17TH ANNUAL CONFERENCE OF THE BRITISH HIV ASSOCIATION (BHIVA)

British HIV Association BHIVA

Dr Simon Barton

Chelsea and Westminster Hospital, London

6-8 April 2011, Bournemouth International Centre

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COMPETING INTEREST OF FINANCIAL VALUE ≥ £1,000:	
Speaker Name	**Statement**
Dr Simon Barton:	Received Honoraria and travel expenses from ViiV, Gilead and BMS in past year
Date	1 April 2011

6-8 April 2011, Bournemouth International Centre

Development of National Tariff and Payment by Results system for HIV outpatients

Dr Simon Barton

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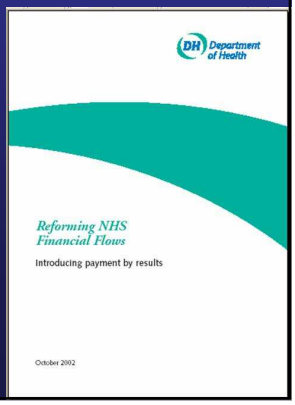
London

UK



Payment by Results

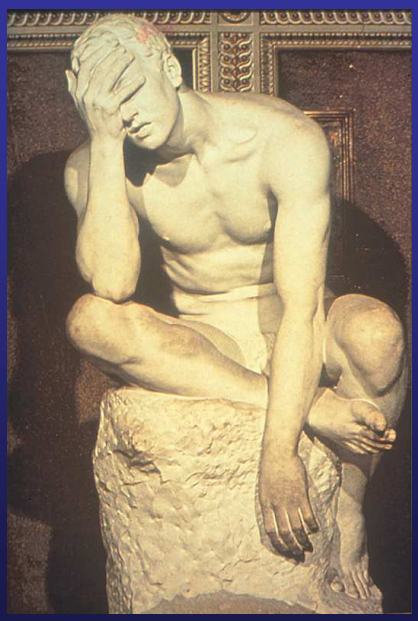
- What is PbR?
- Why is PbR necessary?
- How was it introduced?
- How does PbR work?
- How did PbR work in GUM ?
- How did PbR work in HIV inpatients?
- What does it mean for commissioning HIV outpatients?

PbR = PAYMENT BY RESULTS

- Results !
- Lack of definition of result that would be paid
- Much easier to code a process/pathway/episode
- Part of Tony Blair's 'plan to modernise' the NHS by calculating price for each transaction and then creating a market
- 'PbR is major driver for change in NHS'- Nicholson mission statement 2007

Why is PbR necessary?

- Situation prior to PbR was unsustainable – unregulated market 'free for all'
- International examples – similar systems in most other developed economies
- Support for NHS Reforms – Access (Waiting times), Patient Choice and Plurality of Provision
- Deliver benefits for patients, clinicians and commissioners and providers
  - **Transparency**
  - **Equity**
  - **Efficiency**
  - **Incentives**



The NHS

MAJOR REFORMS : THE PAST DECADE ……

Key Functions		Examples of discrete reforms
Standard-setting and monitoring		National Institute for Health and Clinical Excellence (NICE) National Service Frameworks (NSF) Core and development standards (set by the Department of Health) Clinical Audit
Target-setting		Public Service Agreements, NHS contract
Clinical governance		Legislation
Regulation	Institutional	Healthcare Commission (HCC) Monitor Audit Commission
	Individual	National Clinical Assessment Authority General Medical Council (GMC) Appraisal and Revalidation
Patient/Public engagement		Patient choice of providers Expert Patient Programme Patient and Public Involvement (PPI), LinKS Patient Advice and Liaison Services (PALS)
Payment and Incentives		Payment by Results (PbR) GP Contract Consultants' contract Agenda for Change
Public Reporting		Dr Foster League Tables Star ratings (now superseded by the annual health check)
Commissioning		NICE Commissioning guides, Practice Based Commissioning

And Now for …..

- GP led commissioning
- Abolition of PCTs
- Transition of SHAs
- Formation of Public Health England
- Formation of NHS Commissioning Board
- HIV commissioning by Board/PHE?
- Sexual Health funding to Local Authorities ?
- Except contraception funding to GPs ?
- New Sexual Health Tariff to drive Integration?

