hfma briefing

Contributing to the debate on NHS finance
November 2008

PBR for ambulance services

A review of the issues involved in introducing payment by results for ambulance services in England and the tariff options currently being piloted

Foreword

Payment by results is now an established part of the NHS funding system in England. Having first been introduced on a limited basis in 2003/04, it now covers some £25bn of services, typically accounting for more than one third of a primary care trust's expenditure and around 60% of an acute trust's income.

Reviews suggest it has improved the transparency and fairness of the payment system and contributed to an increase in day cases and a reduction in length of stay. And with the system now embedded, there are moves to refine it, providing a greater link with service quality and outcomes, rather than just activity.

Payment by results has come a long way. But with such good coverage now within the acute sector, it should be remembered that many areas of the NHS remain a tariff-free zone. Mental health, community provision and ambulance services are three areas where links between the work undertaken and the amount paid remain weak.

It would be particularly easy to overlook ambulance services. In overall terms, they represent only a tiny part of NHS spend. But the case for an emergency services tariff is just as compelling as it was for acute services. It could improve transparency, incentivise better cost-effectiveness and underpin new roles for ambulance services that would improve patient pathways and relieve the pressure on accident and emergency departments.

Progress is being made. The Department of Health has identified urgent and emergency care, including ambulances, as one of five priority areas for development within payment by results. And a number of pilot sites are trialling different approaches to local tariffs.

However, there remains no timetable for the introduction of a national tariff for ambulance services. This briefing aims to support the current development work by rehearsing the arguments for an ambulance service tariff and highlighting the issues that need to be resolved and the potential benefits for the NHS as a whole.

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EFFECTIVE DISPUTE RESOLUTION FOR HEALTHCARE CONTRACTING

Introduction

Ambulance services have changed dramatically over the last 15 years. No longer simply emergency transport services, ambulance trusts have increasingly been moving into the realms of treatment. Paramedics and emergency care practitioners trained to treat patients at the scene or on the move rather than simply picking up and dropping off at the nearest accident and emergency department.

Cardiac care is a good example with paramedics administering clot-busting drugs (pre-hospital thrombolysis) or making early assessments about patients' suitability for primary angioplasty (mechanical widening of artery), which would mean the patient being taken straight to a facility with a dedicated catheterisation laboratory.

More recently ambulance services have moved into providing telephone support-based services and even getting involved with GP out-of-hours cover. And a Department of Health report in 2005 – *Taking healthcare to the patient: transforming NHS ambulance services* advocated expanding ambulance services' role even further – including, for instance, the provision of diagnostic services. However, the way ambulance trusts are paid has remained rooted firmly in the past.

The acute sector has seen the introduction of payment by results in England over the past few years – linking payment for hospital services to the actual care delivered. In 2008/09 around £25bn of services were covered by payment by results, accounting for some 35% of PCT spend and more than 60% of a typical acute provider's income.

But ambulance service funding often has no direct link between the activity undertaken – the numbers of patients transported and treated, the types of incidents and patient problems or the numbers of calls received – and the money paid to ambulance trusts. Funding remains on a historic basis. This means that any funding inequities introduced in former years are continued. And incentives to encourage changes in practice are weak.

The Department of Health remains committed to introducing payment by results across a wider range of services and at the beginning of 2008 said that urgent and emergency care (including ambulances) was one of five priority areas for development. A number of ambulance trusts are now piloting different options for tariff funding.

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Structure

Ambulance services have been through a significant restructuring in the last two years. The 31 ambulance trusts operating at the beginning of April 2006 merged in July of that year to form 13 services (12 NHS ambulance trusts and one PCT providing ambulance services). Most of the mergers were straight forward, simply bringing together existing organisations. However two of the old trusts were split. The old Tees East and North Yorkshire trust was split between North East (30%) and Yorkshire (70%). The former Two Shires was split evenly between East Midlands and South Central. Staffordshire Ambulance Service NHS Trust, which was initially working in partnership with the new West Midlands Ambulance Service NHS Trust, formally merged with West Midlands in October 2007. This means there are now 11 ambulance trusts and one PCT providing ambulance services (see side panel)

Patient journey

When someone calls 999, it triggers a series of events that enable ambulance trusts to respond. 999 calls are initially routed to a national emergency switchboard, where callers are asked which emergency service they require. Upon asking for an ambulance, they are routed to the control room of the local ambulance service (this is based on the caller's location as identified from the landline number or mobile phone location).

When the local control room answers the phone, the call taker will take details of where the ambulance needs to be sent and ask a series of scripted questions to enable a primary diagnosis to be made, which dictates the type of response that the trust needs to make. The decision tool used by all but one ambulance trust (the North East Ambulance trust has piloted a system called NHS Pathways) is called the Advanced Medical Priority Dispatch System (AMPDS) and its output is to assign one of the following categories to the call:

Category A – Life threatening condition. (National target: 75% of category A calls to be reached within 8 minutes and an ambulance to be on scene capable of transporting the patient within 19 minutes in 95% of cases)

Category B – Emergencies which are serious but not immediately life threatening. (National target 95% of category B calls to be reached within 19 minutes with vehicle capable of transporting patient).

Category C. – Not immediately serious or life threatening. (Targets agreed locally).

In addition to emergency/999 calls, ambulance trusts can also get requests from GPs, midwives or other healthcare professionals requiring the urgent transfer of a patient or admission into hospital. These calls have traditionally been recorded separately as urgent (or category U). However from 2007/08, ambulance trusts have been required to assign an ABC category to these urgent calls as well.

The call taker will then dispatch a response on the basis of this primary diagnosis/call category. In practice modern systems mean that a response is often dispatched as soon as the call is transferred to the call centre – particularly important as the clock starts ticking on the response targets as soon as a call is put through to the local control room. (This new way of measuring ambulance response times – know as Call Connect – was introduced in April 2008.) In 'automatic' dispatch cases, the response initiated would be reviewed on the basis of this primary diagnosis/call category.

A number of responses could be 'dispatched'. These include: a fully equipped, double staffed ambulance; a single responder on a bicycle, motorbike or in a car; or transferring the call to a phone advisory service where cases can be sorted on a 'hear and treat' basis. These 'hear and treat' advice centres may be run in-house by the ambulance trust (manned with GPs, paramedics and emergency care practitioners) or externally – for instance NHS Direct.

Activity levels

Ambulances have two principal areas of activity – emergency services (typically in response to a 999 call) and non-urgent patient transport services (for instance picking up patients and taking them to hospital for a pre-arranged appointment).

