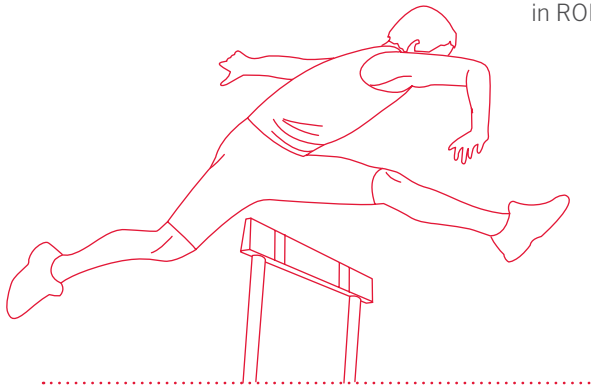
—

Indicate how savings might be **cashed**

1
Element A: Measuring the outcome

The first issue in estimating the savings generated from a project is the measured outcome. Typically this will be the difference between the results for the patients or staff within the project, and a baseline. For example, length of stay for patients undergoing a new rapid discharge process relative to patients treated conventionally, or reduction in inappropriate referrals from a given GP practice relative to the previous year.

Gathering data about the target group is usually relatively straightforward. A far more common source of issues is in the selection of the baseline. The guiding principle is that the baseline should be a fair comparison. Patients or staff in the baseline group should be as similar as possible to the patients or staff in the project. When the only relevant difference between the two groups is participation in the project, we can be confident that the project is the cause of any improvement.



There can also be practical issues with the availability of data that need to be overcome.

Selecting the baseline: historical data

The simplest option for the baseline is usually historical data, for the individual patients, geographical area or particular institution. However this may not be appropriate when the data varies significantly from year to year for reasons that have nothing to do with the intervention. This can easily mask or exaggerate the effect of the intervention we are trying to measure.

For example in an area that is seeing a rising proportion of elderly people, certain conditions and outcomes will be rising year on year. An intervention targeted at reducing issues associated with old age, such as falls, may struggle to show a year on year improvement for the area unless the target patient population growth is included in ROI modelling.

Alternatively, for those interventions that look at historic data for the individual patients in the project, certain conditions may make baselines difficult. For example, conditions that show deterioration over time may mask the effect of the intervention, making it difficult to know what is due to the project and what is due to the underlying trend.

It may also be the case that data has not historically been gathered in the appropriate way. For example, it is possible to access referral records on a practice basis, but not necessarily on a GP by GP basis. Sometimes it is possible to analyse records in such a way as to create this data. For example, while a hospital may not typically collate length of stay data for patients over the age of 75 with COPD and diabetes, the IT team may be able to extract this from patient records. It is also possible to extract comparison data for a particular patient group from larger national databases such as Hospital Episode Statistics (HES-online).

For these sorts of analyses to work, patients must be selected by objective criteria, which can then be applied to a database of patient records. Informal criteria, such as the judgement of staff on the ground that a patient is suitable for admission to a particular service, make the construction of comparison groups from historic records impossible.

Selecting the baseline: geographical data

It may therefore be necessary for projects to use a baseline which is not historical, but which compares with similar patients over the same time period.

Comparison with similar geographic areas can do this. For example, a project might compare the change in the likelihood of emergency admission for those under the care of one community team relative to a similar nearby team.

Clearly care must be taken to ensure that the teams really are similar. The mix of patients is a key factor. It is also worth considering if any other local initiatives might have different effects in the two areas. For example, if one area is part of a pilot for a new reablement service while the other is not, then for certain projects it will be hard to know if any improvement in length of stay is due to the reablement service or the project. However, other comparisons between the two areas could remain perfectly valid.

Selecting the baseline: control groups

If no appropriate geographical comparison can be found, then it may be necessary to create a comparison group. This involves creating and tracking a second group. As far as possible, this control group should be identical to the group undergoing the intervention in all relevant respects. This may increase overall costs, but may be necessary.

Bias within the data

There are two subtle sources of bias that are worth mentioning: self selection bias and mean reversion. While an exhaustive list of the possible sources of bias is beyond the scope of this guide, these are two that occur on many occasions, and illustrate some of the issues that projects should bear in mind.

