HPP 04

CIPFA

RESPONSE

OPTIONS FOR THE FUTURE OF PAYMENT BY RESULTS 2008/9 TO 2010/11

DEPARTMENT OF HEALTH CONSULTATION PAPER

June 2007

AT THE HEART OF PUBLIC SERVICES

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CIPFA is pleased to present its comments to the Department of Health on the Options for the Future of Payment by Results 2008/09 to 2010/11

Options for the Future of Payment by Results: 2008/09 to 2010/11

CIPFA Health Panel Consultation Response

Respondent Details (Please provide the details of a single point of co-ordination for your response)

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Organisations represented within this response	**CIPFA Health Panel**

Date of response:
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but we cannot give an assurance that confidentiality can be maintained. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

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Chapter 2 – Strengthening the building blocks of PbR

Qu. 2.1 – page 29

Classifications
Do you agree with the strategy outlined for the development of classifications to support PbR?

Strongly agree	Agree	Neither agree/Disagree	Strongly disagree	nor disagree
☐	x	☐	☐	☐

Comments:

The strategy outlined is reasonable, we believe that very early on an approach should be developed to managing significant financial implications that may arise from developing the scheme

Continual road testing and impact analysis on commissioners and providers with subsequent development of strategies to minimise material impacts is important.

Sufficient planning and lead time for successful implementation of whole scale changes to current classifications is key

We believe there should also be continual monitoring of the impact of the extension of PBR in connection with other DH policies, the modernisation agenda around patient choice, plurality of providers and implications on breakeven duties to ensure consistent achievement of overall objectives..

Qu. 2.2 – page 29
Frequency of classification updates
What is a reasonable frequency for implementing updates to the classification from 2008/09 onwards; a) annual; or b) biennial?

Comments: b) biennial updates.

This would allow for improved forward planning (provided genuine errors identified in tariff can be corrected more frequently).

See also comments in 2.1 above

Qu. 2.3 – page 32
Currencies
What steps should we take to ensure successful implementation of HRG4 in 2009/10?

Comments:

Clarity around responsibilities, individual steps and timetable for the planning process is essential.

Targets and performance measurement against them should be clear.

It is assumed (given the issues around the tariff timetable & submission of reference costs) that the June 2007 submission will be used to calculated the 09/10 national tariff? This is the first year of submission using HRG4 and there will be many issues with the data submitted due to this (together with the fact that many organisations do not have a full year of OPCS4.3 data on which to base the submission). The unit cost information arising form the June 2007 submission should therefore be used with the tariff calculation with extreme caution.

Qu. 2.4 – page 34
Costing
Do you agree with our approach to implementing patient level costing?

☐	☒	☐	☐	☐
Strongly agree	Agree	Neither agree/Disagree	Strongly disagree	nor disagree

Comments:The panel agrees with the *principles* of implementing patient level costing rather than the approach defined within the consultation.

It is not clear in the consultation whether a sample of trusts or a complete review is intended.

There is concern about IT and back office costs, and clinical time required during the implementation and continued validation process.

The production of guidance (through the clinical costing standards group) will help. Organisations who are struggling with the investment decision need to be persuaded by early implementers of patient level costing and not the suppliers.

It is not clear if there is a requirement for guidance under the Patient Costing initiative to ensure that consistent approaches are taken?

Qu. 2.5 – page 35
Timeliness of data flows
How realistic is it to deliver the proposed improvement in timeliness of data flows from 2008/09 and what issues need to be considered?

Comments:
Reporting timescales can be shortened depending upon how much estimation and assumption is acceptable.

Shortening from 30 days requires investment in both systems and skills. Connecting for Health must deliver to achieve this target
.
National deadlines for 'final payment adjustment' need to allow time prior to this for commissioners to raise queries (within a set period) and providers to respond to queries raised (again within a set period) – national deadlines established for this would help the overall timeliness of data flows.

It may be better to aspire to the changes around freeze points and develop as best practice in the light of actual experience

Chapter 3 – Developing the national tariff

Qu. 3.1 – page 37
Calculating the tariff using data from a sample of providers
What particular issues do we need to consider in accrediting providers' data quality and in determining a 'representative' sample?

Comments:

The following issues should be considered prior to accrediting providers' data quality and in determining a 'representative' sample:

- If the organisation holds ISA for data quality
- Involve the professional body of clinical coders
- Clarity as to whether a normative or average cost basis is used
- Assess the extent of use of bottom up/patient level costing
- A clear training strategy to maintain data coding standards.