How does PbR work?

- National Tariffs derived from actual cost data (annual provider 'Reference Cost' data collection exercise) adjusted for…
- Market Forces Factor (MFF) – unavoidable cost differentials incurred by providers (in terms of excess manpower & estate costs)
- Payment = Activity x Price + MFF
- Additional complexity
  - **Short stay – reduced tariffs**
  - **Long stay – excess bed day tariffs**
  - **Specialist top-ups – service specific uplifts**

Payment by Results (PbR)

THE KEY ELEMENTS

HEALTH RESOURCE GROUPS (HRGs)

- Developed in Australia
- Implemented in the UK (1992)
- Standard Grouping
  - Clinically similar patients
  - Consume similar level of Healthcare
- Used to set a National Tariff (Price/HRG)

NATIONAL TARIFF

- Based on average reference costs
- Separate Tariff (Elective vs Emergency)
- Tariff paid according to actual work
- Trusts compensated through national contracts/local SLA

BASELINE ACTIVITY

- Agreed level of work between PCT and Trust
- Adjustments subject to SLA and risk sharing

FINISHED CONSULTANT EPISODES (FCEs)

- HRG's counted by FCEs

SPELLS

- Providers paid for a "spell" that may include several FCE's

SPECIALIST TOP UPS

- Complex rules/algoritism
- Specific uplifts for certain combination codes

Other Elements…..

Market Force Factors (MFF)

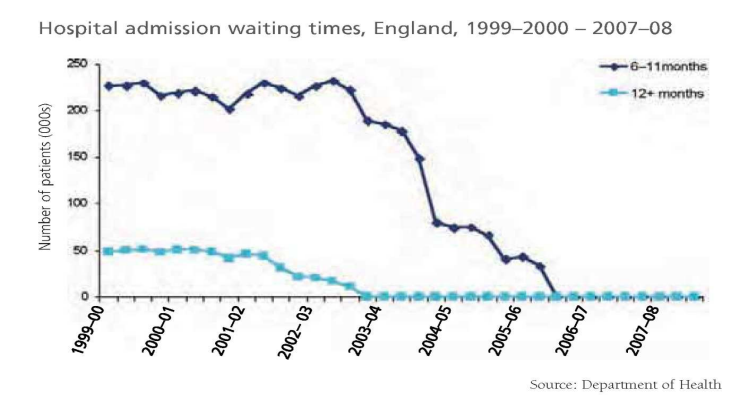
- Protection for providers who currently operate above the National tariff
- Formula for 'step-up' uplift for those currently below tariff
- Providers free to keep any surpluses for investment into service.

What are the checks and balances?

- Who Pays? - Establishing the Responsible Commissioner (from 2005/06 - revised Oct 2007)
- PbR Code of Conduct (since 2005/06 - revised Feb 2008) – sets out expected behaviours of providers & commissioners
- Clinical Coding Assurance (from 2007/08) – Audit Commission's continuing targeted review of providers' clinical coding standards
- New Standard NHS Contract (from 2008/09) – mandates a consistent set of (legally enforceable) commissioning rules applicable to all providers
- 2011 Attempt to implement maximum price ?on hold?

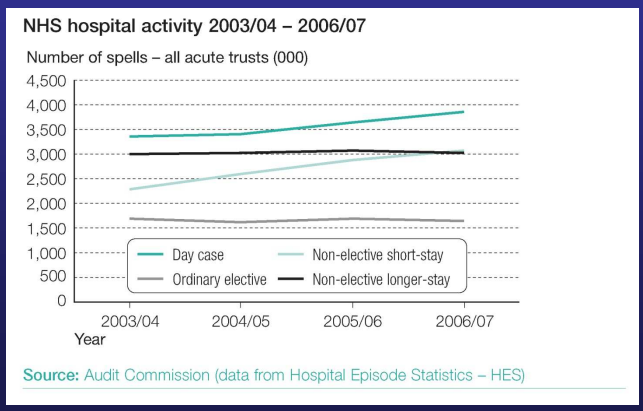
Payment by Results (PbR)

The Combination of PbR and National Targets has markedly decreased Wait Time for Admission to hospital

