hfma GP FINANCE
BRIEFING
Contributing to the debate on NHS finance
May 2011

Payment by results for GP consortia

A straightforward guide to the NHS payment mechanism

Foreword

The Healthcare Financial Management Association (HFMA) is the representative body for NHS finance professionals. With a 60-year history, it has a long track record in issuing authoritative guidance, delivering training and helping to spread best practice in financial management.

Good financial management is the responsibility of all staff and fundamental to delivering high-quality healthcare. The need to have a sound underlying approach to finance, financial management and governance will be increasingly important as the new structure for the NHS – as set out in the government's Health and Social Care Bill 2011 – is introduced at a time of financial constraint throughout the public sector.

This briefing (which follows on from the one we issued in March 2011) is designed to help GP practices prepare for the challenges ahead.

The first briefing provided an overview to financial flows in the NHS and the way in which accountability is embedded in its structure now and in the future, while the second focused on budgeting and budgetary control. This briefing builds on this knowledge by looking at the payment mechanism that currently covers the majority of acute healthcare services in England – payment by results.

As statutory bodies, consortia will assume significant responsibilities in terms of governance and accountability for taxpayers' money. They will assume responsibility for agreeing what care the patients registered with their constituent practices need, negotiating contracts with healthcare providers and monitoring their implementation. About a third of this contracted activity will be paid for under payment by results.

The HFMA is active at national and local level in raising the awareness of how NHS finance works, influencing policy development and raising the skill base of those involved in financial management.

We support NHS organisations and individuals in improving financial management through periods of challenge and change and plan to release further bulletins over the coming months as the transition to the new NHS gathers speed.

We trust that you will find this bulletin helpful and would be delighted to hear your feedback. We would also welcome any suggestions you may have for ways in which we might support your practice and the development of GP consortia.

Andy Hardy, chair of the HFMA's Payment by Results Special Interest Group

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Overview

Under the government's proposals, GP consortia will take responsibility for agreeing what care patients registered with their practices need, negotiating contracts with healthcare providers and monitoring implementation. About a third of this contracted patient activity will be paid for under payment by results (PBR), the payment mechanism that covers the majority of acute hospital services in England.

Under PBR, commissioners pay providers (NHS trusts, foundation trusts and independents) a national tariff or price for each patient seen or treated. The price takes account of the complexity of the patient's healthcare needs. PBR currently covers acute healthcare, with tariffs for admitted patient care, outpatient attendances, accident and emergency, and some outpatient procedures.

PBR is based on the use of a national tariff that links a preset price to a defined measure of output or patient activity. Its key aim has been to enable discussion between commissioners and providers to focus on volume, quality and innovation.

A good understanding of PBR will be important for GPs as consortia become involved in contracts to buy services for their patients. To underpin their role as commissioners of healthcare services, they will need to understand how much each consortium pays for services, why the price is what it is, which services are covered by PBR and which are not. This briefing therfore looks at:

- What is payment by results?
- Why is it important for GP consortia?
- The currency for PBR (what commissioners actually pay for) and how prices are set
- How payment by results works
- The implications for GPs
- PBR in the future.

What is payment by results?

PBR is a system of financial flows introduced in 2003 to 'reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions.' This single national price list for healthcare services is developed by the Department of Health and applies to all providers of NHS care. Its objectives, as set out in the *Code of conduct,* are to:

- Improve efficiency and value for money through enhanced service quality, as both commissioners and providers can retain and invest surpluses and savings to improve services
- Facilitate choice, by enabling funds to go to the services and providers chosen by patients
- Facilitate plurality and increase contestability, enabling funds to go to any provider (NHS or independent sector) that can treat patients to NHS standards, and enabling providers to compete on an equal basis to provide services
- Enable service innovation and improve quality, by rewarding providers whose services attract patients and focusing negotiations between providers and commissioners on quality and innovation, because the price is fixed
- Drive the introduction of new models of care closer to where people live and work, by enabling funds to go to providers offering care in non-traditional and community-based settings
- Help reduce waiting times by rewarding providers for the volume of work done
- Make the system fairer and more transparent, using consistent fixed price payments to providers based on volume and complexity of activity
- Get the price 'right' for services, by paying a price that ensures value for money for the taxpayer and incentivises the provision of innovative, high-quality patient care.

The underlying principle is that the money flows with the patient, supporting patient choice. To find out more about the *Code of conduct*, see the box below.