Any sample of providers should include a number that are classified as specialist

Qu. 3.2 – page 40
Prices that reflect quality and effectiveness
Does the approach outlined provide the right incentives for change that delivers quality care and value for money?

Comments:

This is subjective – there is a need to incentivise change that delivers clearly stated outcomes.

In setting a tariff to drive efficiency there would need to be a standard care pathway attached to allow organisations to benchmark their service (not just their cost)?

It is key that PBR is seen to reward clinical excellence, however a clear framework around criteria for and funding for this initiative needs to be established to avoid developing what could be a divisive mechanism between providers that do and don't qualify.

Experience from the pilots in the North West will be important in concluding whether the approach leads to greater motivation of Providers to meet quality standards or simply increased costs as a result of fees, data quality reviews and additional staff time to make the initiative work.

Qu. 3.3 – page 43
PbR should support commissioning of care pathways
Are there examples of where the tariff acts as a barrier to commissioning care pathways and, if so, what changes to the tariff structure would help overcome these problems (e.g. bundling or unbundling)?

Comments:
The implementation of HRG4 should assist in breaking down components of care within the tariff and more easily allow for elements of the care pathway to be provided by alternative providers.

The inability to review Acute based care alongside community based follow up / rehabilitation is a major barrier to unbundling.

Qu. 3.4 – page 44
Unbundling the tariff

Given the approach outlined, what, if any, are the barriers remaining for unbundling tariffs?

Comments:
Potential barriers for unbundling the tariffs:

- Organisations will resist changes that are unfavourable to their specific circumstances.

- In 08/09 additional 'unbundled' tariffs are proposed. Use of the submitted reference costs in these areas (June 2007) should be treated with extreme caution.

- There is likely to be (in the short term at least) additional administrative effort & cost to ensure the mechanics of unbundling work

Qu. 3.5 – page 47
Applying the tariff to the same service in different settings
Extending the use of HRGs to outpatient and community settings would require coding of activity in the same way as for admitted patient care where a procedure is undertaken. Is this a feasible proposition?

Comments:

This would be very difficult due to the lack of access to systems, specifically within community care. However, it is still important to understand how these costs work for similar activity in other countries.

It is not clear what the implications for coding would be. There is a shortage of coders in the NHS now. The practical ability to facilitate robust coding in primary care would need to be adequately thought through and planned for.

The implications of this policy would lead to the lowest cost delivery mechanism over time and the clinical appropriateness of this would need to be considered

Qu. 3.6 – page 50
Specialised services

What is the best way to refine the approach to funding specialised services in 2008/09 under HRG3.5, and in the future under HRG4, in a way that funds services not institutions?

Comments:
Areas of inconsistency currently exist in service delivery – these need to be minimised prior to any decision on funding for these services. In terms of current funding for specialised services, the use of top ups is not really understood, so to create a tariff for certain HRGs based on those who deliver the highest volume would add a degree of transparency. Beyond 2008/09 the development of HRGs to better identify complex cases would be the most appropriate way forward.

Chapter 4 – Future of tariff setting

Qu. 4.1 – page 56
Governance
Do our new arrangements for tariff setting provide the transparency that stakeholders want in a way that is consistent with the Secretary of State's responsibilities to operate within a fixed cash limit?

Comments:
It may be inappropriate to use an independent body to set tariff at present, given the maturity of system development, the volume of funds now drawn into the mechanism and the need to manage a number of Providers where performance under PBR has not been sufficient to demonstrate potential FT status It would be preferable to set a timetable for further review of this important question that would lead to an eventual transfer increasing the degree of independence and transparency within the process.

Qu. 4.2 – page 57
Multi-year price signalling
Will the proposed arrangements for multi year price signalling (2008/09 – 2010/11) support better service planning, and what additional information would help improve this?

Comments:

The panel fully supports a high level multi-year tariff signalling linked to CSR and also forward notification of changes to tariff recommended by the Clinical Advisory Panel to aid the planning and service delivery processes

Chapter 5 – Extending the scope of payment by results

Qu. 5.1 – page 59
Three generic models of PbR
Do the three proposed models of PbR offer a sound basis for expanding the scope of PbR in the future?

☐	☒	☐	☐	☐
Strongly agree	Agree	Neither agree/Disagree	Strongly disagree	nor disagree

Comments:

The models suggested make more sense than working towards a tariff based solution for All services, as this would not be appropriate or practical for many services.

The approach is a pragmatic way forward. The rationale to defer to a local currency and local price should be understood and agreed between stakeholders as there will be a temptation to simply place all “too difficult services” in this section.