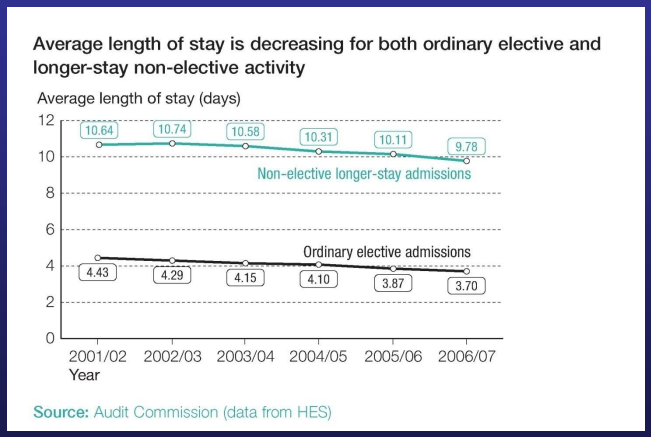


Payment by Results (PbR)

And: Short stay activity has increased



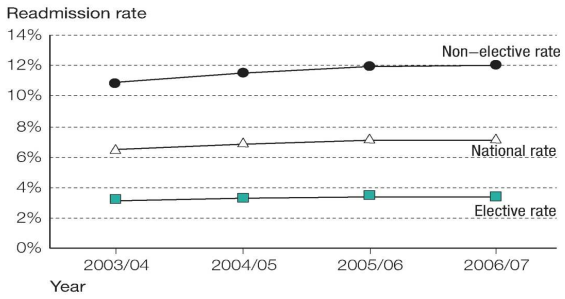
Payment by Results (PbR)



Payment by Results (PbR)

However,

Rates of readmission to hospital are increasing, particularly for emergency patients

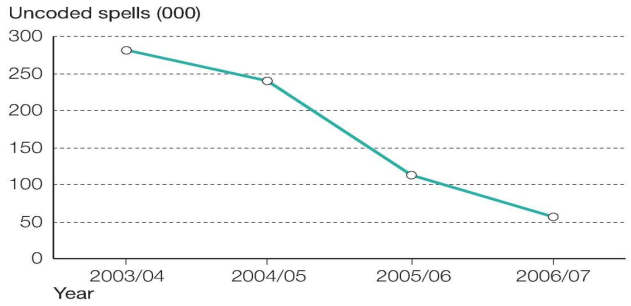


Source: Audit Commission (data from HES)

Payment by Results (PbR)

Data Quality has substantially improved

The number of uncoded spells in NHS trusts is decreasing



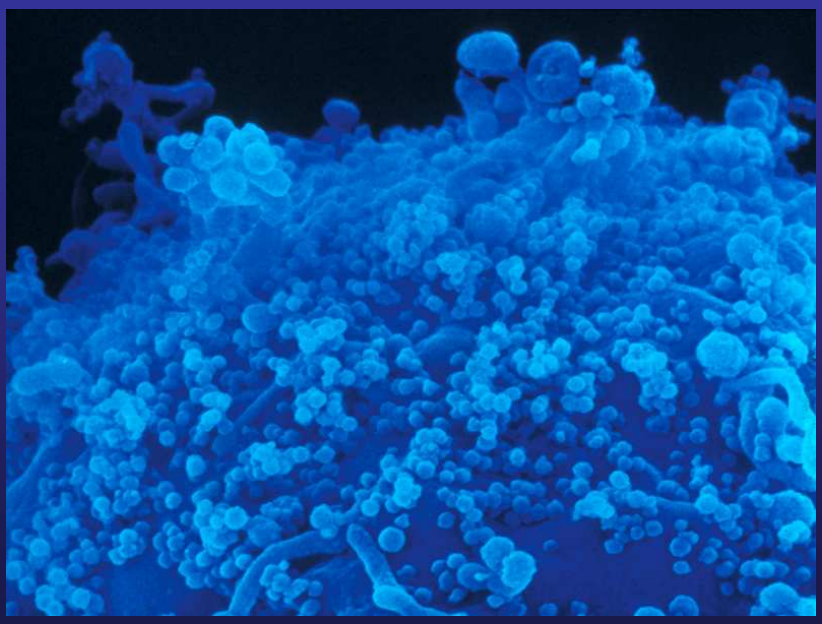
Source: Audit Commission (data from HES)

GUM and PbR

- Implemented in London with support for and from Commissioners
- Variable implementation across NHS initially- dehosting?
- Increased income for GUM clinics
- Linked income to activity
- Increased popularity of GUM with Finance Depts
- Linked to open access and 48 hr target =drove improvement?

