*BRITISH BROADCASTING CORPORATION* *RADIO 4*

*TRANSCRIPT OF "FILE ON 4" – NHS FINANCE*

*CURRENT AFFAIRS GROUP*

| | | |
|---|---|---|
| *TRANSMISSION:* | *Tuesday 2nd August 2005* | *2000 - 2040* |
| *REPEAT:* | *Sunday 7th August 2005* | *1700 - 1740* |

| | |
|---|---|
| *REPORTER:* | *Liz Carney* |
| *PRODUCER:* | *Sarah Lewthwaite* |
| *EDITOR:* | *David Ross* |

*PROGRAMME NUMBER:* *05VY3023LHO*

THE ATTACHED TRANSCRIPT WAS TYPED FROM A RECORDING AND NOT COPIED FROM AN ORIGINAL SCRIPT. BECAUSE OF THE RISK OF MISHEARING AND THE DIFFICULTY IN SOME CASES OF IDENTIFYING INDIVIDUAL SPEAKERS, THE BBC CANNOT VOUCH FOR ITS COMPLETE ACCURACY.

"FILE ON 4"

Transmission: Tuesday 2nd August 2005
Repeat: Sunday 7th August 2005

Producer: Sarah Lewthwaite
Reporter: Liz Carney
Editor: David Ross

---

EXTRACT FROM BRIAN JAMES SPEECH

JAMES: This is now our business and this is now mission critical stuff for us, absolutely fundamental to our future survival as an organisation …

CARNEY: This Chief Executive is rallying his troops. The key to survival is income, and they've got to make sure they bring it in.

JAMES: … we live or die as an organisation on whether we can do the right volume of work in order to bring in the money we need to run our services. So I'm going to just take us through some of …

CARNEY: But Brian James' business doesn't have shareholders, it doesn't have customers, it does have patients. He's the boss of Rotherham Hospital, and he's facing up to radical reforms in the way hospitals are funded. It's a quiet revolution, which the Government says is designed to improve patient care, but it's already led to a series of local disputes, with warnings that increasing financial risk could push some hospitals over the edge and destabilise parts of the health service.

SIGNATURE TUNE

ACTUALITY AT ROTHERHAM A&E

WOMAN: So this chap then in Resus 4, he came in with palpitations. We need to get another ECG from his previous notes, but they're at the Hallamshire.

WOMAN 2: And we need another set of bloods then.

WOMAN: Yes.

CARNEY: Like lots of hospitals up and down the country, the casualty department at Rotherham General Hospital is seeing a constant increase in the numbers of patients. Staff have to treat virtually everyone within four hours to hit government waiting targets. A&E consultant Dr Daniel Stevenson says the weekends are bad, but holidays are worse.

STEVENSON: I was on duty over the Christmas period this year and the department was under extreme pressure, because we had new record levels of attendances. The flow of patients into the department was extremely high and we at the same time were trying to work against a four hour target to have them seen and discharged or admitted within the four hours, and it's obviously stressful. There are people waiting in the waiting room, wanting to know why they haven't been seen and so on. There was a real surge between ten in the morning and two in the afternoon, where we saw upwards of thirty patients booking in every hour, so that was really overloading the system, and patients were actually queuing out through the front door.

CARNEY: Until last year, no matter how many people turned up at Accident and Emergency, the hospital had to treat them all. If there were more patients than expected and costs increased, they had to try and negotiate for extra cash from the people who hold the purse strings, the local Primary Care Trust or PCT. But if they got any extra money, it rarely covered the full costs of the extra treatment. Now every patient who comes through the hospital doors has a price on their head. It's a sea change in the way the NHS does business, the new system is called Payment by Results. One of its chief architects was former Department of Health top adviser, Bob Dredge.

DREDGE: In the simplest form, it means providers of healthcare get paid for what they deliver and equally don't get paid if they don't deliver. The money follows the patient, to use a phrase. Under the old system, in very simple terms, the commissioners, the PCTs, just passed a sum of money each year to the hospitals and more or less said, 'Spend it as you want and we don't really know what you're going to spend it on.' It's a huge change in financial mechanisms, it's a major change in culture, but I think more importantly that it's a change which underpins the whole of the rest of the reforms of the healthcare system which the government's trying to introduce.

CARNEY: Along with the rest of South Yorkshire, Sheffield's Royal Hallamshire Hospital has been a laboratory for the new payments system. But unless it knows exactly how much work it's done, it won't get paid, so for the first time patient records aren't just crucial for healthcare, they are critical to the hospital's income.