In 2007/08, 7.2 million emergency and urgent calls were made to English ambulance services. (In 2006/07, there were 6.3 million. However the figures can not be directly compared as, from April 2007, urgent calls are now recorded with emergency calls and prioritised in the same way – category A, B or C. The majority of these urgent calls are likely to be classified as category C.) Of these 7.2 million emergency and urgent calls, 5.9 million (81%) resulted in an emergency response arriving at the

Ambulance trusts in England

North East
North West
Yorkshire
East Midlands
West Midlands
East of England
London
South East Coast
South Central
Great Western
South Western
Isle of Wight PCT

scene of the incident. Of these calls resulting in an emergency response, 1.8 million (31%) were classed as category A (immediately life threatening incidents) and 2.5 million (42%) were category B (serious but not immediately life threatening). The number of emergency and urgent patient journeys was 4.26 million – a figure little changed from 2006/07 when 3.55 million emergency and 0.72 million urgent patients were conveyed to hospital. About 72% of incidents result in a patient being conveyed to hospital.

Outside of their emergency and urgent work, ambulance trusts undertook some 9.5 million special/planned journeys (patient transport services). This represents a fall of 12% on the previous year (which may be partly as a result of PTS services being contracted to the private sector).

The trend in recent years has been one of increasing demands on the emergency ambulance service. And while the demands on emergency ambulance services are unlikely to reduce, the Department of Health believes new practices and ways of working should lead to fewer patients being transported to hospital (reducing the demand on A&E departments). Its 2005 report *Taking healthcare to the patient: transforming NHS ambulance services* suggested that a wider role in both assessments and intervention for ambulance services could mean one million fewer patients taken to A&E by ambulance.

Ambulance service expenditure

Total turnover of all ambulance trusts in 2007/08 amounted to nearly £1.6bn in 2007/08 (excluding Isle of Wight PCT expenditure on ambulance services) according to draft accounts for the year.

Sources of income and contracts

Emergency ambulance services: Responding to emergency calls for assistance remains the core role for ambulance services. However this involves far more that simply dispatching an ambulance and transporting the patient to accident and emergency. Ambulance services now have a range of possible responses to an urgent call for help. These include: the full A&E response where conditions are assessed as being life threatening; ambulances staffed with urgent care crew for less serious cases; emergency care practitioners for less complex incidents; or even clinical advice over the telephone. These services would all be commissioned by primary care trusts (or a lead primary care trust acting on behalf of all primary care trusts covered by the ambulance trust). Typically emergency service income might count for around 80% of an ambulance trust's overall income, although this depends on the range of services provided by different trusts.

PCTs do not receive ringfenced resources to pay for ambulance services. Instead they receive unified allocations to cover all the services they provide and commission. These allocations are set using a formula that divides nationally available resources between different PCTs on the basis of need. These allocations are also influenced by a market forces factor (MFF) that adjusts allocations for the unavoidable cost differences related to working in different parts of the country. In particular the MFF adjusts for different costs relating to pay and capital.

The MFF does not adjust for the costs of providing services generally in rural areas – the basic contention is that a more spread out population will demand more staffed ambulances to meet the same response targets, so increasing unit costs. There is a specific emergency ambulance cost adjustment (EACA) that aims to reflect the unavoidable cost variations of delivering emergency ambulance services in different areas. This adjusts PCT

Outside of their emergency and urgent work, ambulance trusts undertook some 9.5 million special/planned journeys, a fall of 12% on the previous year

Ambulance trust	Turnover 2007/08 * (£m)	A&E **(£m)	PTS **(£m)
London	236.2	209.5	9.9
North East	80.4	60	16
North West	211.5	162	38
West Midlands	147.9	130	14
East Midlands	134.2	111.8	22.4
Yorkshire	155.0	118.2	28.8
East of England	192.8	135.8	20.2
Great Western	69.0	56.1	7.7
South Western	110.9	92.3	6.2
South East Coast	134.9	120.5	9.7
South Central	110.1	87	12
England	1582.9	1283.2	184.9

** Department of Health, The quarter: quarter 4, 2007/08, June 2008.*
*** Ambulance trust figures*

allocations for: the rurality of the area covered by the PCT; for scale; and casemix (having a higher proportion of emergencies compared with total journeys). This adjustment should be reflected in local price agreements in rural areas. Rurality is explored further in section 5.

Ambulance services are just one of the calls on PCTs' unified allocations. While there are clear links between what a PCT pays and the activity delivered by hospital trusts, the links between the services delivered by ambulance trusts and the payment for those services is often less clear. Local funding is often agreed based on the previous year's payment plus an uplift for inflation and agreed developments and a reduction for cost improvements.

However, there are cases where rudimentary links have been introduced between growth in funding and increases in activity. For example, a unit price may be set for activity (amount paid in previous year divided by actual/contracted activity undertaken, possibly measured in incidents) and this will be adjusted for inflation and efficiency requirements.

An expected increase in activity can then be agreed. This increase in activity at the revised unit price can then be used to calculate the appropriate increase in contract price. (In at least one area, the increase in activity above the previous year's outturn has attracted only half of the set unit price in year one, with the balance paid in year two. The idea is to limit the risks facing the provider and commissioning PCTs from major variations in activity.)

Links between activity and payment are not commonplace in the ambulance sector and only tend to provide a link between growth and crude activity

However, links between activity and payment such as this are not commonplace in the ambulance sector and, in any case, only tend to provide a link between funding growth (rather than the full contract value) and crude activity. The operating framework for the NHS in England 2008/09 pushes all organisations towards introducing greater links between funding and activity even where national tariffs do not exist, calling for payment arrangements to be transparent and fair.

Patient transport services: Patient transport services (PTS) – involving taking of non-emergency patients to their hospital appointments – are an important source of income for some ambulance trusts. However not all ambulance trusts provide PTS.

The Department of Health has indicated that from 2009/10 PCTs will commission PTS services from ambulance trusts. While this has been the aim for a number of years, in practice it has been NHS trusts and foundation trusts that have placed contracts for PTS. This was because the average tariff prices paid to hospital trusts for spells of healthcare included an unspecified amount for patient transport. If PCTs had commissioned PTS services they would in effect have been paying twice for the service. However from 2009/10, the Department has said that funding for PTS is being stripped out of the hospital tariff, enabling PCTs to arrange local contracts for PTS activity.

PTS income might typically account for around 10% to 15% of an ambulance trust's income (although there are wide variations). One ambulance trust could have several contracts in place to deliver PTS for a number of individual hospital trusts or it could have a single contract in place covering a consortium of hospitals. Contracts will often be block contracts setting out an overall sum for a total number of patient journeys. There will often be some weightings given to different types of patient journey (for instance patient in a wheelchair) and there will be some tolerance built into the contracted activity, above which additional payments would be triggered.