The ability to set a local price within a National Currency due to differing geographical cost pressures should be closely monitored and should not be confused with the Market Forces Factor supplement provided directly to Providers (P59) that is being reviewed by ACRA

Qu. 5.2 – page 62
Criteria for applying PbR to different services
How could the proposed criteria for applying the three models of PbR to different services be improved?

Comments:

There should be an increased focus on developing robust data capture models, in areas where it does not yet exist or is very poor (see comments in 5.1 above)

It may help to produce a listing of those services that the Department might expect to see being commissioned in the three categories in 2008/9 as a standard.

It is recognised that the categories provide for significant diversity of delivery in a local service.

The ability to agree that local tariff and local price is being applied due to diversity of provision and not data quality is important.

Qu. 5.3 – page 62
Priorities for developing national currencies
Based on the proposed criteria, what are the priorities for developing national currencies?

Comments:
Suggestions for prioritisation are:

- All other acute services outside PbR
- Mental health
- Community services

Significant thought should be given to the timetable for developing currencies. It is important that PBR is robust and has sufficient development time however the development of a national tariff three years after the introduction of a new HRG is not responsive or forward looking and should be reviewed.

It is accepted that changes to tariff recommended by the Clinical Advisory Panel is a way to recognise changing and best practice , but these are at the margin only

Qu. 5.4 – page 67
Needs-based funding
Which areas of healthcare could most benefit from a needs-based funding approach?

Comments:

Allocations to primary care commissioners could benefit most from a needs-based funding approach, however, a needs based approach is difficult to fit into a tariff based system. A separate system may be needed to deal with healthcare inequalities.

General

Qu. G.1
Of the issues discussed in this document, which are the three most important and should therefore be prioritised?

Comments:

- Improving data quality (linked with proposals around casemix)

- Improved costing at Patient level to develop a National Tariff against a clear service pathway that can be understood by stakeholders and clinicians

- Focus on improving data capture/quality in areas outside PbR (linked with the 3 suggested generic models of PbR)

The implications of changes to the national tariff need to be road tested and if necessary strategies developed to mitigate financial difficulties that may arise for specific organisations from the changes

Qu.G.2
Do you have any ideas for developing PbR that you would wish to pilot? If so, please express your interest here to allow us to pass on to the relevant SHA or to the FT Network as appropriate.

Comments:

Qu.G.3

If you have any additional comments on any aspect of the consultation document, please list here.

Comments:

We would have liked to have seen the terms of reference of the review of MPET and R&D being undertaken in conjunction with the Association of UK Universities.

In addition unbundling of the tariff that is critical to moving work from Acute Providers to the Community should be cross-referenced in the document to areas that discuss a tariff for a pathway to ensure there are no inconsistencies in approach.

The document rightly reflects the results of audits of Hospital data and coding. This has reflected the need for continuous training in this area and more emphasis in the document on training requirements would be beneficial

It is recognised that the Payment by results initiative is technical and it is important that it does not become so complex as to distance clinicians from working with it that was one of the integral features in developing forward the scheme

Annex B

Qu. B.1

If you have any comments on the extension of PbR to the services outlined in Annex B, please list them below, specifying which services your comments relate to.

Comments:

There are a significant number of services that currently fall outside the remit of Payment by Results. Given the lead in time to develop options to develop the national tariff in these areas one possible approach may be not to request PBR development sites but to ask SHAs in conjunction with their local economy and where appropriate the respective clinical expert committee to develop proposals in one area to a specific timeframe to ensure all areas are developed in a way to develop a coherent national programme with milestones

Economic, social or environmental impacts

Qu. I.1

Would any of our proposals lead to economic, social or environmental impacts on you or your organisation?

Comments:

Equality Impact Assessment

Qu.E.1
Equality Impact Assessment
Please outline any ways in which the PbR policy described in this document may impinge on human rights.

Comments:

Qu.E.2
Equality Impact Assessment
Please outline any way in which the PbR policy described in this document may discriminate or cause inequality relating to groups covered by equality legislation: race, disability, gender, age, sexual orientation and religion and belief.

Comments:

Qu.E.3
Equality Impact Assessment
Please outline any way in which the PbR policy described in this document may protect human rights and promote equality (within race, disability, gender, age, sexual orientation and religion and belief) and prevent inequality.

Comments:

WHERE TO SEND YOUR RESPONSE TO THE CONSULTATION

Completed questionnaires, responses and comments should be sent by 22 June 2007 either by email to:

futureofpbr@dh.gsi.gov.uk

or by post to: Payment by Results, Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE.