Payment By Results and Financial Flows

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What are Financial Flows?

- The way the money travels round the NHS
- So far the changes only cover acute care (reaching 80% from April 2006)
- Tariffs will be extended to mental health & community services over the next 2 years
- Financial Flows & the need to reform them led to the Payment by Results policy (PbR)
- PbR sets standard national tariffs/prices for most acute care based on national Healthcare Resource Group (HRG) classification & coding

Why did Financial Flows need to change?

CONTEXT:

- NHS acute activity increases were not keeping pace with the growth of resources or meeting waiting targets
- Block contracting gave Trusts a disincentive to increase capacity
- A return to complex local price negotiation would have been inefficient
- Increased devolution in the NHS e.g. Foundation Trusts and Practice Based Commissioning requires a new, transparent financial framework
- Choice & service redesign require money to follow the patient

Note: Payment by Results policy was originally called “Financial Flows” in Jan 2002

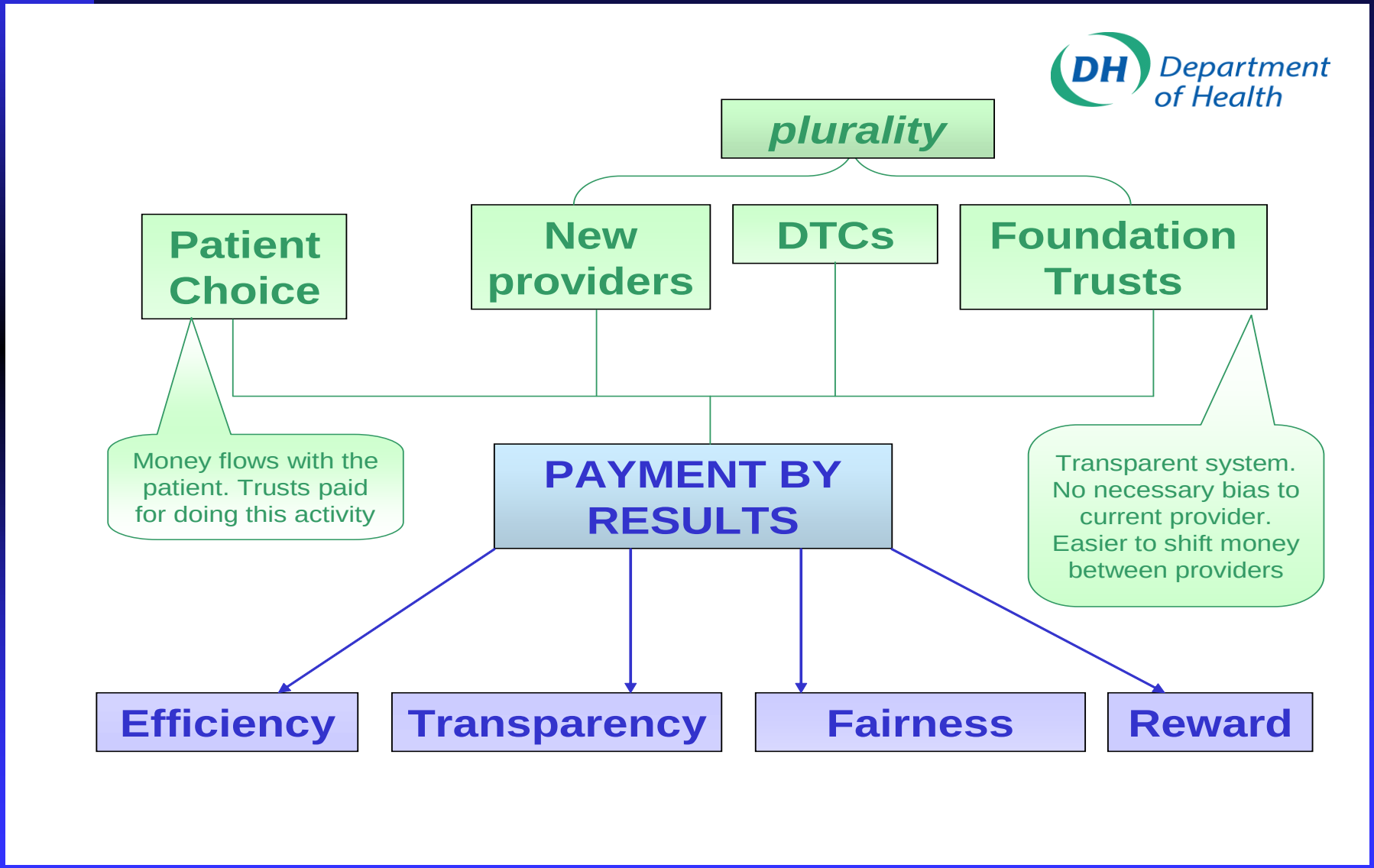
NHS Financial Flows before PbR

- Block contracts - Commissioners funded trusts on basis of history adjusted by negotiated variations reflecting changes in activity
- Placed risks with providers
- Disincentivised investment in extra capacity
- Obstructed shifts of work to new providers

Objectives of Payment by Results

- Integrate finance into the other reforms:
  - Choice, diversity of provision, Practice Based Commissioning
- Create a market where the price is fixed & the competition is on quality & access
- Create a level playing field to attract new providers – private sector, primary, voluntary
- Give providers certainty of remuneration to encourage them to invest in capacity & give Foundation Trusts' private sector lenders confidence in income streams
- Part of a framework allowing the DH to draw back to a strategic role of setting the direction and leave the NHS to manage operational issues within the framework

