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**Shared Responsibility – an answer to Payment by  
Results**

**a study on behavioural and attitude change in the  
South Yorkshire Payment by Results Laboratory**

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## Introduction

Of all the changes to the NHS over this government, Payment by Results (PbR) will arguably have the biggest impact on the mindset and the culture in the short term. Perhaps the other key policy is the widening of patient choice, though this policy is still in its very early stages and will take longer to make its mark.

PbR is not so much a policy in isolation, but a key component within a cluster of policies all leading in the same direction – an increased sense of ownership, responsibility and stewardship for the outcomes and for the resources used.

This study charts the cultural change observed to date in one Local Health Community (LHC) in South Yorkshire, and the behaviours that may (or have already) result from making that shift. South Yorkshire went full PbR 12 months before the rest of England, and what is happening here may illustrate lessons for others.

## Methodology

South Yorkshire was designated as the national test bed for implementing Payment by Results and a number of reports have already been published on the Laboratory project. These studies were carried out early in the deployment of PbR and the South Yorkshire SHA review highlighted the need to look further into the future, both a retrospective review after the policy had had time to become established; also anticipatory, asking what attitude and behavioural changes participants expected because of this policy, and what would be their impact.

Before starting interviews, we need to define the scope. PbR is part of a cluster of initiatives and many of the changes cannot be uniquely ascribed to any one:

- Patient choice
- Foundation Trust and Commissioner/Provider split
- Introduction and support of Independent Sector Treatment Centres (ISTC)
- “Our Health, Our Care, Our Say” white paper and the move of services to primary care.
- The 18 week target has a big impact because of the extra activities to reduce waiting lists

The chosen method of study is in-depth semi-structured interviews, since activity changes may take longer to show the effects.

The South Yorkshire Academy for Health and Care Improvement agreed to design the study, design and perform the interviews, and prepare the report and one of its senior consultant staff, Hugo Minney was appointed to lead the project.

The project was designed in a number of stages:

- Stage 1** will individuals and organisations own up to deliberate behavioural change? (within a defined Local Health Community)
- Stage 2** A) if not, then can we tell whether behavioural change has occurred by looking at the activity data?  
B) if so then can we determine the scale of the change through interview?
- Stage 3** If this behavioural change were observed on a wider scale, what would be the implications
- Stage 4** are the observed behavioural changes widespread? Compare the LHC selected with the other three in South Yorkshire

We would have liked to understand the size and impact of these changes, and how much they vary depending on the culture and specific arrangements in particular Local Health Communities (LHC); because the changes have in many cases not yet had an impact on activity or there is no comparable baseline to show the change, and this interim report only examines the first two stages and discusses how much will be learnt from extending the study.

We decided that an in-depth study of two contrasting LHCs would yield more useful information than an overview from Chief Executives across the whole of South Yorkshire, since in empowered organisations, attitudes at what might seem relatively junior levels may have a substantial impact on outcomes.

*We recognised that by adopting this approach we would not be able to assess how much the size and impact of PbR might vary depending on the culture and specific arrangements in particular Local Health Communities (LHC). A key aim of the scoping study was therefore to determine how much additional insight into behaviour would be gained by replicating this approach in other LHCs in a later phase of the study*

## ***Semi-structured interviews***

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Interviews were arranged with representatives of the Commissioner (Rotherham PCT), the major DGH Provider (the Rotherham NHS Foundation Trust), its Tertiary Provider (Sheffield Teaching Hospitals NHS Foundation Trust), Sheffield Teaching FT's commissioners, Health Informatics (also specialist commissioning) and SHA Public Health. Representatives were sought at the most senior level (Chief Executives), amongst the negotiating teams and information staff, and amongst clinicians and clinical service managers (typically General Managers and Medical professionals). As the results became clear, we invited both Department of Health PbR team and Monitor to contribute.

We were able to highlight contrasts between Rotherham, Doncaster and Sheffield from respondents' experience.

In all, 26 people contributed in 18 interviews.

## ***Compiling the interviews***

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The comments reported in this study represent views of the respondents. The study is a study of opinions and the behaviours resulting from those opinions, and I have not attempted to verify the "facts" behind every opinion. None-the-less, comments are not ascribed to preserve anonymity.

## **Themes emerging from interviews**

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PbR cannot be seen in isolation but as part of a cluster of changes. Complex systems (such as the variety of patient pathways, networks, formal organisations and informal ways of working, etc) tend to adapt and reorganise themselves into a new stability.