Self selection bias occurs in situations where individuals select themselves into a group, implying their motivation to change is greater than the average patient. An example of self selection bias might occur with a programme set up to work with diabetics who wish to improve their self management. It would be difficult to distinguish the effect

Return on investment calculations are dependent on creating an effective baseline – but this may not require a full randomised control trial – but clear, clever identification of a base group against which to measure progress.

of the programme from the effect of the decision by the participants that they wished to improve their self management. If the programme had not existed, these diabetics, due to their positive attitude, would likely have done better than the rest of the diabetic population, or than their own previous history. This bias, known as self selection bias, can really only be completely overcome by a randomised control trial, where there are a number of volunteers, and a randomly selected proportion are admitted to the programme, with the remainder tracked as a control group.

The costs and scale of a randomised control trial are often beyond the budget of many projects and this issue is often dealt with through simply acknowledging the variance self selection may cause in any extrapolation to larger patient populations.

Reversion to the mean is used to describe cases where individuals move back to the historical average for their group. An example of mean reversion might be a program where elderly COPD patients are selected for participation by virtue of a high level of short-term hospital admissions over the past year. The programme team might choose to measure whether these patients had fewer hospital admissions in the year after admission than in the year before. This would introduce significant bias into the experiment. This bias is due to mean reversion. Essentially there is an element of random bad luck in health. While some of the reason that this group had high hospital admissions over the course of the previous year may have been to do with the severity of their condition, or their housing, or their degree of support, some of it was likely to be simple bad luck. They are therefore likely to show some degree of improvement the following year, without any intervention, as they get an average amount of luck. Thus a completely ineffective intervention would show a positive result when admissions were compared year over year; the experiment would be biased.

Statistical significance

Given that we have data which is easy to gather and constitutes an unbiased measurement, the last critical consideration is whether there are enough patients undergoing the intervention for people to be confident that the outcome cannot simply be attributed to chance. This will depend on the size of the effect observed, the number of patients in question, and the natural variation in outcomes that might be observed. The general guidance from the NHS Institute is a minimum of 25 data points, but it is advisable for projects to run their plans past a competent statistician before the project gets underway.

2
Element B: Bridging assumptions

Ideally a measure of savings should be a direct measure of the costed resources used, for example bed days, or a treatment costed below the national tariff. This requires the fewest number of further assumptions and is thus most persuasive.

Where this is not possible, some intermediate measure will be chosen which can be converted into a costed resource by the use of assumptions. While this is less persuasive, it can, given appropriately conservative assumptions, be quite sufficient to persuade a commissioner.

For example, the measured outcome may be an improvement in the degree to which diabetes is well managed. Well managed Type I diabetics will use fewer resources than badly managed ones. While it may be impossible to come to a precise estimate of exactly how much less, it is likely to be possible to come to a persuasive estimate.

When presenting an ROI, it may be worthwhile to consider trading off the total return against the assumptions that are made. A lower ROI can be more persuasive when it is supported by more believable assumptions. Consider again the example of the well managed versus badly managed Type I diabetic. Suppose that the difference in cost between the two is composed of a difference in the number of acute admissions and primary care visits. These may not both be equally easy to confirm. For example, there may be good data to support the number of acute admissions, but weaker data to confirm the number of primary care visits. If the project is showing a very strong ROI, then it may be worth considering excluding the primary care cost from the calculation. A lower ROI will result, but it will be a more convincing case. Following this advice will depend on an understanding of what constitutes a strong ROI. This will change from area to area, and will depend on the perceived risk of the project. However, ROIs well over 100% per year can usually be reduced without substantially changing the persuasive impact.

As the number of different assumptions rises, the construction of a convincing economic case becomes more of an art than a science. Sometimes it will not be possible to take the most conservative option for every assumption in your calculation and still arrive at a positive answer. Then the case becomes a balancing act between various assumptions of varying degrees of uncertainty.

A second issue is that these bridging assumptions should be well sourced. If the effect of a drug on the subsequent likelihood of a stroke is a key assumption, then there needs to be a high quality academic source for the estimate. Often the easiest sources to find are those connected with campaign groups, since they often publicise their materials widely. However, these can prove to be less than reputable sources, selecting their numbers for public impact rather than academic rigor. Do ensure that the source is reputable.