ACTUALITY IN THEATRE

CARNEY: In theatre, surgeon Austen Smith now enters vital details on a computer screen whilst his patient is still on the operating table. Their diagnoses and treatment is turned into a series of codes, which combine to create a price for the patient's care.

SMITH: Once the operation's finished, we can walk across to the screen and just document what's happened. So we've come to the screen, it's a touch screen which I can enter things by merely contacting with my finger. In front of me is a record for the patient which is treated. It tells me that this person came for an operation on their tongue. What we've carried out is described in the box on the screen as 'destruction of lesion of tongue', coded with a code F232. And by touching the screen I can add something to that operation record, which will be automatically included in the Trust's mathematics for what we've done and what the patient's had done.

CARNEY: How does this compare with what you did before?

SMITH: Next to me the old system is still running in parallel. We have a theatre book, which is a big, heavy tome, and you have to write in by hand, where I would have to take the patient's case notes and we would need to write on a piece of paper with biro in longhand. The new system is better in that it's all legible because it's all printed, so you don't have to deal with the legendary doctors' handwriting.

CARNEY: The information is automatically sent to nurses, clinicians and GPs, who follow up the patient's health, but the financial health of the hospital depends on the coders - and the complicated computer packages they use to work out what to charge. Nicky Kearsley, the project's manager, has watched as over the past ten months it has improved the hospitals rate of return.

KEARSLEY: We checked the accuracy of the new system against our paper-based system and found that the data had improved. In terms of the coding, we certainly saw a 35% improvement generally of the codes that were going into this new system.

CARNEY: An overall increase of 35% in accuracy is a huge difference.

KEARSLEY: Yes. In terms of coding we think that will bring us a lot of rewards, I mean, partly because obviously a patient record is very important to have the correct codes, but also for the work we do and we hope that accuracy will bring more money back into the Trust.

CARNEY: Are you getting paid more because you're actually doing more work or are you getting paid more because you're just picking up different details, more details than the old system would have done?

KEARSLEY: I mean, it's probably a mixture of both. In reality, I'm sure Trusts are doing more work. But yes, in terms of the coding, if we collect more details then obviously we can get the financial return for that detail that we're adding into the record.

ACTUALITY AT WORKSHOP

CARNEY: Coding has now become the new buzzword. This morning, the Strategic Health Authority is running one of a series of coding workshops, for Primary Care Trust and hospital staff.

EXTRACT FROM KAREN DUNWELL'S SPEECH

DUNWELL: Well this is going to be a very challenging environment for all of us, because it means that we've got to learn to work together on a new bit of business and that is staying in business.

CARNEY: One of the main speakers is American, Karen Dunwell. She has been retained as a special adviser in South Yorkshire, to help guide them through these critical times. She says accurate coding can add as much as £250,000 a month to a hospital's income, and she sees the potential for UK hospitals to turn their fortunes round, and make money to invest back into services. With extensive experience working for the big American healthcare providers, she saw for herself the impact when the States introduced a similar system to payment by results.

DUNWELL: I can remember in the early days of new funding scheme, my medical record department staff were literally shoe-horned into a small department in the basement, working literally elbow-to-elbow in this tiny environment. Within four years of the funding reform, my entire department was moved up to the penthouse with an air conditioned suite, all of the information technology tools you could possibly hope for, and a commanding view of the Columbia river in Oregon, and it was quite a hallelujah moment for all of my department staff, to be acknowledged by the staff and the consultants about the importance of the work we were doing.

CARNEY: Because if you didn't do it well, what would happen?

DUNWELL: If we didn't do it well, and we saw that happen in the United States, hospitals closed, they couldn't maintain financial viability and they lost the business to competing forces who were able to be more efficient, more quality oriented and just do a better job of billing.

CARNEY: NHS Foundation Trusts like Rotherham Hospital are now financially self supporting. If they don't make a surplus, they've no money to invest in new health services, and they need to balance their books because they can't be bailed out. That means they need to be competitive. Payment by results has introduced a new national price list or tariff, which means what's paid for an operation will be the same anywhere in the country. So hospitals can only make a profit by working more cheaply than the national price. But Rotherham's Chief Executive, Brian James, is relishing this commercial challenge.

