

Understanding PbR & Developing Practice Based Commissioning Plans

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Payment By Results - Context

- Devised 2002 to complement NHS reforms
- National tariffs (price list) for acute care
- Supports:
 - Patient Choice
 - Diversity – new entrants to care market
 - Shift from secondary to primary
 - Independence of Foundation Trusts
- Transparency - where does the money go?
- Predictability – helps Commissioners & Providers to forecast their expenditure/income

Implementation

- Scope - growth for 15 HRGs in 2003/04
- Rolled out to cover 48 HRGs 2004/05 (BUT all HRGs in Foundation Trusts areas)
- Plans to cover emergency care outpatients and A&E in 2005/06 withdrawn due to volatility of information/volume
- Covers all HRGs, outpatients and A&E for 2006/07 (despite hiccup on initial tariff calculation)

Basis of National Tariffs

- HRGs
 - Healthcare Resource Groups
 - iso-resource
 - UK equivalent of USA DRGs
 - Clinical chapters – the New Specialties?
 - Recently revised – more sophistication
- Prices
 - Initially set at average cost
 - Expect move to normative pricing
 - Likely to fall over time

Key Variations

- Coding
 - Depth of coding - large disparity between trusts (ranges from 80th to 130th percentile)
- Counting
 - Significant variation in practice between trusts
 - E.G. some care can be classed as : inpatient; day case; outpatient or ward attender depending on trust's local view
- Variation within trusts
 - some specialties high & others low

Information

- Information is the life blood for managing care & resources in the post PbR world
- Trusts gradually coming up to speed
- FTs notably going much faster
- Commissioners not keeping pace
- PbR greatly increases volume of information
- NHS Wide Clearing Service, (and one day soon the Secondary User Service) = Gold Standard source (NB of data NOT information)
- Monitoring spreadsheets from trusts can be helpful but = intelligence NOT facts

Commissioning in a PbR environment

- Volatility – previous system dampened financial variation
- Monitoring, information, forecasts
- Clinical dialogue – no surprises, new tech
- Planning underpinned by sophisticated metrics
- Action on the analysis & intelligence
- Innovation – certainly cannot afford to meet NHS targets by more of same