3
Element C: Cost assumptions

Even when directly measuring the use of a resource such as bed days, a cost associated with that resource is still needed. Sometimes the national tariff will provide an appropriate number, but on other occasions an estimate will be required. Again, assumptions should be conservative.

Cashability

It is worth considering the issue of 'cashability' – to what extent can a saving be converted into cash in the short term. Cashable savings can be released for the wider system, which is clearly valuable. However, productivity improvements are valuable even without being cashable, where service quality and outputs are improved instead.

In order to consider the cashability of a project, it is necessary to have a simple understanding of the broad rules on commissioning, so that one can understand what savings are cashable and for whom. A brief introduction is in the annex.

Simply, innovations that reduce length of stay or increase staff productivity largely benefit the provider organisation, such as an acute trust. Innovations that prevent admissions or further treatments benefit the commissioner. Some innovations may benefit both parties, for example, preventing readmissions.

For providers to cash a benefit, there will often have to be some capacity closed. Thus there needs to be consideration of the scale of benefit necessary to reduce posts or beds. A saving of a few bed days may not be sufficient to eliminate any posts, and thus not save much cost.

For commissioners to cash a benefit, there needs to be a reduction in demand, and some comfort that new demand is not going to fill the capacity. For example a reduction in elective admission will not be cashable if there is a long waiting list.

Some projects will have benefits for both commissioners and providers. For example, providers will now have to absorb the cost of patients who are readmitted within 30 days of their original discharge. A project that prevents readmissions may provide savings for both commissioners and the acute trust. In this instance there are cash savings for both sides.

Projects need to understand who benefits from their work, and be prepared to split out those savings amongst the various bodies that benefit. The annex to this document gives a brief introduction to how commissioning works in the NHS, which may help projects understand the flow of money through the system, and their own impact on it.

In this context it is also important to make sure that costs are not simply being moved around the system. Rapid discharge may put extra cost onto the community sector, while saving money for the acute sector. Such cost-push issues should be acknowledged up front.

4
Calculation: Project savings ÷ Project costs = ROI

Project costs

The cost of the project is the last input into the economic case and calculation of ROI.

While the overall cost should be simple and accessible from the project budget, not all of these costs will be relevant for every audience. The ROI case is often tailored to the commissioner (or similar budget holder) who could grant sustained funding to projects. The commissioner is going to be interested in how much it will cost to sustain the project in the following years (as well as how large the consequent savings will be). Any development costs already incurred, and which are not likely to reoccur, can be excluded from the calculation. The ROI is then the saving divided by the ongoing costs.

In contrast, the original funder will also want an ROI on its RIF investment, and this should include the development costs.

Sometimes scale will be an issue; the cost of delivering the new service will not be exactly proportional to the number of clients, especially when the initial project has been small scale. For example, a telephone service for MS patients may pilot with a small number of patients. A substantial increase in the number of patients could be accommodated with only a small increase in the number of telephone operators. The ROI of the pilot may be significantly lower than the ROI of the full scale service. For services of this type, a model of what the service would look like at scale is needed.

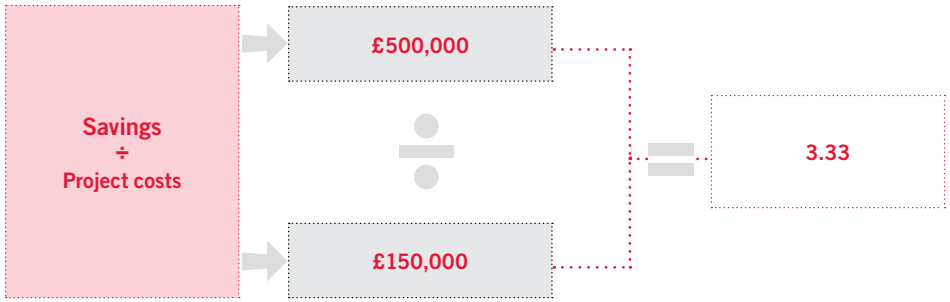
Project savings

The final project savings figure will be a culmination of the three elements described in this guide. It should be a final figure that conservatively estimates the total savings that will be achieved by the project, either over a year or for the duration of the project.