JAMES: We can't rely on anybody else to help us out if we get into financial difficulty and therefore we've got to put a much greater emphasis on managing our finances than we ever have done before. Every patient we treat in the hospital comes, if you like, with a package of money. So it's absolutely imperative that we attract the patients we need in order to generate the income we need in order to run the organisation as a successful enterprise. I think there's a huge amount of latent entrepreneurial potential within the NHS and I think once we release that potential then we'll see quite different forms of service being developed.

CARNEY: This sounds like an extraordinary change in the nature of the health service.

JAMES: I think it's a massive change, and I think the biggest change will be a cultural one. NHS culture has to change and evolve to one that is much more alike that required to operate in the commercial sector, where the customer is king.

CARNEY: You are talking like a businessman. You're not talking like a traditional NHS manager.

JAMES: No, I think that's quite interesting. I've actually been in the NHS, this is my thirtieth year. People shouldn't assume that simply because we work in the public sector, that we aren't entrepreneurs. We can behave, act and operate as entrepreneurs and indeed payment by results gives us the stimulus to actually do that.

CARNEY: Payment per patient is a powerful incentive. If hospitals treat more people, they increase their income and bring waiting times down. They're the winners. But for every winner there's a loser - and more hospital work means increased costs for Primary Care Trusts, the purchasers who foot the bill. Alan Wittrick, the Chief Executive of the Strategic Health Authority, has been analysing payment by results for South Yorkshire's Primary Care Trusts, and says some financial strains are beginning to show.

WITTRICK: The early indications are that the balance of risk has moved a little bit from the hospital sector into the Primary Care Trust sector, and we know from the last three or four months of the year the impact of payment by results probably increased the cost on Primary Care Trusts in the system by about £4 or £5 million across the whole of South Yorkshire.

CARNEY: Is there a risk under this new system that because you're paying per patient, if the level of activity goes up, that at the end of the year the Primary Care Trust might not have enough money in its budget to pay all the costs, and Primary Care Trusts are working on a fixed budget?

WITTRICK: Primary Care Trusts are indeed working on a fixed budget, and that's why they need to have in place some contingency plans, and to the degree to which they don't have that, they will find themselves very stretched towards the end of the year, yes.

CARNEY: Michael Sobanjo, Chief Executive of the NHS Alliance, thinks budgets might become more than a little stretched. He represents Primary Care Trusts nationwide, and is worried that the incentives in payment by results are favouring the hospitals, to the point where some community-based services may be at risk.

SOBANJO: If hospitals are more efficient and get more patients through the door, then that puts the bill up. Now that might be good for the local health economy; means lower waiting lists and so on. But if Primary Care Trusts are cash limited by law, then they have to live within their means, and that may mean that increased hospital activity has to be balanced out against other clinical developments elsewhere.

CARNEY: You mean cuts?

SOBANJO: It could be cuts, matter of priorities is the language that's often used, but if you've only got one pot of money and you spend more in one sector, then it follows that you've got less to spend in other areas.

CARNEY: How serious could this situation get?

SOBANJO: I suppose the nightmare scenario is that hospital activity would run away, Primary Care Trusts would be then placed in a position of overspending heavily and would then be breaking their legal requirements, and that is the reasons why all Primary Care Trusts are being urged to put into place measures of demand management to control hospital workflow.

CARNEY: But it's difficult, a hospital can't turn away patients who arrive at casualty, for instance. In the past eighteen months, Rotherham has seen around a 25% increase in attendances at A&E. Dr Daniel Stevenson is examining his latest patient.

ACTUALITY OF DR STEVENSON WITH PATIENT

STEVENSON: Come in, have a seat.

MAN: Hiya.

STEVENSON: So it says you've got an injury to your left arm. Is that right?

MAN: Yes. When I come back off holiday, I bruised up and then I found a lump come out two weeks after.

STEVENSON: Okay, so when did you come back from holiday?

MAN: Last month.

STEVENSON: You first noticed this problem about a month ago?

MAN: Yeah, about a month ago, since I come back off holiday.

CARNEY: Anecdotal evidence suggests patients who aren't necessarily emergencies know they can be seen within four hours, so are simply bypassing their GP or the out of hours doctor service - which is just what Dr Stevenson's patient has done.

MAN: I've been to my doctor's. He's basically not bothered really, so I just thought I'd come here and check that lump out and check my neck out. Basically I can't really get an appointment at the doctor's. It takes about a week for an appointment really, so it's quicker to see the hospital.

