



Practice Based Commissioning Payment by Results at a glance

What is Payment by Results (PbR)?

PbR is a funding system for care provided to NHS patients in England which pay hospitals on the basis of the work they do. It does this by paying a nationally set tariff for similar groups of patients (HRGs) based on the national average cost of treating patients in each group.

Payment by Results...

- Creates a fixed-price market for hospital activity; competition will therefore be on quality and access
- Is a disciplined approach which increases transparency in the dialogue between commissioners and providers about the nature and management of demand, the real and opportunity costs of services, and getting the best health return from the available resource.
- PbR is a means to an end. It operates as one of a number of interlocking policies designed to ensure that financial incentives are aligned with and support better health and health reform.
- Is part of a framework allowing the DH to take on a strategic role, leaving the NHS to manage operational issues within that framework.

PbR

Across the world over 20 countries are using or developing prospective payment systems

What does PbR mean for practice based commissioners?

PbR clarifies the cost of choosing secondary care provision, which gives a clear benchmark for service redesign and an incentive for encouraging cheaper alternatives. Practices acting on this incentive will ensure that acute providers are used only for the treatments and services they alone can do, thus making best use of scarce skills and resources.

PbR tariff is the currency used to forecast the capacity and cost of meeting both current and future needs. It is a new tool however and commissioners need to be aware of potential teething problems. Most significant is the fact that coding of treatment (and therefore billing under PbR) is far from standardised nationally, and to some extent open to interpretation.

PbR in 2006/07

More than £22 billion worth of services are being delivered under PbR. This is around 35% of primary care trust (PCT) revenue allocations, or over 60% of acute hospital income.

To compensate, PCTs and Practices need to:

- be aware of the composition and baseline activity of each major hospital provider
- closely monitor variation in Trusts coding
- include coding issues in commissioning dialogue.

New service models – 'unbundling' the tariff

The PbR tariff covers the whole episode of care that practice based commissioners are reviewing, and any plans to remove a section of it need to be carefully costed. The March 07 PbR consultation document, published by the Department of Health, proposes guiding principles for 'unbundling' the tariff to allow money to follow the patient where services such as diagnostics and rehabilitation are commissioned directly from primary care. However, final rules governing this are still to be confirmed and any pathway changes should be planned in collaboration with providers to ensure:

- a shared clinical understanding of the new care pathway
- the financial assumptions of commissioner and provider are aligned
- changes do not overly destabilise the local health economy.

Risk management for PBC Groups and consortia

PbR opens practices to risks as well as opportunities and where groups of practices are working together clear agreement is needed:

- Will risks be pooled or is each meeting their own?
- How will savings be shared?
- What will happen if adverse variations emerge?

Options for the future of Payment by Results 2008/9-2010/11

This consultation document, published by the department of health in March 2007, sets out key objectives, basic principles and piloting arrangements for development of PbR. A summary of proposed developments in the PbR system 2008-2011 is contained in the appendix.

Three key objectives:

- Incentivise better health and healthcare
- Drive innovation, productivity and responsiveness
- Help maintain a clinically sound, transparent and sustainable transactional framework for commissioning NHS Services

Three basic principles:

- PbR must make clinical sense
- Proposal of structured development of PbR through a three yearly cycles aligned with spending review and NHS planning cycles.
- PbR is a national initiative, operated locally.

DH working closely with SHAs to PbR development sites to pilot and evaluate:

- Local currencies for services outside scope of national tariff
- Alternative currencies or funding models for services already covered by tariff.

Conclusion

Payment by Results facilitates practice based commissioning but also has the potential to increase volatility. PCTs and Practices need to work together to manage this without undermining the intended stimulus for change.

Frequently Asked Questions

Q: What is included in the scope of PbR and what is excluded?

A: In 2007/08 PbR covers all admitted patient care, outpatient activity and accident and Emergency activity. There are a number of exclusions from the mandatory tariff which include: community services, walk-in centres, mental health and learning disability services as well as a number of specialist services. Full details for 2007/08 can be found on the DH Payment by Results website (see link below).

Q: When should services moved out of hospitals be paid at tariff rate?

A: Services traditionally provided in hospitals that are re-provided in the community through PBC will only attract tariff rate if the new community-based service exactly reflects the relevant Payment by Results and/or OPCS definitions. Tariff will not apply when a service currently provided by a hospital is offered by a GP or other primary care professional in a primary care setting receiving notional or cost rent reimbursement (or other equivalent benefit)

Q: How can we deal with hospitals which seem to be increasing activity or up coding to increase payments?

A: Robust information is vital to monitoring activity levels with providers. Comparisons with previous years as well as national averages and best practices are a starting point. It is not practicable to verify every referral is coded correctly therefore practices, consortia and PCTs need to smart check – identifying the optimal proportion to check and only follow up with more detailed analysis once an anomaly has been spotted.

Q: How can tariff unbundling be used to support PBC initiatives?

A: The 07/08 tariff includes indicative tariffs for the acute phase of care for a range of in-patient services (fractured neck of femur, stroke, hip replacement and pneumonia) and diagnostic imaging. The updated (April 07) code of conduct for PbR states that “under the arrangements for unbundling of tariff from 07/08 onwards, providers and commissioners will need to engage with each other in adjusting tariffs, particularly where local plans include commissioners seeking to move part of a pathway to an alternative setting.” (paragraph 15.7) This will make implementation of new models of care and pathway redesign easier for practice based commissioners.

Further Information

This guide is intended only to give a high level overview of the issues around practice based commissioning and Payment by Results. Full guidance can be found at the DH website below.

DH Payment by Results site

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en>

Developed with support from N A Wilson Associates

Appendix:

Summary of proposed developments in the PbR system 2008-2011

PbR 2008/9

- National tariff applied to acute, specialist services, and 'like for like' in the community
- Currency will be based on HRG3.5 (as in 2007/8).
- Increase range of indicative tariffs to give commissioners additional flexibility to 'unbundle' payments where particular services are commissioned direct from primary care.
- 2008/9 tariff to be published in September and finalised by December 2007.
- Improvements in PbR for maternity and specialist services.
- Exclusions to tariffs for particular services, drugs and medical devices - funded separately.

PbR 2009/10

- HRG4 will be introduced as the currency for the national tariff
- Better differentiation between routine and complex cases.
- New national currencies for radiotherapy, chemotherapy, renal dialysis, rehabilitation, specialist palliative care

PbR 2010/11

- Continue with HRG4 and any benefits from refinement of currencies during 2007/8.
- 2010/11 tariff will be calculated from 2007/08 data.
- Opportunities for further enhancements to PbR based on outcomes from the work of PbR development sites during 2008/09.

Further information see *Options for the future of Payment by Results 2008-2011*, DH, March 2007