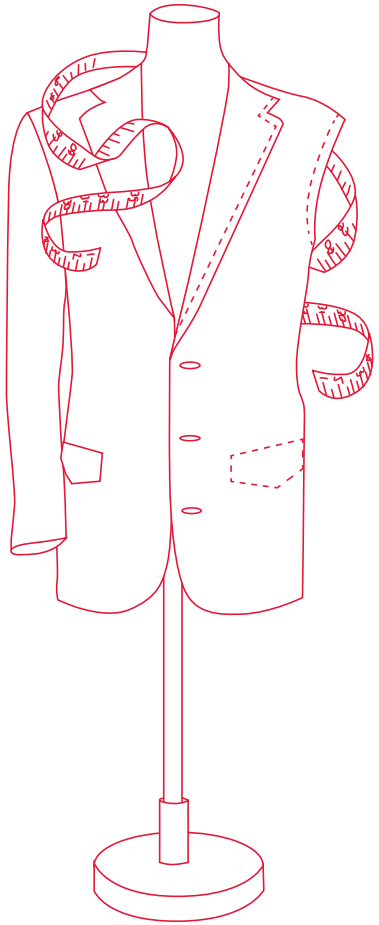
This figure should then be divided by the total project costs (either per year or absolute, depending on the savings figure) to present the ROI ratio. The persuasiveness of this ratio will depend on the assumptions behind the projected cost saving and project costs. Remember, these should follow the core principles of conservativeness, robustness and simplicity.

ROI figures can be expressed as multiples of the original investment or as a ratio.

Figure 3: Simple ROI calculations



3
Further considerations: tailor to your audience



The economic case is often targeted at a specific individual or committee that has the power to provide sustained funding for the project beyond the end of the RIF investment. This group will have its own particular views on what constitutes convincing evidence, and every group will be slightly different.

It is therefore important to run your ROI case past the relevant people as early as possible. If they find the measurement plan insufficiently rigorous, or disagree with the assumptions, then the project will be undermined from the beginning.

On the other hand, it is possible that the group in question has more relaxed standards than the project itself, and view the measurement plan as overkill. The project may be wasting effort.

Certain key assumptions such as cost per bed day vary significantly from institution to institution, and the group can let you know what they believe to be appropriate.

Finally, an opportunity to input at an early stage will give commissioners some sense of ownership of the project, which is useful in the longer term.

Conclusion

In the present fiscal environment it is vital that NHS innovators can show that their project makes good financial sense, as well as good clinical sense.

In order to do that, we recommend that the economic case follow a few simple principles:

Make conservative assumptions, including on cost

—

Be as simple as possible

—

Show robust and accurate measurement of the chosen outcome

—

Show how savings might be cashed

—

Be tailored to the specific audience for whom it is intended

Understanding and building economic evidence for innovation projects helps build overall understanding of the progress and impacts for the whole of the project team. Investment in creating ROIs brings dividends beyond the economic case.

Annex – Commissioning in the NHS

Following the release of the NHS White Paper, *Equity and excellence: Liberating the NHS*, in July 2010, as well as the Comprehensive Spending Review in November 2010, the commissioning environment of the NHS is set to change drastically. This is extremely relevant to projects seeking permanent funding, as the costs and benefits of service and product changes within the context of the NHS may be shifted to different bodies, thus potentially changing target funders.

Current system

There are 152 regionally determined Primary Care Trusts (PCTs) in the UK these currently commission services from NHS providers, commercial providers and volunteer organisations, as well as from primary care service providers, which include GP practices, dental practices, community pharmacies, optometrists, etc. PCTs must ensure that adequate services are available for their local population by assessing needs and purchasing services.