The study aims to highlight areas for focus, both behaviours which are potentially damaging to effective delivery or care, and beneficial results either from the policy or in response to the unhelpful behaviours.

## ***The overall impact of the basket of policies***

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Respondents agree that the **principle of PbR** is right, and that it is still **evolving**. In year 1 negotiations between commissioner and provider tended to be around details (e.g. bed days) and the big benefits were to be gained from reaching national targets. The key outcome was that they agreed to work together to avoid conflict. One respondent emphasised that PbR polarises: if money is a problem, under PbR it will be more so.

PbR is much more than just a pricing or finance tool, it is, **regulatory system** that also ensures good quality, and using tax-payers' money in the most effective way for most cases (some e.g. symptom-based acute care and mental health were cited as two particularly difficult examples to put into PbR)

And it puts people's **focus** in right place: Productivity/Efficiency (Value Added), Referral rates and Demand Management. PbR doesn't operate in isolation, it is the foundation which ensures that providers are rewarded for attracting more patients – the basis of patient choice. Trusts have made themselves more competitive and more attractive by planning ahead to reduce waiting lists and improve care quality.

The provision of health care, like everything else, relies on **relationships** (whether contractual, through a shared vision or personal). PbR has introduced **Clarity** – helping people to work together –

commissioners acting like commissioners, providers like providers. Of course the balance in this relationship relies on the capability of each party, and there are huge risks with this approach if the commissioners remain information-poor; but now the responsibilities and risks are clearly understood, and with tariff price set according to a pricing formula, discussions are **moving from price** for the service to actively managing demand, waiting lists, quality of care and alternative provision.

There is an important point which both Rotherham and Sheffield saw fit to mention: the fundamental difference between a relationship based on rules and contractual sub-clauses, and a relationship with a **shared direction of travel**. As one respondent put it, the difference between Contract and Compact. The provider has to manage within an envelope of income, and the commissioner to plan for, and pay for, the needs of their population.

- PCT business planning focuses its energy on activity and financial consequences, and its business interface with the provider(s) continues throughout the year
- New services (particularly in the community) used to only develop based on affordability, but with money following patients there's more investment in new pathways in the community as alternatives to hospital
- Hospital clinicians are much more aware that every activity uses resources, and can make more efficient use of resources often with either no effect or with improvements in patient care (e.g. shorter Length of Stay may mean that the quality of service is better – no MRSA or other complications - this has to be understood in conjunction with readmission rates). Clinicians are also interested to benchmark both their practice and their outcomes against national and peer averages, and to accept and use change improvement tools
- Hospital clinicians take more interest in recording each diagnosis and each activity – ensuring both their own income and accurate patient records. This has reduced the number of times diagnostic tests are duplicated (e.g. where the GP diagnosed on the basis of tests but the hospital has to re-test because it has no record of the results)
- There is less of a feeling of corporateness, and more of a focus on individual team performance, with real feelings of concern. The hospital may focus on survival – community care for the patient could impact on the income the hospital needs.
- PbR mechanism and the code of conduct are open to interpretation

Both communities, and many respondents, emphasise that they still passionately care about people of their health community.

The fixed tariff was an area of controversy. Different providers are starting from different cost bases, e.g. anyone with Private Finance Initiative obligations would have less flexibility to change.

Rotherham FT has always been able to provide care cheaply, but for those above the average cost (such as Sheffield) the imposition of a fixed tariff may cause problems.

## **What works well**

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PbR has had impacts on the way commissioners and providers interact, on what is expected from each, on the delivery of healthcare services, and on financial stability. The effects are widespread and varied. The interviews were structured in terms of "what works well", "what works badly", and "what this means", so I've reported in these terms.

With a focus on **information**, the commissioner can now understand better what happens on a patient pathway (Pathways of Care) and the Value for Money from the service. This has redressed the old imbalance between a provider with all of the information and activity, and a commissioner with neither. The target approach is working well, and PbR can directly support the shift from secondary to primary care, justifying any investment. PCTs can negotiate for a **bundle of benefits** including services, accuracy, performance, and change.