Other income: The principal source of other income for most ambulance trusts is the provision of out-of-hours primary care services for PCTs. This is a model being pursued in many parts of the country following the introduction of the new GP contract, which led to many GPs giving up responsibility for out-of-hours care. However other income could also include Department of Health grants for emergency preparedness, urban search and rescue services, education and development funding, resuscitation training and event income.

Ambulance service costs

Along with NHS trusts, foundation trusts and primary care trusts, ambulance trusts are required to submit costs for their activities as part of the Department of Health's annual reference costs exercise.

A reference cost index (RCI) shows the average cost of an organisation's aggregate activity compared with the same activity delivered at the national average cost. An organisation with costs equal to the national average scores 100, with higher cost organisations scoring above 100 and lower cost organisations scoring below 100. A market forces factor is used to adjust for the unavoidable cost differences faced by organisations in different parts of the country (these unavoidable costs relate to the costs of staff, land and buildings). By adjusting for MFF, the index scores should be able to be compared to give a more accurate reflection of relative costs.

The 2006/07 reference costs index for ambulance services suggest a wide range of costs for providing ambulance services ranging from 81 up to 163 – or from 19% lower than national average costs to 63% more than national average costs (a range of 82 percentage points). However even discounting the Isle of Wight, which has unique circumstances (such as transferring patients from the island to the mainland), the range stretches from 81 to 113 (South Western) – a range of 32 percentage points.

A simple interpretation of the published reference costs would appear to suggest that four ambulance trusts would benefit from a tariff based on national average costs (Five trusts had reference costs below 100 in 2006/07, however Staffordshire has subsequently merged with West Midlands Ambulance Service NHS Trust). One would see no change in funding while seven would face varying degrees of income reductions and financial challenges.

Putting potential winners and losers to one side, the reference costs would suggest that there may be significant scope for cost improvement if, as with acute hospitals, a national tariff was introduced for ambulance trusts based on national average costs.

However a number of additional factors are likely to influence the RCI scores in addition to relative costs and relative cost effectiveness. For instance the way data is collected and costs apportioned may be different from trust to trust. In different parts of the country different arrangements may exist for who pays for, for example, oxygen or even thrombolysis drugs (on the basis that the acute tariff would usually contain an element to cover the administration of these drugs). And different organisations may have interpreted costing guidance in different ways, particularly over the inclusion of out-of-hours activities, aborted incidents or the apportionment of estate costs between emergency and PTS work.

Some of the cost differences may be accurate but entirely legitimate. For instance, while the MFF adjusts for certain unavoidable cost differences, there is no adjustment for the higher costs of delivering ambulance services in rural locations or in highly congested areas. Large geographic areas may dictate the need for more response units – with corresponding higher staff costs – to enable national target times to be met. In reality, what constitutes best practice in terms of the type of response to meet the required performance will vary from area to area depending on the demographics. This will inevitably lead to variations in the costs base.

The reference cost index is constructed from costing information submitted by ambulance trusts for delivering a range of activities. Up to 2006/07 costs

REFERENCE COST INDEX 2006/07 Organisation	Unadjusted index (organisation wide)	Paramedic services	MFF	MFF-adjusted index (organisation wide)
Isle Of Wight NHS PCT (Ambulance Data)	155	155	0.9497	163
London Ambulance Service	116	116	1.1054	105
South East Coast Ambulance Service NHS Trust	108	108	1.0135	106
South Central Ambulance Service NHS Trust	106	106	1.0370	102
South Western Ambulance Service NHS Trust	104	104	0.9217	113
Yorkshire Ambulance Service NHS Trust	103	103	0.9409	110
East Midlands Ambulance Service NHS Trust	100	100	0.9435	106
East of England Ambulance Service NHS Trust	100	100	0.9934	100
Great Western Ambulance Service NHS Trust	96	96	0.9937	96
North West Ambulance Service NHS Trust	84	84	0.9467	88
West Midlands Ambulance Service NHS Trust	82	82	0.9648	85
North East Ambulance Service NHS Trust	79	79	0.9359	84
Staffordshire Ambulance Service NHS Trust	75	75	0.9286	81

were compiled for categories A, B, C, urgent incidents and other services (including out of hours services, major incidents and telephone advice). The reported costs – published as reference costs schedules – were compiled and reported separately for urban ambulance trusts and rural ambulance trusts. (From 2007/08 – costs for which were submitted in summer 2008 – urgent calls were required to be given an ABC category and so will not be reported separately).

The incidents within each category are further broken down into a maximum of 32 sub-sections identifying the patient's condition/symptoms (for instance abdominal pain, heart problems, bleeding or traffic accident.) The published reference costs also provide a further breakdown of the activity undertaken (for instance the responses, calls and patient journeys that correspond to the reported level of incidents). In total there were 92 separate reference costs categories in 2006/07 against which costs could be allocated – category A (32), category B (32), category C (23), urgents (1), and other (4).

The reference cost schedules appear to show substantial detail about the cost of different types of incident. For instance, they suggest that average costs of an incident involving a patient with a heart problem was £186 in an urban trust, compared with £220 in a rural trust (based on 16,000 incidents in urban areas and 14,000 in rural areas). However it also suggests substantial variations within similar areas. For instance the interquartile range (range for the middle 50% of organisations) for the same type of incident in urban areas stretched from £152 to £240, while the comparable range in rural areas was £188 to £252.

Despite suggesting a mine of useful detailed information, there are concerns about the validity of the data reported. We will look at this in more detail later on.