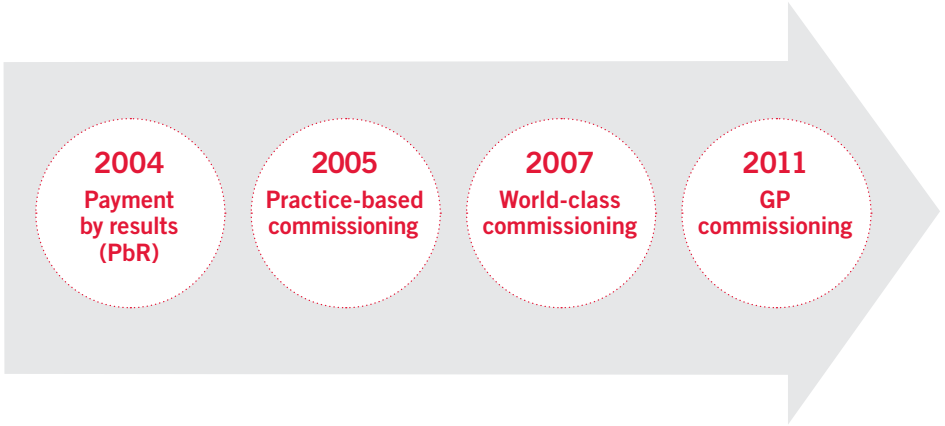


Figure 4: Changes in the commissioning environment (2004-2012)

PCT clusters

PCT clusters, to be operational in June 2011, are sub-regional groups of existing PCTs which will be responsible for reducing management costs, enforcing the QIPP agenda, and leading clinical service reconfiguration. They will not, however, be responsible for the performance of their member PCTs nor for general commissioning.

PCT clusters will also help shape the development of the GP Commissioning Consortia, commission services that maintain or improve quality, and manage down PCT legacy debt. There may be a long-term role for them as independent services to help manage financial risk, provide commissioning support, or even to help manage the contracts for local primary care providers on behalf of the NHS Commissioning Board.

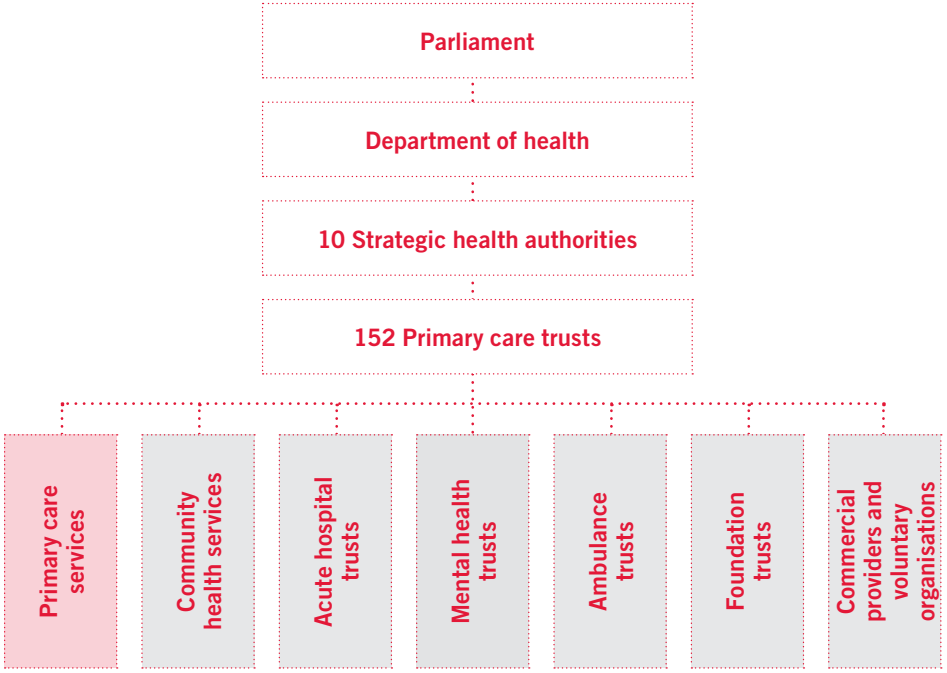


Figure 5: The current structure for commissioning in the NHS

New system – April 2013

The government aims to reduce NHS management costs by 45% over four years by dismantling PCTs and strategic health authorities (SHAs), thus reducing bureaucracy. Under the new structure, every GP practice will have to join a consortium which will, in partnership with local authorities, determine funding of services for patients referred on from GPs. These consortia will take full financial control in April 2013.