**Choice** in particular has helped to reduce waiting times and Length of Stay (LOS), driving efficiency, flexibility, and development of business cases for new services (some examples include Community Matrons, Dynamic Case Managers (Falls, CHD, COPD), Primary Care Centre including Diagnostics, new care pathways, Breathing Space), and has made the Trust more responsive to GP views. **New services** in the past weren't closely monitored for effectiveness; new pressures have improved both

the business cases and the monitoring and evaluation – though tariff unbundling still requires some negotiation.

**Relationships** are now more **robust and professional** though these early implementors went through a dip in relationships on the way. We found that the best role for Chief Executives is to influence not negotiate, i.e. reach agreement avoiding public embarrassment and clinical disaster; negotiation should be left to the negotiating teams. All sides share a vision of health services: e.g. in Rotherham the vision is for “a smaller, efficient, effective local hospital”. The more formal relationship has not led to increased administration (at least not for negotiations – there are more data analysts).

Where a provider can show that they **deliver better patient services**, the provider will benefit from increased activity. This is particularly important where care pathways are being designed to avoid hospital – for Rotherham FT, attracting a higher proportion of patients from a diminishing pool is barely keeping up with the overall attrition rate – Rotherham FT still plans to close 1 ward per year in spite of having increased patient preference to the point where 15-20% of work comes from outside Rotherham.

The advent of **Patient choice** has driven a push for better access times, even before GPs and patients take advantage of this. The **18 weeks** referral to treatment time initiative includes diagnostic waits as a part of the overall patient experience, and makes waiting time available for public scrutiny. But choice goes a lot further: keeping older people out of hospital (or at least away from the risks of hospital acquired infection and institutionalisation) improves their quality of life and end-of-life care/dignity, and at the same time frees up beds - hospital community geriatricians can give care at home. Rotherham day hospital (run by Rotherham FT but funded outside PbR) now offers assessments to the elderly to avoid hospital attendances, and both Sheffield and Rotherham hospitals have active programmes to keep the elderly out of hospitals: some elderly prefer the attention and care of hospital even without clinical need, but regardless of the new commercial slant hospitals continue to provide services that are “right for patients” with cost as a secondary consideration. On the other hand, legacy specialist units in District Generals (e.g. Rotherham FT specialist colorectal surgery service) may no longer be justified.

For the patient “**information therapy**” is now planned into the care pathway, a real step forward in empowering and engaging patients.

**Clarity of relationship/ Clear objectives.** Understanding the process makes it easier to standardise and to get it right, consistently. Organisations, teams and individual clinicians plan clear patient pathways across organisations, agree contract variations and revisions to targets throughout the year (instead of all the contractual negotiations being confined to a few months), and benchmark both targets and outcomes.

PbR is **liberating resources**, so that patients get a better service. Hospitals and other providers have a much clearer view of their income over a number of years, based on the activity they actually expect (both Rotherham and Sheffield hospitals commented that PCTs saved on their budget by under commissioning e.g. for A&E use, and Sheffield Teaching FT stressed that they felt they were being unfairly blamed for the deficit in Sheffield – over performing on an under commissioned budget was not their fault). Foundation trusts collaborate to provide services (at early stage) e.g. with Doncaster ENT, and Oral Surgery, with Barnsley Ophthalmology, and it's having the desired effect:

- Reduced OP and IP waiting time (from 2yrs to 6 mths, but not without problems e.g. referring back to GP because patient clinically doesn't need to be seen),
- numbers of outpatient 1<sup>st</sup> and Follow-up appointments reduced (e.g. 40% diabetics annual assessments have been moved to Primary Care),
- achieving cancer targets.
- Managing demand is now a PCT problem (previously the hospital would have had to deal with extra activity at marginal cost) – according to the hospital this puts incentives in the right place where they can be acted upon
- Hospitals have more incentive and more flexibility to provide care and manage the waiting list

In Sheffield the health community still has to take £20.5mill out of its cost base; but PbR has instilled cost discipline amongst staff, and fortuitously created a pseudo-pricelist for private providers and consultants, so the FT commissions extra and specialist work at PbR prices. Largely the

improvements have been self-funding through reducing outpatient appointment, reducing excess bed days and consultant productivity.

Rotherham has a slightly different situation, with the rebasing exercise giving the Foundation Trust an extra £11mill in 2005/06 and up to £14mill 06/07 (2006/07 the PCT is only part funded for this), and the extra money has allowed Rotherham FT to get ahead on its cost-improvement targets (target 4.5% =£6mill); but the change in the flow of money has affected the providers, internalising debates about the funding for **new developments**, which has strengthened the quality of both business cases and monitoring.