REFERENCE COSTS SCHEDULE 2006/2007 URBAN AMBULANCE TRUSTS: CATEGORY A INCIDENTS

Code	Paramedic services: category A / red (urban)	No of incidents	Nat av unit cost (£)	Interquartile range of unit costs		No of data submissions
				lower £	*upper £*	
PS01A	01 Abdominal pain/problems; abdominal / back pain	457	189	154	209	4
PS02A	02 Allergies (reactions) / envenomations (stings, bites); allergic reaction	13,501	184	148	212	5
PS03A	03 Animal bites / attacks	194	155	133	202	5
PS04A	04 Assault / sexual assault / rape; assault / trauma	20,199	132	107	161	5
PS05A	05 Back pain (incl. non traumatic)	16	111	17	97	3
PS06A	06 Breathing problems; breathing difficulty	248,199	200	166	227	5
PS07A	07 Burns / explosion	370	201	139	217	5
PS08A	08 Carbon monoxide / inhalation / hazardous chemical; environmental emergency	2,392	162	145	217	5
PS09A	09 Cardiac or respiratory arrest / death	27,667	208	179	287	5
PS10A	10 Chest pain	277,507	214	209	239	5
PS11A	11 Choking	3,730	168	131	180	5
PS12A	12 Convulsions / fitting	68,011	177	152	223	5
PS13A	13 Diabetic problems	7,360	188	159	210	5
PS14A	14 Drowning (incl. near) / diving / scuba accident	657	196	189	213	5
PS15A	15 Electrocution / lightning	470	175	139	210	5
PS16A	16 Eye Problems / injuries	99	236	64	181	2
PS17A	17 Falls / back Injuries (traumatic); falls / accidents	54,963	183	154	230	5
PS18A	18 Headache	126	229	118	214	4
PS19A	19 Heart problems / A.I.C.D.	15,956	186	152	240	5
PS20A	20 Heat / cold exposure	29	194	114	173	2
PS21A	21 Haemorrhage / lacerations; bleeding	41,802	174	143	215	5
PS22A	22 Industrial / machinery accidents	341	219	204	223	5
PS23A	23 Overdose / poisoning / ingestion	10,151	160	138	197	5
PS24A	24 Pregnancy / childbirth / miscarriage; gynaecological	20,703	191	133	195	5
PS25A	25 Psychiatric / suicide attempt; mental / emotional	563	186	189	204	5
PS26A	26 Sick person (specific diagnosis)	633	207	172	231	4
PS27A	27 Stab / gunshot wound	5,549	174	136	224	5
PS28A	28 Stroke / CVA	295	234	194	256	4
PS29A	29 Traffic / transportation accidents; RTAs	6,403	235	205	275	5
PS30A	30 Traumatic injuries (specific)	12,851	180	147	222	5
PS31A	31 Unconscious / fainting (near) /passing out (non-trauma)	142,317	195	169	209	5
PS32A	32 Unknown problem (incl. collapse - 3rd party); sick / unknown / other	34,136	138	105	178	5

Why introduce payment by results for ambulance services?

The Department of Health has indicated that its aim is for the majority of health service activity to be funded through payment by results. Its most recent consultation *Options for the future of payment by results* clarifies that payment by results does not necessarily mean a national currency and a national price. But it is clear that linking payment to activity and services provided remains a clear policy goal. Payment by results aims to deliver a system that is: fair; transparent; and rules based. These are aims that should apply to the funding of ambulance services as much as any other NHS service.

One of the clear aims of payment by results for acute hospital services is to support patient choice. Patient choice is not directly relevant to emergency ambulance services (although there are links between the choice agenda and PTS). However other aims of the system are just as relevant to the ambulance sector as they are to other parts of the NHS.

For instance, a key aim of payment by results for hospitals is to reward good performance and drive cost improvement. Hospitals that deliver services at less than the tariff price make a surplus on their activities that can be reinvested in patient care. Hospitals with services that cost more than they receive through the tariff are driven to look for cost improvements or risk making a deficit on those activities.

Paying for services on the basis of what was paid last year plus growth means there are weak incentives for poor performers to improve their cost effectiveness. And cost effective providers receive no reward for their good performance. The range of costs shown in the reference cost indices for ambulance trusts (some 32 percentage points from lowest to highest cost provider, excluding the Isle of Wight) suggests there may be scope for cost improvement overall. And there is a simple issue of equity. Using historic budgets as the basis for future contracts can potentially be seen as rewarding poor performance.

There is another key reason why payment by results could be beneficial for ambulance services – to support change in the sector. The Department of Health's report *Taking healthcare to the patient* (undertaken by London Ambulance Service chief executive Peter Bradley – the Bradley Report) was clear that ambulance trusts had a far wider role to play in providing mobile healthcare services, offering a range of assessment and interventions in both planned and unplanned care settings. It is anticipated that at least one million patients currently attending A&E could be cared for at the scene or in the community.

If ambulance trusts are to change practices, as a minimum they need to receive the right level of funding to provide these different services. However a tariff could also be used to incentivise the introduction of alternative or new services. In a similar way, unbundling the tariff in the acute sector – breaking a tariff payment for a whole patient pathway into tariffs for the component parts of that pathway – is seen as a way of providing a funding stream for the development of alternatives to traditional hospital treatments.

Finally there are concerns that the absence of payment by results for ambulance services is creating pressure for ambulance trusts. With acute activity paid for at tariff rates, there are concerns that increasing resources are being sucked into the acute sector, reducing the money available for PCTs to spend on non-PbR activity. Ambulance services, along with other non-PbR areas such as mental health, face a potential financial squeeze. A lack of tariff also means there is no incentive for commissioners to manage demand for ambulance services or put in alternative care pathways.

When the Department of Health first unveiled its payment by results policy, there was an expectation that ambulance services would be included within the regime by 2008. However this has not happened and only modest progress has in fact been made.

In 2007's consultation paper *Options for the future of payment by results*, the Department admitted that a 'national tariff for emergency ambulance services will not be possible until beyond 2010/11'. However a number of pilot sites have been set up to investigate local solutions to linking payment to activity.

In a further response to the consultation, in January 2008, the Department said that urgent and emergency care (including ambulances) was one of five priority areas to expand the scope of payment by results. However there are concerns that the lack of a specific deadline could in reality mean a much longer timescale for an ambulance service tariff.

There are concerns that the absence of payment by results for ambulance services is creating pressure for ambulance trusts

What are the options for linking payment to activity?

The currency used for payment by results in the acute sector is the healthcare resource group. With more than 20,000 codes used to describe specific interventions and diagnoses, having a different payment for every single procedure or condition would be unworkable. Instead procedures and diagnoses are grouped to clinically meaningful isoresource groups (ie it makes sense to clinicians to group these procedures together and they consume similar levels of resource). These groups are known as healthcare resource groups (HRGs). The version currently in use in the national tariff in 2008/09 is version 3.5 and includes some 650 HRGs. However a new version (HRG4), due to be introduced as the basis for the national tariff from 2009, will extend these groupings to more than 1400.

NHS hospitals submit the local costs for delivering each HRG undertaken as part of the annual reference cost collection. This leads to the calculation of a national average cost for each HRG. These costs, adjusted for inflation, efficiency requirements and for the introduction of new drugs and technologies, are used as the basis for the national tariff. Reference costs submitted in summer 2007 for the year 2006/07 (using HRG4) are due to form the basis for the national tariff in 2009/10.

There are currently no HRGs for ambulance service activity, although the reference cost incident sub-categories are sometime viewed as HRG equivalents.

The first step in developing a tariff for ambulance services is to identify a currency – ie the units of activity that ambulance trusts would be paid for delivering.

Option A: Incidents

The simplest currency to develop for ambulance services would be based on the initial categorisation of calls as A, B, C. The advantages of such a system would be that it is simple – clearly passing the 'transparency' requirement. There is also costing information already collected to create the tariff from the annual reference costs information.