STEVENSON: I mean there's not a great deal to see in your arm really, it all seems to be working all right. It doesn't look like anything serious. I think if you probably just continue with what you're doing with the ibuprofen …

CARNEY: A trip to casualty means a bill for the Primary Care Trust. It can't control who arrives here, but in a radical move it's making sure that the casualty visit doesn't end up with further costs if they can be avoided. In Rotherham's A&E department, Nick Escrit is on the lookout for patients who could be treated in cheaper community facilities or in their own homes. It's better for the patient and the budget. He's one of a team of fast response nurses, paid for by the PCT, who get sent into casualty to divert patients from hospital.

ESCRIT: The patients we provide the service for tend to be fairly frail and infirm. My previous experience as an actual accident and emergency nurse prior to the fast response service, this type of patient, they're actually admitted to the hospital, often for social problems rather than for physical problems. And unfortunately, in those circumstances, we often find that there's quite a prolonged stay. We are stopping a lot of hospital admissions. I think last month alone we had 72 referrals, most of which actually came from this department, Accident and Emergency, many of which we were

ESCRIT cont: able to get back out into some kind of community care, whether it be at home or in a residential or nursing home.

CARNEY: What's emerging from payment by results is a sort of financial power struggle, between parts of the health service whose interests now directly compete. If a hospital doesn't attract patients, it loses money, whilst it's in the interests of the Primary Care Trusts to keep people out of hospitals as much as possible. And, ironically for a policy that's meant to put an end to old-style negotiations over price and cost, it seems its complexities are leading to disagreements about precisely price and cost.

ACTUALITY AT COUNTESS OF CHESTER HOSPITAL

MAN: I'm looking for a friend. Can you tell me what ward he's in, please?

RECEPTIONIST: He's actually on ward 54.

MAN: 54.

RECEPTIONIST: Through the double doors, up the stairs, top of the stairs, turn right.

CARNEY: In the bright foyer of the Countess of Chester Hospital, people are turning up for evening visiting. The hospital's got three stars, the highest rating, and unlike many last year, it managed to balance its books, even making a small surplus. Chief Executive Peter Herring welcomed the introduction of payment by results because for the first time he saw the opportunity for the hospital to get its just rewards.

HERRING: Under the old system, generally any increases in activity - particularly around emergency activity - was subject to protracted negotiation, generally after the event, and I wouldn't say in all circumstances we were always fully rewarded for the increased activity that we had to deliver.

CARNEY: So did that leave you short?

HERRING: It did on occasions, yes. Generally negotiations end up with some sort of compromise, and quite often that means that both parties in a sense have to either give up a bit more but certainly in a lot of instances we had to live with the consequences financially from that increased activity.

CARNEY: But payment by results was meant to change all that. However, it became clear that implementing the practice wasn't as straightforward as the principle. The hospital reckoned they were owed £5.3 million for work they'd carried out. Faced with higher bills than they'd expected, the two local PCTs offered £3.9 million. The negotiations weren't just about numbers of patients, but what price bands and tariffs they were in. The hospital argued that not only were they treating more people, but some of them were iller, and needed more complex and expensive care. Peter Herring, the Foundation Trust's Chief Executive, found himself and the PCTs at odds over the charges.

HERRING: There is an issue that Primary Care Trusts have had with us, in terms of the case mix of our inpatients primarily has changed over the course of the years. As far as I'm concerned, our patients are more complex. If we have more neonatal babies, that's quite obviously more complex. If we have more caesarean operations, that's clearly more complex. Generally the average cost of treating a patient in the hospital will appear higher, but for good, sound, clinical reasons.

CARNEY: The minutes from the Primary Care Trust's report that eventually they offered you £3.9 million for work that you'd done, was that enough from your point of view?

HERRING: No it wasn't, we were clearly under the payment by results was indicating a far more significant sum, but we have now reached resolution around the figure of about £4.9 million, so that has satisfied both parties, I think, in terms of 2004/5 outcome.

CARNEY: So you were arguing about a million pounds either way?

HERRING: It was about of that order, yeah, yeah.