In both cases the implementation of PbR has helped the provider to focus on **Productivity/Efficiency**, using tariff as a yardstick, and has engaged doctors, nurses and all clinicians in service redesign. Consultants and clinical directors thought that they were doing things “for patients”, though in practice this often meant not driving strategy but just vetoing change. Managers and clinicians are more cost-conscious, medical staff are focussed on resource use and activity, PbR has provided an impetus for changes not so much to the formal management structure but to lines of influence, with General Managers reporting that they can plan ahead whereas formerly they were firefighting. As the results develop (reduced LOS, cost improvement, patients still getting quality service, the opportunity to initiate change) more and more people come on board. Initiatives include:

- Interqual – an audit of “how they get through the door” (still resistance because of the commercial and medical risk)
- 4 hour wait target in A&E – the hospital had tried adding consultants with very little effect (it was “the manager’s problem”), but once the consultants themselves started looking for solutions it was solved quickly

Respondents in interviews drew parallels with the USA ‘**production line**’ approach for common elective surgery e.g. hip replacements, planning around three groups of patients:

- 1 Standard pathway for high volume short LOS (<6 dys),
- 2 standard path + modification (one co morbidity 1-2 wk LOS), and
- 3 case management for complex (dementia, poly-pharmacy up to 70 dy LOS)

and systematising pathways which led to greater consistency and levelling up to quality

## ***What works badly***

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Not everything went well. Certainly in the early days each side blamed the other and levels of scrutiny appeared to be obstructive whilst they **learnt to trust** each other. The Code of Conduct for PCTs requires them to sign a contract by a certain date, in contrast with the code for Foundation Trusts which requires them to sign a good contract; with a result that monitoring quality outcomes rarely appears in the contract. But whilst at the start commissioner accused provider of generating activity, and in return were accused of diverting activity with no assessment of the impact on the hospital, now it’s recognised that there are rogue elements in hospitals acting a little over-enthusiastically, and commissioner and provider collaborate more over community services.

However relationships aren’t helped by **poor data dictionary** and difficult to interpret **descriptions** – coders and clinicians request more guidance including examples, and where a definition is introduced mid-way through a year, to be allowed to retrospectively code cases that should have been in that definition. Examples include:

- “possible angina” vs “probable angina” result in an additional £500. the difference is badly defined, and is the difference between an extra admission to ward vs fast response team in A&E
- Poorly defined conditions e.g. Critical Care, Sick Baby, use of a Clinical Decision Unit from A&E (in some Trusts counts as admission which in turn impacts on how quickly Social Services have to act to care for patient = more bed days, in others is not treated as admission or charged for),
- Surveying patients for co-morbidities could result in increased payments even where the co-morbidity is not relevant to the condition or treatment

- The data dictionary doesn't keep up with new services being developed e.g. anti-coagulation services in the community, day case early pregnancy assessments, etc (though it is a sign of PbR's success that people expect the data dictionary should keep up)

PbR **encourages short-term fixes**, solutions for this year that create problems for other parts of the system. Staff and patients get worried that they will lose their services. This leads to a focus on services affected by tariff, which can mean that other services take a back seat when the board considers modernisation priorities, putting government initiatives (e.g. Long-Term Conditions NSF highlighting the need for more rehabilitation services) in conflict. Even transferring patient pathways out of hospital didn't always help – not only was the hospital left with the same fixed costs to apportion amongst less income, but the same doctors who had delivered the service in hospital were now going out to the community, which meant that capacity was if anything less in the hospital to deliver the service.

Services provided in the community as an alternative to hospital, has so far not appeared to reduce demand for hospital, rather to have **generated more demand** in addition. The challenge to hospital viability may reduce outreach, causing hospital doctors to delay discharge in order to manage intermediate or step-down care for their patients. Added to this, the whole basis of tariff price levels is on average pricing, which means that organisations are chasing a falling average, and that **half** of the organisations will be **above the average** for a given procedure and presumably have their viability threatened. This is further compounded by financial constraints: in 2005/06, 36 FTs made provision of £28million for commissioner non-payment; the situation in 2006/07 is worse, with provision of £14million for Q1 alone.