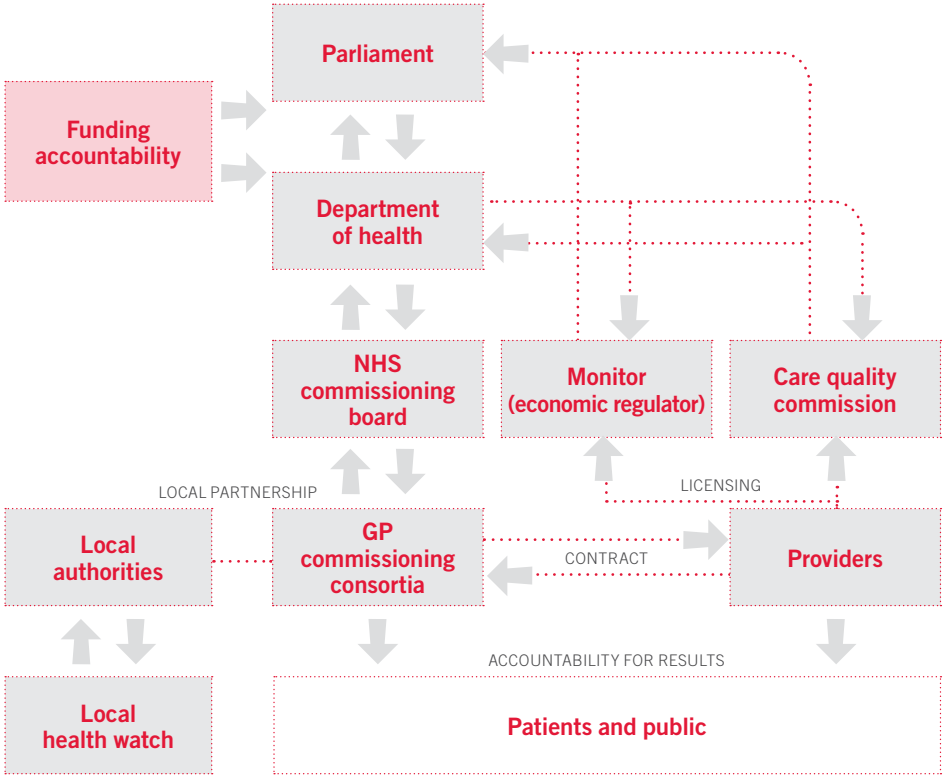


Figure 6: The proposed new commissioning structure for the NHS[4]

[4] NHS White Paper; *Equity and Excellence: Liberating the NHS*, July 2010

Other issues

Along with the new commissioning structure of the NHS, several policies will be introduced which may change the manner by which certain projects add value to or increase costs of different bodies within the NHS. Basic commissioning structures and methods, as well as significant new regulations, are outlined below.

Payment by results, block and cost and volume contracts

Payment by Results (PbR) is a system that has been rolled out in the NHS since 2004, which pays hospitals and other service providers per completed procedure according to a reference cost that is determined by national average costs and adjusted according to market forces. Healthcare Resource Groups are approximately 500 groupings of patient events which utilise approximately the same amount of resource, and are used to determine activity costings. The market forces adjustment accounts for the fact that a procedure in London will have greater overhead costs than the same procedure in Devon.[5]

The block contract system, where hospitals receive a flat contract to care for a patient population regardless of the actual activities carried out, was based on historical activity and expenditure. Although this system is typically beneficial in ensuring sustainability for small providers, it did not allow enough flexibility for changing levels of activity.

Cost and volume contracts are similar to block contracts, except that they allow the provider to purchase additional amounts of service at a pre-arranged price.[6] These types of contracts attempted to address the lack of flexibility of block contracts, and remain particularly relevant to mental health trusts and community based services. Unfortunately, even under cost and volume contracts, there was no incentive for hospitals to increase throughput since they received no additional funding.