CARNEY: We asked for an interview with Cheshire West Primary Care Trust. They said yes, and then pulled out. And Cheshire isn't the only part of the country where costs have become a bone of contention. Over the past year there have been similar disagreements, but all the trusts we approached were reluctant to talk. Clearly it's a sensitive issue. Part of the problem, as the PCTs see it, is that payment by results creates such strong incentives for hospitals. There's a worry that it could even lead to manipulation of data to increase a trust's income. In other countries, where similar systems have been introduced, it's called 'code creep' or gaming; and Michael Sobanjo, the Chief Executive of the NHS Alliance, which represents 80% of Primary Care Trusts, says it could happen here.

SOBANJO: I think there's two types of gaming. There's the unintentional gaming, where simply invoices are coded improperly; and then some people suggest there is intentional gaming. As an example, if a patient goes into hospital and stays for less than forty-eight hours, then only a percentage of the tariff price becomes payable. If they stay for more than forty-eight hours then the full tariff price becomes available. Of course, the perverse incentive there is to keep hold of those patients who otherwise should have been discharged under forty-eight hours for longer simply to increase the hospital's income. Now I don't have the evidence to suggest to you that is happening, but those people who are cautious and apprehensive about the untoward side effects of this new system point to situations like that and say there is a potential for a perverse incentive here, and we have to knock that out of the system.

CARNEY: But why would hospital keep patients in longer than they need to? There's pressure on beds already and clinically it wouldn't be a good thing to do.

SOBANJO: Well, one would hope that we have a system where the information, the clinical priorities and the financial incentives are all aligned, and that's what payment by results is intended to do. But if you have a little kink in the rules, such as the one I described about the forty-eight hour stay, then it may well be that a hospital under financial pressure bows and makes the wrong judgement and puts finances before clinical need.

CARNEY: That's a very serious accusation.

SOBANJO: I didn't say it was happening. I said there are those people who are concerned that that type of perverse incentive could be in place and those are the things that we have to guard against.

CARNEY: The most public of rows about coding and counting patients happened in Bradford last year when the three Primary Care Trusts there disputed thousands of invoices from Bradford Teaching Hospitals NHS Foundation Trust. The hospital had forecast that over four years, the new payments system would generate a £10 million surplus. But the disputes added to other serious financial problems and the hospital ended up predicting an £11.3 million deficit. Monitor, the regulator for foundation hospitals, called in independent consultants to report on Bradford's financial position. As part of their investigation, the consultants examined the dispute over payment by results. Their report revealed:

READER IN STUDIO: Bradford Teaching Hospital is facing significant challenges from the PCTs as to the accuracy of its coding, as well as with its admission criteria for inpatient stays. The amount queried (£2.4 million) represented 21% of the total amount billed to North Bradford during this period.

CARNEY: Altogether, North Bradford queried just over three thousand out of nine thousand invoices from the hospital. The consultants thought half could be resolved by checking documentation on an item by item basis, but the rest were challenges about inpatient admission policy. For example, in October a board meeting of North Bradford PCT was told that whilst examining one set of invoices:

READER 2 IN STUDIO: The PCT had gone through the records patient by patient. It was found in some instances that patients who had been classified as 'ward attenders' at a cost of £600 had, in fact, only gone for their blood pressure checking and therefore had not been inpatients.

CARNEY: According to the Independent Regulator, Bill Moyes, about £4 million of the hospital's income was subject to disputes about how patients were coded and charged.

MOYES: I don't think the trust really assessed the risks that it faced and whether its systems were up to it, and its systems didn't prove adequate to operate payment by results. I think, in truth, attitudes got very polarised.

CARNEY: You brought an independent consultant in. What were their conclusions about the dispute?

MOYES: I think the consultant's view was that if both parties had worked hard, the income side could have been resolved, but what was missing was strategic leadership. The Chairman, in our view, did not help the trust recognise that it had to reach an accommodation with the three Primary Care Trusts, because they were its income. But most important of all, the trust, again in our view and in the consultant's view, simply was not tackling its cost problems, it was letting its cost problems deepen and therefore it was getting itself into a more and more tight situation.

CARNEY: Monitor removed the Hospital Trust's chairman, John Ryan, for failures in leadership, amongst which was a failure to negotiate a working relationship with the local PCTs. Today John Ryan still sees the disputes over payment by results as the problems of implementing a new and radically different system.