Rotherham is very proud of the fact that they share a **single patient SPEL database**, running reports using the same data. They point out that many other health communities, including some in South Yorkshire, spend more time verifying the data and ensuring that they are all working on the same version than planning better care or affordability. Similarly respondents noted that Sheffield suffered with having a consortium of commissioners – sometimes they appeared to spend more effort negotiating between each other than with the FT. Providers complained at the level of interrogation of the data, particularly where a patient may not know which GP they are currently registered with so the request for payment doesn't reach the right GP or PCT before the cut-off period, can mean that some treatment bills aren't being paid.

The main **risk** to PbR is from the government itself. The commissioner / provider market is not a free market, and any manipulation of tariff may cause out-of-proportion knock-on effects. Two areas highlighted where capacity needs to be maintained regardless of actual activity: A&E and Infectious Diseases, need **standby capacity** in case of a sudden requirement. There will be others; all need an income structure which supports the maintenance of standby capacity. In addition, there are strict rules in place to prevent cross-subsidy, and sometimes in conflict to these rules for the apportioning of overheads and fixed costs. This makes it difficult for existing NHS providers (whether hospital or community) to compete with independent providers.

At least 80% of both problems and successes in PbR are leadership issues. Although we continue to talk about strengthening commissioning, in practice providers benefit.

## ***The Crystal Ball if nothing changes, what will result?***

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The NHS is known for being in a constant state of change. However respondents commented that this time there is just **too much** – a cluster of initiatives such as PbR, choice, tariff are manageable together, but adding Independent Sector Treatment, Agenda for Change and reconfiguration (Creating a Patient-Led NHS) makes it difficult to interpret cause and effect. One described it as a policy jigsaw where we never seem to get the full picture.

## **Redefining Targets & Commissioning for Targets**

In order to ensure that PbR really does what it says, rather than paying for activity, there needs to be a **new definition of results**. This is fraught with difficulties – a health status measure such as SF36, which measures patient quality of life, may be more affected by the friendliness of the staff than the clinical quality of the operation. Clinicians should set the standard of clinical quality, but patients are perhaps less concerned about the latest new treatment than the patient's perception of quality (waits,

parking, food, staff friendliness). Trusts need rules to maintain clinical quality and freedom to react to patient desire.

Where services are being moved from hospital to community, or provided in a different way, a recurring theme was the need for the commissioner to understand the **time lag**. For example, a Breathing Space Centre may only have a marginal impact on hospital attendances in the first year of operation (the same applies to Community Matrons, etc), with much more in a second or subsequent year. Changes in a hospital setting, which are driven by process rather than patient behaviour, can be much more immediate; Rotherham Hospital expects to reduce LOS to the extent that it predicts the closure of 1 ward per year, and to reduce waiting time for Out-Patients to 6 weeks.

The basic principles are correct (pay for activity undertaken within a resource envelope), but it is important that the system doesn't become more complicated.

### An Optimistic View

In Sheffield at least, Secondary Care has been the easy option, the 'cheap' way to deliver care. It is probably appropriate to move some care out of hospital and into the community, and PbR is seen as **fair**, by both hospital clinicians and GPs.

There will be some transitional problems, but PbR gives commissioners and providers an opportunity to build trust, and to engage the expertise of the hospital clinicians in designing alternatives to hospital.

Commissioners will take more **responsibility** for demand management, access to services and the management of chronic conditions, and keep existing providers in the loop with regards to future plans; hospitals will **take action** on the expensive pathways and will take down unwanted services in a **planned and managed** way. Clinicians will take responsibility for all of this and will drive the changes which meet the needs of the patient.

PbR will certainly drive up **data quality** nationally, and ensure data consistency between providers and commissioners. This information can help both sides to look at gaps in service provision and the viability of low-demand services.

The emphasis on internal reporting and devolution of responsibility will drive a culture change – Rotherham hospital observed increased staff loyalty and commitment, and patient choice should also mean patients engaged in and satisfied with their own healthcare.

With the money following the patient, and especially with unbundling, respondents expect to see more flexibility, a more integrated approach across separate organisations, more empowerment of professionals on the front line.

### A Pessimistic View

An alternative view, supported by responses, is that PbR will result in defensive behaviour and **mistrust** between commissioner and provider, and between providers who think they are in competition with each other.

Focus on **short-term targets** and increased workload on the finance and coding departments could lead to short-term horizons, with providers not given time or space to plan for the extra activity needed to meet a new target, and instead of planning ahead to meet the targets sustainably, paying private companies, consultants' overtime and temporary staffing to meet short-term requirements.