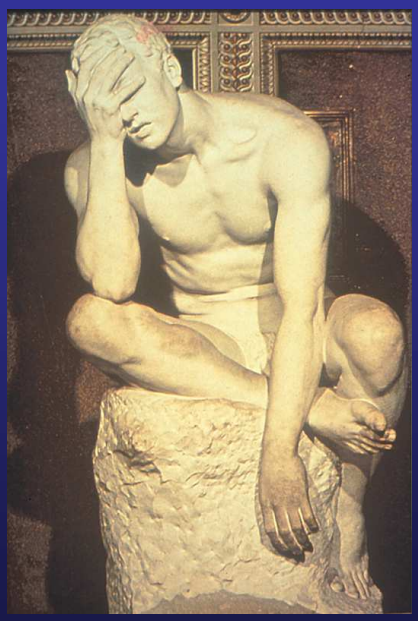
BUT……

- Concerns that Commissioners having to pay for activity they had not agreed to
- Concerns that GUM clinics doing simple tests on asymptomatic patients and making 'profits'
- Concerns that Trusts that invested in expanding services did better
- Concerns that those not on PbR (ie provider PCT GUM) were very disadvantaged
- Concerns that no tariff for FP or integrated SH was preventing developments



Payment by Results and Specialised Commissioning

- PbR does not yet apply to the majority of specialised services, because many are treated by complex care pathways for which trusts negotiate a local price with commissioners based on the content of the package of care.
- Other services include the use of high cost drugs, eg Haemophilia, and charges to commissioners are based on the costs of the drugs used.
- Specialist commissioners are working with clinicians and finance managers to cost complex pathways and produce a tariff for specialised services which is common across providers.
- Services where this work is underway include HIV, Paediatric Intensive Care and Blood and Marrow Transplantation, and is being undertaken in collaboration with the Department of Health and clinicians and commissioners nationally



HIV Outpatient PbR Tariff Development Project

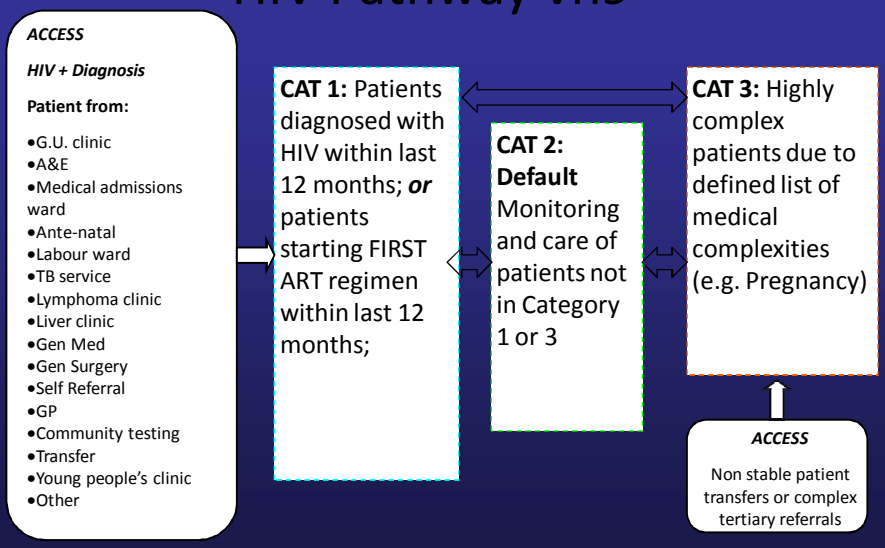
The development of a national payment by results HIV outpatient tariff: capturing patient complexity

The national payment by results reference group, established in 2008, aims to develop and pilot a national tariff for HIV outpatients. Representatives include the Department of Health, HIV clinicians, BHIVA and BASHH, commissioners and the Health Protection Agency.