DH schematic Financial Flows after PbR



Scope of PbR

- Most acute activity in Foundation Trust communities from 2004/05
- Was going to cover all NHS areas in 2005/06 BUT was deferred
- Now covering most acute activity in all areas from 2006/07
- Supports Practice Based Commissioning

Challenges arising from PbR

- Quality of information
- Capability and capacity of commissioners
- National regulation of PbR
- Unexpected steep increase in acute emergency admissions
- Slow pace of service redesign
- Lack of clinical involvement in design & implementation

Quality of information

- Previous internal market & fundholding 1992/93 to 1997/98 greatly improved clinical coding
- Some areas let coding slip back from 1997 as it became less critical financially (providers & commissioners)
- The new HRG coding is much more complex than previous specialty coding
- HRGs had been used for reference cost comparison but PbR adopted HRGs & Spells as a currency

Capability and capacity of commissioners

- Sophisticated finance information & IT capability is needed to manage PbR contracts due to the increased complexity & financial volatility
- Practice Based Commissioning increases the quantity of information geometrically
- Practices need to be able to check/audit cases to ensure they are getting what they pay for
- How can all this be done within an acceptable level of transaction/management cost?

National regulation of PbR

- Price setting is a complex ongoing task requiring clinical input
- Tariffs introduce a new resource equalisation task – moving Trusts toward national tariff prices
- HRGs are a new currency and there are large variations in the depth & quality of coding
- PbR prices have been set on historic activity & expenditure
- Prices will tend to fall because of economies of scale & new technologies
- Tariffs could impede service redesign if “splitting” is not allowed, too much local adjustment will negate the advantages of tariffs

Steep increase in acute emergency admissions

- Is the increase unforeseeable?
  - Out of hours, generous tariffs
- Other countries have set very low tariffs for increases in emergency medical admissions
- Accidentally created a big incentive for practices & PCTs to redesign emergency care to invest in managing cases in a primary/community setting
- PbR assumes PCTs & practices will be incentivised to manage demand.
  - if not, large recurring overspends will result

Slow pace of service redesign

- Service redesign and NHS efficiency improvements have not kept pace with growth monies nor with the underlying expectations of the national Growth + Reform strategy
- PbR gives PCT & practice commissioners incentives to accelerate the pace of change:
  - successful redesign will bring better care & extra resources
  - Failure will increase inappropriate care & result in financial failure

Clinical involvement in PbR

- The original policy had only limited clinical involvement
- Involvement has increased as the policy has evolved
- The rewrite of Healthcare Resource Groups with clinical input gives clinicians the opportunity to homogenise the care that lends itself to tariffs & more tightly define the (highly specialised) care that does not.
- Tariffs will always lag behind cutting edge best practice – how can that be addressed?

PCTs – PbR questions

- Knowledge – has the PCT got the expertise to manage PbR and PBC?
- Can that be shared across a larger catchment?
- How do you secure the necessary skills, avoid a key person situation and train successors?
- PbR, cost volume contracting, PBC and plurality of provision greatly increase data volumes – how do you ensure accuracy and deliver meaningful reports to decision makers?
- Risk matrix – what are they, how likely to occur, who will do what to control, who pays?

Practices – PbR questions

How does PbR affect service changes we want to make under PBC? (1)

- PbR determines the cost of the area of acute care you are reviewing
- Tariffs cover whole episode of acute care – if you only want to take on part of that care then you may not save anything
- Special rules for tariff splitting – it is expected to be a rare occurrence
- Changes should be planned in collaboration with providers to
  - ensure a shared clinical understanding of the new care pathway
  - ensure the financial assumptions of commissioner & provider align

Practices – PbR Questions

How does PbR affect service changes we want to make under PBC? (2)

- Patient choice is not restricted by plans, contracts or estimates of referral volumes – money follows the patient
- Capacity Plans – practices & PCTs develop PbR costed capacity plans to shape Local Delivery Plans, ensure waiting targets can be met & inform providers of likely capacity needs.
- Referrals above the capacity plan/contracted activity levels have to be paid for at PbR rates (subject to damping factor for emergencies)
- Practices need to exercise caution reinvesting savings – PbR charge for activity can change (coding) up to 3 months after discharge

Practices - PbR issues

- Managing large quantities of information requires good IT, intelligent summarisation & investigation /resolution of variances by shared services or PCT staff
- Shared PBC across practices needs very clear agreements:
  - are you pooling risks or each meeting own?
  - how will you share savings?
  - what will you do if adverse variations emerge?
- How will you check PbR charges? (who and when)

PbR Opportunities

- PbR clarifies the cost of choosing an acute solution – that gives a clear benchmark for service redesign options to beat
- Practices acting on that incentive will only use acute care for things that ONLY acute hospitals can do thus making best use of scarce skills
- PbR assists in modelling/forecasting the capacity & cost of meeting needs & trends

Conclusion

- Benefits outweigh the risks
- “new commissioners” cannot afford NOT to make a substantial investment in information, finance & Information Technology at PCTs & PBC practices
- PCTs must involve clinicians in commissioning & in the implications of PbR – the main issues, trends, opportunities & risks MUST be summarised to avoid being overcome by detail
- New NHS financial management equation is:

Growth + PbR + no redesign + no PBC = bankruptcy