PbR technically offers no profit-margin, which means **no margin for error**: this can lead to behaviours that reduce risk to an individual and an organisation, which typically will fragment the system and reduce safety nets. There is a real danger that cost pressures will damage the ability of centres of excellence to develop new standards of care, and will hold back development e.g. active management of stroke, or Thrombolytic therapy which have potential to save much larger costs in the future.

As one respondent put it, PbR could be paving the way for the introduction of much bigger changes, e.g. health insurance run by the private sector.

## ***What are people doing to make the service better?***

That rather pessimistic note sparked off a reaction in the respondents – “how can I make it better?”. During the interviews I was introduced to the book “Redefining Health Care” by Mike Porter<sup>1</sup>, and its key message the Care Value Chain, not as an exemplar of how health should be in UK, but because of the questions it asks.

Action from the interviews points include:

1. Take a population perspective rather than provider perspective – recognise that for many things, both sides want the same outcome
2. Negotiate around whole contract rather than individual points in isolation
3. Improve the finance and information systems so as to show the whole picture – Rotherham’s shared information system ensured that information was consistent between negotiating partners
4. Recognise that relationships are built around people and organisations (rather than framework agreements), invite the other side to internal meetings
5. Make the choice to be reasonable rather than adversarial – give-and-take unless rules are clear cut, especially where GPs support provider (e.g. new roles, audit)
6. Give commissioners the levers to improve patient outcomes/ quality (e.g. payment based on a measure of patient outcome)
7. Understand “consequential actions” and share a vision through “felt responsibility”<sup>2</sup>
8. Providers need to inform front-line clinicians so that they can plan for improvement. General Managers can help consultants understand PbR and introduce change tools
9. Use the skills of hospital staff to target, set up and run community services
10. Have confidence to implement local solutions to local problems – DH should set simple rules with room for local flexibility (the spectrum of response to the current rules ranges from slavish compliance to disregard)

### **In summary**

The NHS plan is good for patients – but in times of change there will be losers as well as winners. PbR brings this into sharp focus – a service which is no longer used will not have an income, whereas a service which is in high demand will have the opportunity to expand. This simple feature has the potential to drive a complete culture change in commissioners and providers – on the one hand potentially leading to defensiveness, short-termism and lack of innovation, and on the other to ownership, co-operation, trust and forward planning.

To get there, Department of Health needs to set a clear direction but maintain a light touch on the rules.

There are a few tweaks needed within the framework of PbR and the systems which support it to make it easier to implement, but DH should resist the temptation to legislate for every possible outcome and trust local communities work together in the interest of their local population and the sustainability of local health services.

Respondents were excited about the opportunities that PbR brings – a mechanism to engage front-line clinicians, both medical and non-medical, making changes that will deliver better effectiveness of healthcare. We recognise that this policy isn’t perfect, and look forward to a mechanism with margin built in so as to capitalise on new ways of working and to transition legacy services at an affordable pace.

<sup>1</sup> *Redefining Health Care* (Mike Porter, Harvard Business School Press 2006)

<sup>2</sup> *Robin Douglas of OPM Consultancy rehearses this concept*

## Recommendations

The original proposal identified four phases to the study:

- Stage 1** will individuals and organisations own up to deliberate behavioural change? (within a defined Local Health Community)
- Stage 2** A) if not, then can we tell whether behavioural change has occurred by looking at the activity data? B) if so then can we determine the scale of the change through interview?
- Stage 3** If this behavioural change were observed on a wider scale, what would be the implications
- Stage 4** are the observed behavioural changes widespread? Compare the LHC selected with the other three in South Yorkshire

This study addressed Stage 1, and got a positive response. However as we began to explore Stage 2 there is no clear picture yet of the scale of the problem, nor may there ever be.

The key options at this stage are therefore:

- ⇒ assume that we have identified enough to report these findings as conclusive, and that further research may turn up more examples but not substantially change the direction of the findings
- ⇒ research South Yorkshire and possibly the rest of the country so as to return a definitive report on the impact of PbR

On balance, I feel that further research will not substantially change the direction of my findings and the study to date has highlighted important issues for national consideration.

Therefore I recommend no further studies extending this one but circulation of this report and review of the cluster of policies which cause these emergent behaviours.

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