RYAN: They felt we were admitting the patients, not only to beat the four hour rule but also to get more income into the trust. Ludicrous. Now I'm not saying that there weren't some places where perhaps it was borderline and maybe they took the decision to admit the patient, and sometimes, particularly if the department is struggling to find out what's wrong with a patient and the patient needs more diagnostic procedures and so on, then sometimes they were admitted, but they're small numbers. In some instances, like obstetrics, a number of invoices were found to have been overcharged and that was sorted out. But I think the point is that this is or was a new system, and people were busy trying to code the procedures and price them up and so on and yes, mistakes were made, but then, you know, I think that's inevitable in introducing a new system.

CARNEY: Do you think the hospital was overplaying its hand in this new system - that effectively patients were being put into treatment groups which absolutely maximised the income the hospital could get?

RYAN: No I don't. I don't believe that for one minute. I mean, I do accept that some of the invoices may well have been wrong and some of the coding procedures may well have been wrong and so on, but I'd argue that, well, yes it's swings and roundabouts, we'll get some right, we'll get some wrong, and if we owe you, we'll pay you back. But no, there was never any intent whatsoever to make money out of this system.

CARNEY: Since last year, the top team at Bradford Teaching Hospitals Foundation Trust has changed. The hospital initially agreed to record an interview, but later cancelled it. None of the Bradford Primary Care Trusts would be interviewed either. But in a joint statement from the Hospital Trust and all three PCTs they said:

READER 2 IN STUDIO: Before the end of the year, all contracts were resolved to our mutual satisfaction, and we have collectively gained a much greater understanding and common interpretation of the system.

CARNEY: But coding and tariff issues haven't only created difficulties between hospitals and PCTs. There are serious concerns about their impact on some specialist services.

ACTUALITY AT ORTHOPAEDIC CENTRE

CARNEY: The Nuffield NHS Orthopaedic Centre is rated by its patients as one of the country's top hospitals. It's MRSA-free and has an enviable reputation.

MCNALLY: Afternoon, John.

RUDD: Afternoon, Mr McNally.

MCNALLY: So how are you doing from the surgery yesterday?

RUDD: Not too bad. Surprisingly well, actually, feeling-wise.

MCNALLY: You look well.

CARNEY: John Rudd is recuperating after an operation here, and he's glad it's a specialist hospital. John knocked his hip getting on a plane - not a serious event for most people - but he's paraplegic and couldn't feel the injury, which eventually turned into a serious ulcer, infecting half of his pelvis.

RUDD: If it wasn't for this centre, I think by the end of the year I probably wouldn't be here.

CARNEY: Do you know how long you were down in the operating theatre yesterday?

RUDD: I do now, seven hours. I didn't at the time, no. Didn't expect to be that long, but it was major, major surgery.

CARNEY: His surgeon is consultant Martin McNally, an expert in limb reconstruction and bone infection. John's operation was so specialist that fewer than ten of these procedures are done each year.

MCNALLY: He had a very large ulcer on the outer side of the right hip. The skin and the muscles had all been eaten away by the infection, so that the bone and hip joint were visible in the base of the wound, and so it was a very unpleasant site, with lots of infection extending deep into the tissues. We had two consultant surgeons, one plastic surgeon and myself, and the procedure is really in sort of three parts. Firstly identifying all of the infected tissue and removing that, then taking out the bone, and then the plastic surgeon fills the large defect which is left with the surrounding muscles from the leg and from the side of the pelvis.

CARNEY: So there were lots of different specialists working together?

MCNALLY: Yes. We also have a consultant anaesthetist and we also have a consultant in bone infection, who is a physician, who looks after all the antibiotics and the treatment of the infection itself. The unit has been set up to cope with the more difficult end of the bone infection spectrum. The facility we have with all the surgeons and all the specialist nursing staff available allows us to take on patients who otherwise we simply would not be able to offer the type of treatment that they need.

CARNEY: But the national tariff - or price list - that's been introduced by payment by results doesn't cover this type of high cost work. 35% of the Nuffield's patients undergo complex operations, but the payment by results software that identifies patients only registers 1% as being in the specialist category, so attracting a higher price. As Chief Executive Ed MacAlister-Smith explains, the sums just don't add up.

MACALISTER-SMITH: A straightforward hip replacement, of which we do quite a number in this trust, would get reimbursed through the tariff and we're entirely comfortable with the pricing of that. But we also do a range of much more complicated hip replacements, and of course that costs us a lot more than the tariff income that we're getting for that procedure. So, as an example, we do hip replacements for people who have haemophilia, and people will understand that managing the blood problems for somebody who is having a major operation, who is a haemophiliac, is quite expensive and complicated and takes a high level of skill. Somebody who might have quite a lot of difficulty with a rheumatoid problem, which they might have had since childhood, that kind of issue would take a lot more skill, be a lot more complex, it would take a patient quite a lot longer to recover from, and yet that's still an operation that's called a primary hip replacement, and the tariff payment that we get for a primary hip replacement is about £6,000, and some of those more complex procedures can cost us up to £30,000. There's a difference between the £6,000 income and the £30,000 cost that we have to bear, and we can't do that.