TARIFF PAYMENT

Under PBR, payments made to providers of care for NHS patients are linked to the activity and services provided. Each time a patient is treated, the organisation giving the treatment receives the relevant tariff payment – the price for that procedure in that year's table of fixed charges.

CODE OF CONDUCT

The *Payment by results code of conduct* is a practical guide issued by the Department of Health on how PBR should work. It is aimed at all commissioners and providers and outlines '...the principles that should govern organisational behaviour under PBR and set(s) expectations as to how the system should operate'. It aims to:

- **Establish core principles, with ground rules for organisational behaviour**
- **Minimise disputes, as well as guide the resolution of them.**

A new version of the code is published for each financial year and the 2011/12 code is available on the Department's website.

CONTENTS

Why was PBR introduced?

Block contracts
Before PBR was introduced, most primary care trusts (PCTs) had simple 'block contracts' with the hospitals their patients used – effectively a fixed amount of money for the year ahead. Many of these contracts were not based on patient activity, work done and/or achievement of plans – the hospital effectively received an amount of funding irrespective of the number of patients treated or the type of treatment provided.

Many of the risks in the system were carried by providers. Rising activity levels would increase provider costs, without any extra income. Meanwhile, commissioners faced no additional financial costs if increasing numbers of patients were referred to hospital, but could not be reimbursed if fewer patients were treated. Block contracts were generally based on historical patterns of care and reflected local costs of providing care.

As agreements were set at local prices negotiated between commissioners and providers, a commissioner's real purchasing power was affected by the relative costs – or efficiency – of the providers with whom they placed contracts.

PBR was a key tool in the delivery of the NHS reform agenda as set out in the Labour government's 2000 NHS Plan

Tool for reform
PBR was therefore a key tool in the delivery of the NHS reform agenda as set out in the Labour government's 2000 NHS Plan. The 2002 budget settlement announced a large and sustained increase in NHS funding, guaranteed for a five-year period. The government at the time wanted to be sure these resources would be used to develop and deliver more and better services. To achieve this, there needed to be a financial system in place that contained the right balance of reward, incentive and equity – hence the introduction of PBR.

As well as paying providers of services for the actual number of procedures they carry out at the preset tariff rate, PBR also rewards efficiency.

For example, if the cost to a provider of delivering a particular service is higher than the tariff paid, the provider needs to make savings as it is making a loss for every patient treated. If the provider's costs are lower than the tariff paid, it makes a surplus that can be retained and reinvested in the organisation in new buildings or patient facilities.

How PBR has developed

As we have seen, PBR constituted a fundamental change to the way money moved around the NHS. To allow time for organisations to prepare and manage the move to the new system, a five-year programme was set for its introduction (from 2003 to 2008).

The original aim was that by 2008 all commissioning would be within the framework of PBR. However, this objective was not achieved and a number of services still remain outside the scope of PBR – most notably community, mental health and ambulance services. For these services, the price paid still has to be worked out through negotiation between commissioners and providers each year.

Over the years a lot of thought has gone into the development of PBR and three basic principles have emerged:
- PBR must make clinical sense
- NHS organisations require stability and predictability as PBR continues to grow
- Local innovation should be encouraged in pursuit of national objectives.

The possibility of using costs from a sample of providers to set the tariff rather than using national averages, and of expanding the use of normative pricing – that is, setting a tariff price based on a judgement about what efficiencies can be achieved or to encourage the take-up or dropping of particular treatments/activities – has also influenced its development.

Why is PBR important for GP consortia?

We've looked at PBR in theory but how will it affect what GPs do under the new regime?

As consortia assume responsibility for agreeing what care the patients registered with their constituent practices need, they will begin to negotiate contracts with 'any willing or qualified provider'.

Healthcare contracts are agreed to a national timescale established each year by the Department. They set out the level and quality of the services required and their cost.

Consortia contracts will need to follow a standard format, to be developed by the new NHS Commissioning Board. Contracts will be agreed at consortium level with providers and it will then be up to individual practices and GPs to stay within the contracts' terms and to manage activity within the funding available.

It is therefore important for GPs to understand how their decisions tie in with those overall contracts, as well as appreciating when the price will be charged by the provider under nationally set prices and when a price needs to be negotiated.