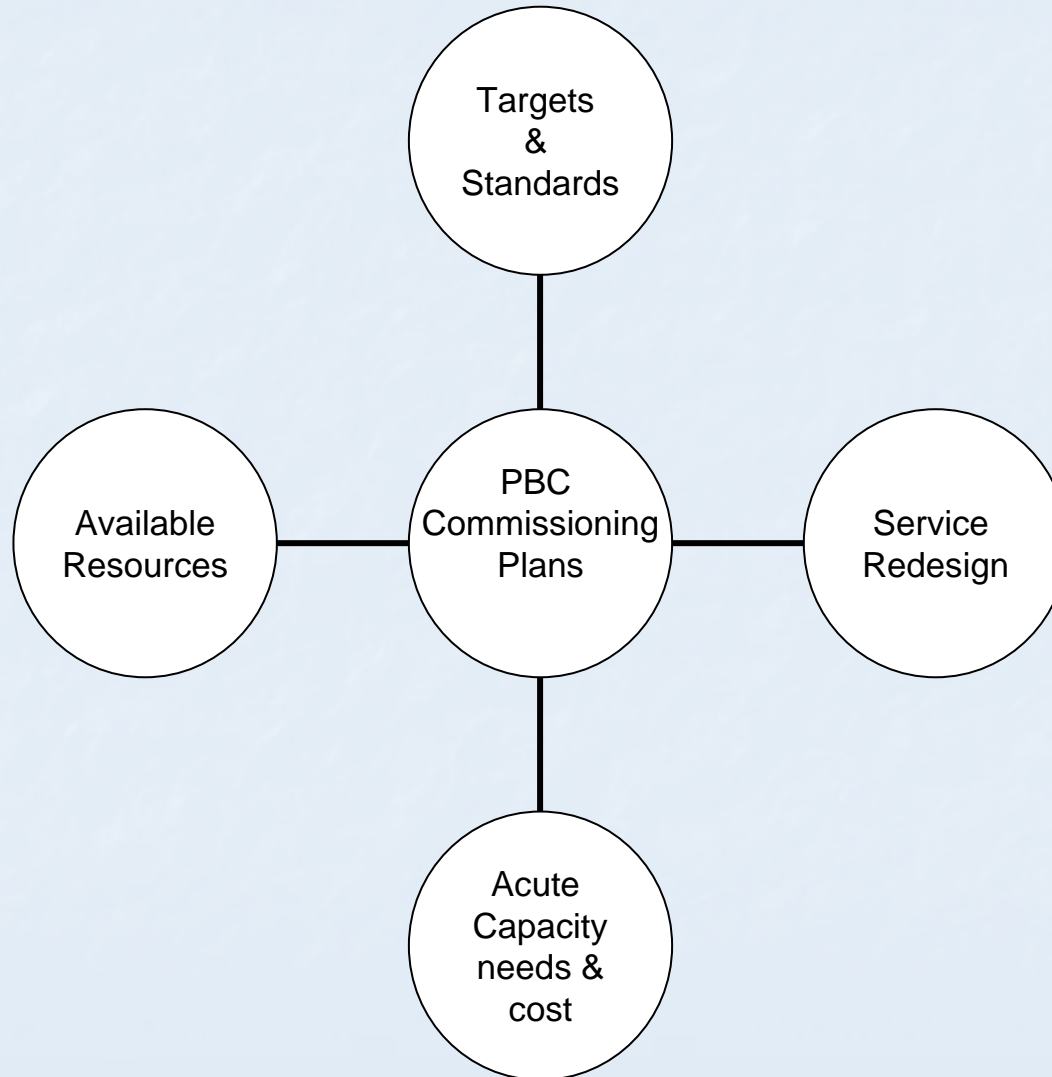
Procurement

- Procurement will become routine rules based processing – real decisions are commissioning:
 - Standard national tariffs
 - Standard national contracts
 - Standard national targets
 - National quality standards
- Decisions on volume & direction of referrals = GPs & patients in partnership
- Decisions on local patterns of care = GPs, Clinicians & public involvement WITHIN available resources

Hot PbR issues

- Normalisation of coding – original assumption of natural convergence is not happening
- Setting tariffs:
 - technical calculation
 - New technologies
 - value judgements on normalisation
- Extending tariffs to cover 2° to 1° care shift
- Managing transition of trusts to tariff (rich are getting richer and the poor...)
- Managing transition of commissioners to tariff + fair shares (Purchaser Parity Adjustment problems)
- Are ISTCs viable/needed with falling tariffs?

Practice Based Commissioning Plans



PBC Plans (1)

- Practices' vision and plans to improve services
- Resolve the balance between needs, resources & new ways of working
- Founded on robust information:
 - Baseline (budget) activity, cost (at tariff)
 - Forecast/trends (if do nothing)
 - New technologies
 - Opportunities to redesign services (realistically costed)
- Meet national targets & standards
- Match Local Delivery Plan (ideally LDPs will become aggregate of PBC plans)

PBC Plans (2)

- Debated with local clinicians
- Involve patients/interest groups
- Deliver better care + better value for money
- Match local strategies about future patterns of care (e.g. major hospital reconfigurations)
- SHA & PCT planners **MUST** involve PBC GPs from the outset in developing strategic projects
- Be agreed with PCTs
- Include clear accountability arrangements

Accountability

- National policy, international health policy & commonsense favour a 2° to 1 ° shift:
 - Convenient access for patients
 - Continuity of care
 - Better value for money
- Duty to improve services through redesign in PBC - change is main purpose of PBC
- Controls are needed because PBC puts GPs in a position where they are making decisions that transfer public money to their businesses
- Controls protect GPs from allegations of abuse of position & the public purse from leakage

Controls

- PBC plans and associated business cases need PCT Board approval BEFORE implementation
- Plans & Cases should be rigorously assessed for value for money
- One benchmark is tariff (including the probability that it will fall in real terms)
- Peer review of proposed staffing levels & outputs
- Clinical & planning dialogue with Trusts to ensure vacated capacity is not backfilled