CARNEY: As a go-ahead hospital, the Nuffield wanted to become a Foundation Trust, but when he made its business case, Ed MacAlister-Smith got a shock.

MACALISTER-SMITH: If we look at our business plan over five years, what we see is that, as a trust with an expenditure of about £60 million a year, we were going to lose, under the payment by results regime, something like £7 million, which is a huge sum of money and which we didn't believe that we could make savings to accommodate. And so the regulator, not surprisingly, turned us down on that basis. This would be the adverse impact of the application of the payment by results scheme to orthopaedics.

CARNEY: Did it strike you as ironic that here you are, one of the top specialist hospitals in the country, meeting every criteria for Foundation Trust status, and you've been stymied by another government policy?

MACALISTER-SMITH: Clearly we were very disappointed and we are very determined to overcome these problems and to succeed in due course in becoming a Foundation Trust. We wish we could have done it earlier.

CARNEY: The Department of Health has now agreed to review the tariffs. We wanted to interview a minister about the impact of payment by results, but none was available. However, in a statement, the Department said it was consulting widely with the NHS to address some of the issues that have been raised during early implementation. It also said that it had excluded some specialist services from the new payment system until it was confident it had got the tariff right. This is critical for the government, because payment by results underpins the whole drive for Patient Choice that's at the heart of its health policy - where patients carrying packages of money will be able to choose where to be treated, whether at their local hospital or by a private provider or in an independent sector treatment centre. But Kieran Walshe, director of the Centre for Public Policy at Manchester Business School, warns that as the policy develops, so too could the financial risks for some hospitals.

WALSHE: The introduction of Patient Choice adds to the volatility. It's very hard to predict how much patients will actually want to exercise the opportunity to choose amongst, for example, acute care providers, acute hospitals. Even a small shift in activity at the margins can have a big impact on the financial position of an acute hospital under payment by results, so even if Patient Choice only gets quite small numbers of patients to move, it could still have big implications for the viability of an acute trust.

CARNEY: So are we going to see hospitals going bust?

WALSHE: Well that's really the $64 million question. The political reality is that this is a very challenging set of changes being implemented very fast with very little room for manoeuvre and enormous risk, and I think most people in healthcare organisations feel that, but it's quite hard to voice that view. I think that payment by results is absolutely right in principle, but the pace of change and the ambition with which it's been done has big risks to it, politically and financially and in terms of the delivery of health services to patients. So it's too far too fast.

CARNEY: But the leading proponent of payment by results, Bob Dredge, who developed the policy for the Department of Health, says it was always designed to be revolutionary.

DREDGE: There was certainly a sense that we wanted to put some radical thought across the NHS, that we wanted to shake some of the inefficient behaviour, inefficient practices that were apparent across the country. The old system was just too comfortable. To implement the extent of changes which the government wanted across healthcare, there had to be some discomfort, some change in the mindset.

CARNEY: So was the intention of payment by results really to rock the boat?

DREDGE: It was certainly to shake the boat, if not rock the boat, yes. There was a sense, I think, in central government that the NHS wasn't performing, that it wouldn't deliver sufficient against the new monies the government were going to put in without a whole set of other changes around it.

CARNEY: But this system has the potential to destabilise the NHS, financially it's very risky.

DREDGE: It's risky in theory, but in practice the good performers won't have anything to fear, and the poor performers, I think, have got enough time and flexibility in their incomes to actually change the way they do things to respond.

DREDGE cont: But yes, there is the potential to destabilise and some services will be destabilised, but frankly, I think there was a sub-plot that said we wanted to do some of this.

CARNEY: At the moment, payment by results is being phased in. Apart from Foundation Trusts, most hospitals only use it for planned operations. But next year it's due to be extended to all acute services, including Accident and Emergency. With a third of Hospital Trusts in the red and the Audit Commission warning that the new system could introduce significant financial instability, payment by results could yet produce casualties in the NHS.

SIGNATURE TUNE