However it suffers from a number of key weaknesses. First it focuses predominantly on the ambulance response rather than encouraging a wider role for ambulance services in emergency healthcare. The Department of Health's consultation paper in 2007 *Options for the future of payment by results* suggests that such an approach could incentivise trusts simply to transport people to A&E rather than treating them at the scene. Picking up and dropping off at A&E may be more expensive for the health economy – tying up key resources in a hospital, incurring costs and triggering payments by the relevant PCT to the hospital under payment by results. But it may be cheaper for the ambulance trust because:

- Treating at the scene would involve increased investment in training
- Savings from reduced hospital admission/treatment would benefit the commissioner rather than the ambulance trust
- In urban areas the distance to A&E is often only short

There is also an issue (as with some of the following options) that payment would be linked to the initial categorisation of the incident based on telephone assessment rather than the actual patient condition. As the Bradley report pointed out, ambulance services categorise approximately 30% of their calls as category A when in fact only around 10% are truly life threatening. So an ABC tariff would not necessarily incentivise improvement in categorization.

Such a system would not reflect the need to maintain capacity regardless of usage and, without a specific adjustment, would not recognise the higher costs faced by trusts operating in rural areas, where the low population density can increase running costs.

Option B: Incident sub-categories/reference costs

For the purposes of reference costs, incidents (A, B, C and U) are already broken down into a maximum of 32 sub-categories (see ambulance service costs section) and split between urban and rural trusts. This could provide the basis for a detailed tariff providing different payments for patients with different conditions/symptoms. For instance, using 2006/07 reference costs, an ambulance trust might receive £219 for responding to patient who has had

an industrial or machinery accident or £214 for responding to a patient complaining of chest pain (where the problem is believed to be life-threatening). The reference costs include an 'other costs' section capturing the costs of telephone advice, out-of-hours services and major incidents – enabling these 'non-traditional' responses also to be captured.

The downside of using reference cost categories as the basis for a future tariff is that this would link payment very closely to call categorisation as assessed over the phone and not the patient condition. As ambulance trusts move towards the recommendations of *Taking healthcare to the patient*, costs will increasingly be driven by actual patient condition as much as by initial call categorisation. The patient condition will dictate the expertise required and therefore the training costs and the time spent at the scene. This will have an impact on costs that might not be covered by a tariff based primarily on call categorisation..

Such a system might again incentivise a simple 'pick up and convey' response, rather than more costly care on the scene. There are also concerns about the validity of the current reference costs data, although these could be overcome by developing a tariff based on costing a 'best practice' response rather than using national average costs.

As with the earlier option, a system based on incident sub-categories would not reflect the need to maintain capacity regardless of usage.

Option C: Calls/reports of incident

A tariff could be constructed on the basis of calls/reports of incidents. This has the attraction of better recognizing the demands placed on the service. Not all calls result in an actual incident. For instance, a response may be triggered by a call but is subsequently stood down because the patient recovers. This would not be recorded as an incident, and so would not attract payment under an incident-based tariff, but would still consume resources. By linking funding to calls, ambulance services would be paid for the demand they receive, leaving them to deal with that demand in the most efficient and patient-focused way. It could in fact incentivise the adoption of more cost-effective services where appropriate, such as clinical advice lines. However it is viewed as a crude way of paying for a range of services that vary widely in the resources they consume and also suffers from the same flaw as earlier options in not reflecting the need to maintain capacity regardless of usage. A further flaw is the fact that there are often numerous calls relating to the same incident – particularly in the case of a road traffic accident. These additional calls will not necessarily lead to an increase in costs. The tariff would be sensitive to the ratio of calls to incidents, which could be influenced by external factors such as 999 awareness campaigns.

Option D: Resources sent (eg double staffed ambulance or single responder paramedic)

Basing a national tariff on the resources sent has attractions in that it matches payment to ambulance trusts' key cost drivers – staff and the vehicles used to get to the scene of an incident. Telephone-based clinical advice could also be logged, costed and turned into a tariff. However without further breakdown, a system based on resources sent would not differentiate between the different care given – and crucially the time taken – during different incidents or types of patient condition and would not reflect the need to maintain capacity regardless of usage. It could also be criticised for providing potential for gaming – with more resources sent leading to an increase in income.

Option E: Hear and treat, see and treat, see and convey

A tariff could be constructed on the basis of the type of response provided by the ambulance trust (see table1 for example).

TABLE 1

Category	Response	Tariff
A	See and treat	1
A	See and convey (general)	2
A	See and convey (specialist unit)	3
B	See and treat	4
B	See and convey (general)	5
B	See and convey (specialist unit)	6
B	Hear and treat	7
C	See and treat	8
C	See and convey (general)	9
C	Hear and treat	10

Using such a tariff would more closely reflect the real costs connected with the response made and treatment/transport given. This should increase the incentive to treat calls in the most appropriate way and reward investment in training and development

to enable staff to undertake more treatment.

However, data is not currently collected in this way. This could delay the introduction of a tariff, while data is collected or an initial tariff could be produced using estimates.

Option F: Patient pathways/unbundling

There is a move across acute services to unbundle the tariff into the different component parts of a patient pathway, enabling different providers to deliver components of the pathway and receive funding for the care delivered. An ambulance service tariff could be based on a similar framework. For instance, an ambulance provider could receive the A&E tariff plus a call out tariff for patients treated at the scene, who would otherwise have been transported to A&E triggering an A&E tariff to be paid to the hospital.

A possible tariff could be structured as in table 2. This could be taken a step further by seeing each episode split into three component steps: access (including handling the call and performing any triage); assessment; and intervention (which could involve treatment, treatment and transport or a referral to a different part of the care system). Such a tariff (see table 3) would support different providers delivering different parts of the pathway.

Option G: Normative tariff

All the above tariffs would be set by collecting data in the required format and producing costs for the various component parts. As with the acute sector, tariffs would largely be based on – or at least informed by – national average costs (an alternative might see tariffs set on the basis of costing a best practice pathway/intervention). But tariffs could be set normatively based on the value of different responses to the service as a whole rather than the cost. For instance, a tariff could be set at a level higher than the average cost of delivery for see and treat type responses. This might provide good incentives for ambulance service providers to make the investment needed in staff training and development to make a reality of the envisaged wider role in healthcare delivery.