Service Delivery & Drugs

- The pathway is for service delivery and aiming for "National Currency National Price" for year of HIV outpatient care
- Separate work going on looking at drugs
- Intention is to go down the "National Currency Local Price" approach with suite of benchmarking information to assist contract discussions
- Also intend to support it all (service and drugs) with a national dataset.

HIV Pathway vn9



Data and more data..

- Detailed and fully coded 2009/10 activity data collection covered over 14,000 attendances from 8 different sites
- Sense checking covered over £230m of costs, 27 organisations, 26,093 patients and 149,081 attendances.
- Includes returns from all SHAs and 5 community providers and 1 "designated treatment centre combination"
- Financially neutral for both commissioners and providers for 2010/11 (nationally but will be individual winners and losers locally)

Clinical Data collection exercise

- **Results: R**esults for data collected indicate that
- 14% of patients were categorised as "new",
- 61% as "stable" and
- 26% as "complex".

- The definition of complex patients was broad, ranging from co-infections (e.g. TB), to co-morbidities (some relating to treatment) and a range of psycho-social conditions (e.g. severe depression). Of the patients categorised as "complex", 67% of patients did not fit pre-assigned categories of complexity.

Stakeholder involvement

- Version 10 of the pathway updated to reflect stakeholder feedback and now:
  - New is only for newly diagnosed (in England) or newly started on ART
  - Complex is only for medical reasons
  - Attendances & Tests in line with 2009/10 data collection
  - Overall weighted service delivery tariff per patient year (excl MFF) around £2k

Drugs costs

- Approx 60% of all costs spent on HIV clinical outpatient care are to provide ART (and 10-20% pathology costs)
- Differences in prices across NHS
- Role of VAT/Home delivery
- Role of Tendering
- Changes in guidelines/practice and negotiation

- WHY NOT BUY THEM NATIONALLY ?

Next Steps

- Now: Health Protection Agency engaging with (currently) 6 pilot sites re IT systems and taking dataset going through approval process
- 2011/12: Shadowing for (open to all)
- 2012/13: will be National Currency / Local Price (as confirmed in DH PbR Road Test Guidance)

- ESSENTIAL THAT THE CLINICAL MANAGEMENT COSTED IN THE TARIFF MODEL IS PROVIDED IN EACH SERVICE…

- ……THUS DESIGNATION/ASSESSMENT/CONTRACTING WITH EACH CENTRE/NETWORK BEFORE TARIFF INTRODUCED IS ESSENTIAL PRE - REQUISITE...

Current work and project next Steps

- V10 pathway finalised and currency, Drug reporting and banding proposal
- Hand over in Feb 2011 to National PBR team to implement
- Finalise Commissioning Rules/framework
- Sense Checking with BASHH/BHIVA and Commissioners
- Value for money in paying by PBR for HIV OPD will require clarity and assurance that services are being provided to the standard and outcomes set Nationally ? Who to set? Who to endorse? Who to audit?

BUT and THIS IS A BIG BUT ..

- PbR was not designed for a healthcare system that is 'prioritising front line services' and decreasing management costs ?
- Has at its core the outcome of making some services 'too expensive' and thus unaffordable / taken over or cease ?
- Needs constant revision to drive clinical change not vice versa
- Requires clarity over research/training costs
- Does not rate Quality or Governance

Implications for HIV OPD PbR

- **Service leads will need to be very 'financially aware' of their services and very clear on governance and Service standards**
- **Need National definition set and system of coding HIV care**
- **Accuracy of data collection**
  - **IT systems will need programming**
  - **Output quality will only be as good as input quality**
- **Need to negotiate effectively with Trusts and Commissioners as teams and networks**

WE MUST…

- Ensure principles of care in HIV (and SH) are embedded in tariff development
- Challenge any system that impinges on open access/confidentiality or undermines NHS service provision
- Utilise PbR to encourage innovation to improve patient care and reward best practice whilst fully recognising that not all case mix are identical
- AND ensuring that any new system of funding avoids perverse incentives or ever undermines our Public as well as Individual health care role