PbR was introduced to improve efficiency, increase value for money, facilitate choice where payment follows the patient, enable service innovation and improvements in quality, and reduce waiting times. PbR, however, essentially rewards hospitals for treating more patients by paying them accordingly. The more they actively work to reduce patient admissions, thereby reducing overall costs to the NHS, the less income they earn.

[5] http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/PaymentByResults_booklet.pdf *Accessed Dec 6, 2010*

[6] http://www.comfirst.org.uk/commissioning_what_does_it_mean *Accessed Dec 6, 2010*

Marginal tariffs

In order to address the costly incentive for hospitals to treat more patients rather than working to reduce admissions, new guidelines have been introduced which pay hospitals a proportion of activity costs if they exceed baseline amounts of activity. This amount has been set at 30% of the cost of emergency admission patient events, with the remaining 70% of the procedure cost being retained by the commissioner and spent on demand management schemes for the particular location in question. The baseline amount of activity will be calculated as the value of the full 12 months of activity in financial year 2008/2009 priced at the 2010/2011 tariff.

One disadvantage to this system is the circumstance where a hospital or provider has a natural increase in activity over 2008/2009 levels. This scheme will force hospitals to look at new ways of tackling increasing admissions, which is positive for the NHS as a whole, as long as quality of care does not suffer in its wake.

Readmission payments

The Health Secretary, Andrew Lansley, announced on 8th June 2010 that hospital trusts will not be paid for the second visit if they discharge a patient who returns within 30 days with an emergency case related to their original admission. Hospitals in England will be paid for initial treatment but not paid again if a patient is brought back in with a related problem within 30 days.[7] The reasoning behind the new policy is to discourage trusts from discharging patients too early to try and save money[8] by penalising bad practice.

However, there are two circumstances which adversely affect care providers: firstly certain patients may be prone to coming back in at no fault to the trust; secondly, it may encourage trusts to keep patients in hospital longer than necessary in order to guarantee non-readmission, thereby increasing costs.

[7] http://www.bbc.co.uk/news/10262344 *Accessed Nov 26, 2010*

[8] http://worthsolutions.com/blog/2010/06/nhs-readmission-policy-is-sticking-plaster-on-a-bad-system *Accessed Nov 26, 2010*

CQUIN

Through the Commissioning for Quality and Innovation (CQUIN) payment framework, introduced in April 2009, hospital or care provider income is determined not only by activity through the PbR scheme, but is also conditional on quality and innovation.

These contracts require commissioners to make 1.5% of contract value available for providers to earn if they achieve locally agreed quality improvement and innovation goals and, for acute providers, the two national goals of:

—

Reducing avoidable death, disability and chronic ill-health from venous thromboembolism (VTE), and

—

Improving responsiveness to personal needs of patients (patient experience questionnaire).

The changes for 2010/2011 include the increase in contract value available to earn from 0.5% to 1.5%, as well as the addition of the acute provider national goals listed above. In all cases, setting appropriate targets for each provider will prove to be the key determining factor in the success of the programme.

Best practice tariffs

In 2010/2011, four tariffs based on the cost of providing 'best-practice' care rather than national average cost will be introduced to incentivise and adequately reimburse the elevated costs of providing high quality care. These tariffs are as follows:

— 1

Incentivise surgery on a day case laparoscopic basis (gall bladder removal)

— 2

A streamlined elective cataract pathway, where patients are treated in a joined-up and efficient manner

— 3

Pay for best practice to encourage prompt surgery in hip fracture cases of the elderly

— 4

Pay for best practice to support National Stroke Strategy and NICE Clinical Guidelines on best practice assessment and treatment for acute stroke

This series of guides is designed to help funders and project leads to set up and sustain innovative projects across the NHS. The *How to* guides draw together the material on supporting health innovation which the Young Foundation has been delivering and refining as part of its support for the Regional Innovation Funds (RIFs).

The methods, techniques and approaches described within should act as a guide to the innovation process rather than a definitive and restrictive roadmap to success. By embedding these principles into future innovation activities we hope to further increase the quality, support and eventual success of innovators in the NHS.

These guides have been collated by the Young Foundation and NESTA working to support, advise and increase the capacity of the RIFs.

NESTA Making Innovation Flourish