TABLE 2

Category	Response	Tariff
A	See and treat	Call-out tariff + A&E tariff (high)
A	See and convey – general	Cat A tariff
A	See and convey – specialist unit	Cat A tariff + quality premium
B	See and treat	Call-out tariff + A&E tariff (standard)
B	See and convey - general	Cat B tariff
B	See and convey – specialist unit	Cat B tariff + quality premium
B	Hear and treat	Fixed tariff based on cost/value
C	See and treat	Call-out tariff + minor A&E tariff (minor/MIU)
C	See and convey - general	Cat C tariff
C	Hear and treat	Fixed tariff based on cost/value

TABLE 3

Access	Assessment	Intervention
Triage of calls	Cat A (fast response) 'see and assess'	Treat
	Cat A (fast response) 'see and assess'	Treat and convey
	Cat A (fast response) 'see and assess'	Refer
	Cat B (semi-fast response) 'see and assess'	Treat
	Cat B (semi-fast response) 'see and assess'	Treat and convey
	Cat B (semi-fast response) 'see and assess'	Refer
	Cat B (semi-fast response) 'hear and assess'	None
	Cat C 'see and assess'	Treat
	Cat C 'see and assess'	Treat and convey
	Cat C 'see and assess'	Refer
	Cat C 'hear and assess'	None

Key issues

National tariff vs local tariff

The approach for acute healthcare has been to develop a national currency and national price tariff. However the Department of Health has identified three generic models for payment by results: national currency and price; national currency, local price: and local currency and price. The Department says there are no plans at this stage to introduce national currencies and tariffs for ambulances. It is not clear whether the current piloting of different models is aimed at identifying the 'best' currency for a future national tariff or at establishing a range of currencies for use in local tariffs. There are pros and cons to both approaches. A local tariff would sidestep any need to adjust national prices for local market forces or rurality/urbanity. However it may make benchmarking across different organisations difficult and provide weak incentives to match national best practice. A national approach may provide better opportunities to benchmark and drive efficiency. However it may be insensitive to local circumstances and would require a robust mechanism to adjust for the impact of local market forces and the unavoidable costs relating to operating in rural or urban environments.

Rurality/congestion

There is a strong argument that ambulance trusts in rural or sparsely populated areas face higher costs because of the longer journeys, meaning higher staff costs per journey and higher fuel costs, and lower demand meaning fewer economies of scale. A rurality adjustment could be made to any tariff payments in the same way that the market forces factor (MFF) currently adjusts for unavoidable cost differences related to location arising from staff, land and buildings. This MFF adjustment is applied to tariff rates for activity undertaken by acute providers and paid directly to hospitals. (An emergency ambulance cost adjustment does exist and is used to adjust allocations to PCTs.)

The need for a rurality adjustment has perhaps reduced with the introduction of larger ambulance trusts. Mergers do not reduce the costs of covering a rural area but larger trusts often cover both rural and urban areas. Any 'underpayment' – resulting from a national average tariff not covering costs in rural areas – is more likely to be balanced by 'overpayments' for urban activities. However there is still a consensus that rurality adjustments are needed. For instance the HFMA's brief survey of ambulance trusts (see appendix), which involved two-thirds of the existing 12 ambulance trusts, found that of trusts favouring a national rather than a local tariff, all respondents backed an adjustment for rurality for ambulance services.

But while there may be agreement that a rurality adjustment is needed – the level at which the adjustment should be made is less clear. Adjustments could simply be made at ambulance trust level with a single weighting applied to each trust to reflect the rural/urban make-up of its territory. Alternatively operating patches within each trust could be used or the areas covered by PCTs. The latter was a slight preference in the HFMA survey (although there was backing for both trust and patch level too) and has the advantage of being aligned with the allocations received by PCTs.

The Department of Health has examined two rurality measures to analyse the impact on the reference cost index of the former 31 ambulance trusts. (In crude terms a trust with an RCI of 100 would expect to exactly cover its costs from a tariff set on national average costs, while a trust with an RCI of 120 would have costs that were 20% more than the income it might expect through tariff.)

In general, the rurality measures both had similar impacts, reducing the RCI of rural trusts and increasing the RCI of urban trusts. So for instance, Cumbria had an RCI of 150 in 2005/06, suggesting it was the most expensive of the 31 ambulance trusts in existence at that time. However adjusting for rurality would have changed its RCI to 106 (using either rurality measure), and moving it up some 10 places in the relative cost rankings. Meanwhile London Ambulance Service's RCI of 107 would have moved to 129 (ONSUR)* or 126 (TWGM)**, moving the trust a similar number of places down the relative cost rankings.

The application of any such rurality measure on whatever tariff was put in place would have a significant impact on funding flows. However there is a counter argument that simply applying a rurality measure would ignore the costs caused by traffic congestion in highly urban areas. It is believed that recent analysis by the Department of Health has shown that operating in sparsely populated areas and in very densely populated urban areas (where congestion is likely) both have an upward impact on costs making the relationship between costs and population density more of a U-curve.

Ambulance trusts in rural or sparsely populated areas face higher costs because of the longer journeys

* ONSUR – a measure based on Office of National Statistics' classification

** TWGM – a geometric mean of ward-weighted population density

Market forces factor (MFF)

All acute providers receive the same national tariff rate from PCTs for activity covered by payment by results. These providers may then receive a top-up payment (paid centrally, not out of PCT allocations) to compensate for the different, unavoidable costs of operating in different parts of the country. This market forces factors (MFF) adjustment takes account of cost differentials relating to staff costs, land and buildings. All organisations first receive a 'raw' MFF that pegs their position around the national average. Revised MFFs are then calculated by setting the lowest MFF to 1, with all other organisations having higher MFFs. In terms of the tariff, the organisation with a revised MFF of 1 simply receives the national tariff rate for activity. All others receive a central top-up indicated by their MFF (for example a trust with a revised MFF of 1.25 receives a top-up worth 25% of the national tariff for all its payment by results activity).

It would be expected that an MFF adjustment would be applied to any ambulance service tariff. There have been concerns about the way the MFF is calculated using private sector pay as a proxy for the cost differences facing NHS employers. Many managers argue that national contracts and pay rates dictated by Agenda for Change mean that NHS pay does not face the same variations as private sector rates, apart from in London where the high cost area supplement applies. As one respondent to the HFMA survey put it: 'a paramedic is on the same band whether employed in Newcastle or Chichester, but market forces factor assumes employment costs are greater in the latter.'

A national review of the MFF has been undertaken and the results were due to be published alongside PCT allocations for 2009/10 and 2010/11 towards the end of 2008. However, the review was expected to endorse the continued use of private sector pay rates in determining unavoidable staff costs faced by NHS employers across England.

Who pays?

In the acute sector, who pays for treatment is clear – the PCT that hosts the patient's GP practice. This fits with allocation policy, which gives PCTs budgets to meet the health needs of their populations.

However this is not so simple for ambulance trusts. Patients taken to hospital by ambulance may often be in no condition to provide details of their GP practice or their own address. So any payment system that depended on identifying each patient's relevant purchaser would at best rely on other organisations to provide retrospective information about patients conveyed to A&E. The complications mean such a system is likely to be unworkable, at least in the short term. The alternative is to take a hosted approach with charges made to the PCT covering the areas in which an incident took place.

To date, PTS has been another difficult area. Although the aim has been for PCTs to commission PTS, in practice it has been NHS trusts and foundation trusts that placed contracts for PTS. This is partly because average tariff prices paid to hospital trusts for spells of healthcare included an unspecified amount for patient transport. However, from 2009/10 it is understood that PTS costs have been unbundled out of the acute tariff, enabling PCTs to start commissioning PTS.

Patients taken to hospital by ambulance may often be in no condition to provide details of their GP practice or their own address

Case study 1: North East Ambulance Service NHS Trust

North East Ambulance Service is piloting a local tariff based on patient pathways and unbundling, considering different tariffs for different stages of the emergency care pathway as well as for the different categories of incidents. It claims to be the only trust piloting a tariff for patient transport services (PTS).

The trust started with an ambitiously detailed approach that would have seen 79 different pricing pathways. This involved breaking the patient pathway initially into two parts – work undertaken in the contact centre or control room and then the field operations. The plan was to further break down these pathway segments and identify tariffs for the different activities and responses that could be undertaken within each segment

Within the control room five separate activities were initially identified:

- Call handling
- Triage and assessment
- Emergency medical support officer (EMSO) advice
- Nurse advice
- Capacity management system (CMS) referral

On the fieldwork side, the different actual accident and emergency responses were identified as:

- Dispatch to incident
- Treatment at scene
- Transport to hospital

However limitations with existing data have resulted in two simpler tariff models being investigated. Under both models, contact centre activity has been divided into just two separate activities – call handing and triage. In the first model a very simple approach has been used for the operations section of the pathway. The pathway is divided into: dispatch (the cost of dispatching vehicles); see/treat (time spent on scene treating or assessing patient); and convey (transfer of patient from scene to hospital).

A first draft of the tariff was as shown in table 4.

A second model (table 5) takes a slightly more detailed approach, boosting the payment for see and treat only (reflecting the longer times spent by crews on the scene in these cases). For cases that involve transportation to hospital, the treatment or time on scene is amalgamated into the charge for conveyance. (Each incident would attract only one of see/treat only or the see/treat and convey tariffs).

Both tariffs are being tested and discussed with commissioners.

TABLE 4

	Contact centre		A&E			
Category	**Call**	**Triage / assessment**	**Dispatch**	**See/treat**	**hospital**	**Tariff for complete pathway**
	£	**£**	**£**	**£**	**£**	**£**
A	5	14	18	129	50	216
B	5	14	20	101	52	192
C	5	27	23	98	53	206
Urgent	5	4	38	68	76	191
Police/Fire call	5	2	18	73	47	145
Transfers	5	2	19	89	92	207
Others	5	6	9	53	50	123

TABLE 5

	Contact centre		A&E			
Category	**Call**	**Triage / assessment**	**Dispatch**	**See/treat only (a)**	**See/treat and convey (b)**	**Tariff for complete pathway (includes a or b)**
	£	**£**	**£**	**£**	**£**	**£**
A	5	14	18	166	171	203/208
B	5	14	20	115	148	154/187
C	5	27	23	113	142	168/197
Urgent	5	4	38	106	143	153/190
Police/Fire call	5	2	18	73	120	98/145
Transfers	5	2	19	89	180	115/206
Others	5	6	9	53	103	73/123

The tariffs suggest that there could be some major changes in the fund flows from PCTs to the trust if the tariff is strictly applied. However this is unlikely to happen in the near future. Instead the initial approach will be to charge the overall tariff charge to commissioners along the same percentage split as the current service level agreements. At present, under the current service level agreements, charges per incident range from £1.41 to £2.85 between the involved PCTs.

The tariff has also highlighted a fundamental issue for the ambulance trust itself. There has been historical cross-subsidisation of patient transport services and emergency planning services in the organisation. Introducing the tariff for emergency services in isolation, based on current costs, would lead to a potentially destabilising reduction in income for the ambulance trust.

If nothing else, this underlines the importance of ensuring PTS activity also moves to tariff at the same time, ensuring the trust as a whole does not face a significant income shortfall. Although PTS has been subsidised by emergency activity, it is not an expensive function with its roughly £22 per patient journey comparing well with an estimated national average of £27, suggesting that the trust is underfunded for PTS rather than being inefficient.

The trust is in the early days of examining options for a PTS tariff. A simple charging system based on mileage, similar to taxi charging, has been considered. However it is recognised that this would not reflect the, often significant costs, incurred in other parts of the pathway. For instance anecdotal evidence suggests that porterage (from the patient's residence and at the hospital) can add 25% to PTS staff's working day. A tariff that simply charged on basis of distance travelled to hospital would not capture this.

A tariff with fixed and variable elements has also been considered. This might involve a currency based around the following priceable units of activity

- PTS booking charge (with different rates for planned and same day bookings)
- Porterage (with different charges based on the mobility type of the patient – for instance walking case, need for wheelchair or stretcher)
- PTS transport journey (again with weightings for mobility types)

Breaking the charges down to this level of detail requires more activity information than is currently held. And there are also issues around the manual recording of activity in dedicated day care units. However the trust is in discussion with commissioners about the options around PTS tariffs .

In general, the trust is planning to operate the tariff in shadow form during 2009/10 with the tariff going live in April 2010.

Case study 2: London Ambulance Service NHS Trust

London Ambulance Service is the biggest ambulance service in England accounting for around 15% of all ambulance service expenditure and providing day-to-day emergency services to 31 primary care trusts. The trust has piloted four different currencies with a view to discussing with commissioners the best way forward in terms of a local tariff.

For all four currencies it is looking at an approach that involves a mixture of fixed and variable (activity-based) charges. The fixed charge – viewed as a type of 'network connection' charge – would provide some guarantee of covering the ambulance trust's fixed costs and recognise that the ambulance service faces substantial costs in ensuring an emergency response is available, even if it is not actually used. The fixed/variable split could also be used as a mechanism to phase in the tariff, with an initial high fixed rate (say 70% of charge based on a per head rate) dampening any step change in funding flows, and then the split could be moved in subsequent years to provide an increasing link with activity. (This would differ from the risk arrangements for accident and emergency departments. The current A&E tariff is based on a 80/20 fixed/variable split – with 20% of tariff withdrawn for underactivity, but 100% of tariff paid for overactivity.)

The first model uses a very straightforward currency of incidents or calls. Depending on the decisions around the split between fixed and variable charges, this would produce the draft tariff shown in table 6 (using 2008/09 figures).

A second currency (table 7) would follow a see and treat, hear and treat, see and convey approach, effectively providing 10 draft tariff prices.

Two further options have also been investigated. One would use the AMPDS codes (as with reference costs) however there would be no split for ABC categories – so a PS10 code (chest pain) would attract the same tariff regardless of whether the incident had been categorised as A, B or C. This has been trialled as an alternative to reference costs (which are split into A, B and C), however, results prove that the call categorisation is a key cost driver and tariffs are all quite similar if the A,B,C categorisation is removed. The final option uses illness codes as assigned by paramedics to patient notes once they have assessed/treated/conveyed patients. While this provides good links to the actual patient condition, it is potentially undermined by concerns over data quality and current paper-based recording systems.

TABLE 6

Currency	Tariff (100% variable)	Tariff (30% variable, 70% fixed)
Calls or incidents	£147.65 per call, £219.96 per incident	£19.49 per head of population plus £44.29 per call or £65.99 per incident

TABLE 7

Category	Response	Tariff (100% variable)
A	See and treat	£149.53
A	See and convey – general	£254.35
A	See and convey – specialist unit	£312.89
B	See and treat	£124.79
B	See and convey – general	£235.20
B	See and convey – specialist unit	£295.47
B	Hear and treat	£45.04
C	See and treat	£146.41
C	See and convey – general	£251.02
C	Hear and treat	£45.04

TABLE 8

	Option 1	Option 2	Option 3	Option 4
Biggest increase in PCT payment (%)	12.5%	6.7%	6.4%	6.3%
Largest decrease in PCT payment (%)	7.8%	7.9%	5.1%	5.7%

An analysis has been undertaken (using data from 2005/06 – 2007/08 and projecting activity forwards to assess the impact on payments by PCTs. Based on 2008/09 projected activity, the largest movements in PCT payments would be as shown in table 8.

A small joint working group from the London Ambulance Service and PCTs has been formed to analyse the activity and costs under each of the currencies and to propose next steps, with a view to shadowing adn introducing a real tariff as soon as possible, possibly in 2010/11.

Each incident attracts a flat rate – there are no distinctions for different A,B,C or urgent categories

Case Study 3: West Midlands Ambulance Service NHS Trust

West Midlands Ambulance Service has opted for a simple, straightforward tariff. The basis for its tariff is a modified version of an incident. For the purposes of reporting (using the KA34 central return), incidents are defined as those in which a response arrives at the scene of the incident. This means that calls resulting in telephone advice or in a response being sent but then stood down before arriving at the scene would not be counted. So the trust has used a modified version of an incident – known as a contract incident – which includes cancelled responses and clinical advice.

Each incident attracts a flat rate – there are no distinctions for different ABC or urgent categories and no breakdown using the AMPDS/reference cost sub-categories. However while the currency is common for all the trust's commissioning PCTs, each PCT actually pays a different tariff rate.

This has initially been shadowed on the basis of historical spending although the trust is looking at using rurality factors to set PCT rates – so each PCT would pay a tariff rate based on the overall average for an incident multiplied by its rurality factor. The trust already has robust rurality measures at locality level and is looking to see if these can be established at the lower PCT level. A simpler variation on this rurality model is also being considered with PCTs placed into one of three rurality/urbanity bands – average, high urbanity, high rurality.

The simplicity of the system is seen as its key advantage. However it also has other benefits. It incentivises the development of more cost-effective responses – for instance, there would be incentives to develop cost effective clinical advice services to replace the more traditional response where clinically appropriate. There could also be no suspicion of gaming as ambulance trusts would receive no financial benefit from moving incidents between different categories. However there would be no incentives to develop new pathways and services if the costs to the trust were higher than those covered by the flat rate tariff. This could be addressed by the inclusion of contractual clauses setting non-conveyance rates or by including a separate tariff for treatment activity.

The trust is currently operating the tariff in shadow form and is planning to introduce the tariff (using a rurality adjusted flat rate) from April 2009.

Appendix 1

HFMA ambulance trust PBR survey

At the beginning of 2008, the HFMA conducted a small survey of ambulance trust finance directors to gauge views on the development of an ambulance service tariff. The survey (right) found unanimous support for the introduction of payment by results for emergency services. Individual finance directors said the payment system was needed to ensure consistency with central NHS policy, to provide fair remuneration for work undertaken and to allow development of cross-organisational clinical pathways. There was less agreement about the specific currency that should be adopted, reflecting the different approaches being pursued by pilot sites around England. All respondents either backed the use of rurality adjustments to national tariffs or using a local tariff to enable local cost differences to be accommodated. All directors backed the need to phase changes in, with periods between two and four years suggested as workable.

Do you support the introduction of PBR for ambulance services?	
Yes	100%
No	0%

What would be your preferred currency for the payment of tariff?	
Incidents (A, B, C or U categories)	0%
Incident sub-categories (HRGs/ reference cost categories)	25%
Calls/reports of incident	0%
Resources sent (ambulance or paramedic)	0%
Combination of above	75%

Who should pay for ambulance service activity?	
Patient's PCT	25%
PCT where incident took place	75%

What approach should be taken to an ambulance service tariff?	
National tariff + market forces factor (MFF)	0%
National tariff + MFF + rurality payment	43%
Local tariff	57%

If national tariff is used, and adjusted for rurality, at what level should rurality be applied?	
Ambulance trust level	29%
Locality level (ie internally identified patches within ambulance service area)	29%
PCT level	43%
SHA level	0%

Over what period should any changes be introduced/ transitional relief provided?	
Big bang, no transitional relief	0%
2 years	29%
3 years	43%
4 years	29%
5 years	0%

At what rate should increases/decreases in activity be charged?	
Full tariff applies to all activity	0%
Full tariff for commissioned levels of activity with variations at marginal rate	0%
Block payment to cover capacity + tariff for activity levels	50%
Receive marginal rate for additional activity in year with remainder paid in year 2	50%

How should clinical advice (from clinical support desks) be charged?	
Flat fee for any advice given	14%
Fee based on diagnosis	57%
At same rate as traditional response	29%

How should higher cost services (such as emergency care practitioners (ECPs) providing treatment) be reflected in PBR?	
Separate tariff for incidents involving ECPs	50%
Local top up paid outside tariff	25%
Other	25%

How should the impact of high cost drugs (such as thrombolytics) be reflected in tariff?	
Separate, locally agreed payments outside tariff	25%
Unbundled tariff payment for drugs administered	38%
Other	38%

All directors backed the need to phase changes in, with periods between two and four years suggested as workable

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