Where PBR applies and there is no negotiation of price, securing the best quality service possible for the anticipated number of patients within the available resources takes priority. Where prices for healthcare activity must be negotiated between the commissioner and the provider as PBR does not apply, another dynamic is added to discussions. We'll look briefly at establishing local prices later in the briefing.

The government's intention is that GP consortia play a key role in local health economies, working closely with providers across all sectors, local authorities and local HealthWatch, as well as their patients. Identifying, developing and commissioning the best patient pathways and ensuring all parties are appropriately reimbursed for the services provided, while remaining within the available resources, will depend on GPs having a good understanding of the components of the national tariff.

In particular, when deciding what treatment to recommend, GPs will have to pay far more attention to affordability when considering the options available, which will inevitably influence the decisions made.

The tariff will play a major part in understanding the costs of current and planned activity levels. As GP consortia develop strategies to ensure patients are given the appropriate treatment in the right setting, the tariff will help them understand the cost of avoidable referrals and admissions and the opportunities, where appropriate, to develop community-based alternatives to hospital care.

Consortia will be accountable for the money spent and the decisions made – taxpayers' money comes with strings attached and has to be accounted for in an open and transparent way.

A consortium will establish contracts within the resources available to them, but they will be charged by providers for the actual patients treated and the actual treatments provided.

Consortia will need to verify these charges, some of which will be at national tariff rates, some of which will have a locally agreed price.

GP consortia will pay providers for the work done, while ensuring more money isn't spent than is available to them – ensuring they achieve the statutory obligation to remain within the overall revenue resource limit. To find out more about these limits, see the box below.

REVENUE RESOURCE LIMITS

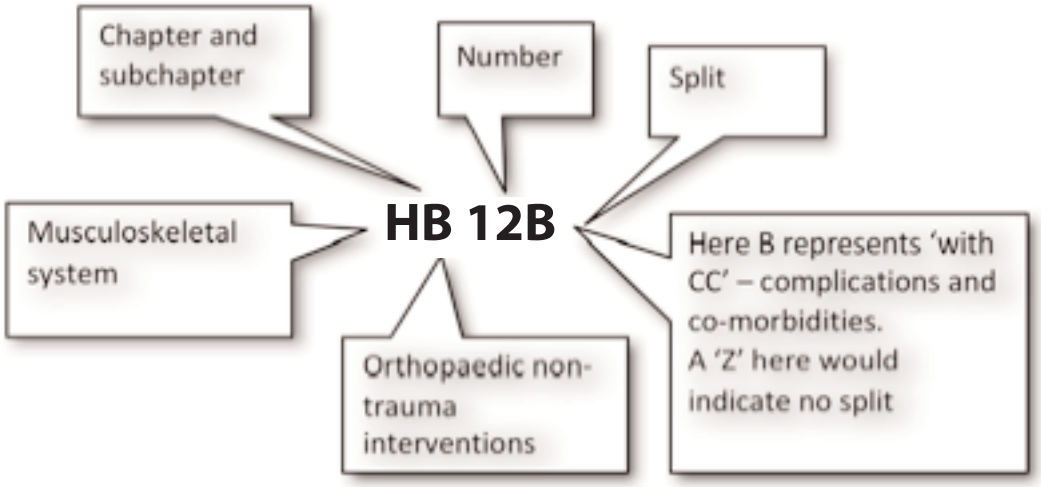
At present, both strategic health authorities (SHAs) and PCTs have revenue resource limits for their expenditure.

This limit is the total funding allocated for revenue (day- to-day) spending and is set by the Department of Health each year. SHAs and PCTs must stay within their resource limits, which are part of the annual statutory performance targets for these bodies.

Revenue resource limits are important in ensuring that the NHS as a whole does not spend more than the money available each year. A similar limit applies to capital expenditure, which covers spending on land, buildings and equipment.

The government's intention as set out in the *Health and Social Care Bill* is that GP consortia will play an important role in managing total NHS resources. The NHS Commissioning Board will have a commissioning resource limit that will only be achieved if all GP consortia keep spending within their allocated commissioning budgets.

MEANING OF AN HRG CODE (EXAMPLE: HIP PROCEDURE)



The basis for the system

Having examined what PBR is and the role it plays, we need to look at the basis for the payment system. Payment by results is based on the use of a prospective, tariff-based system that links a preset price to a defined unit of output activity (or currency). It may sound simple, but for the system to work, two key questions must be answered:

- How is the activity measure defined?
- How is the tariff determined?

What is the activity measure used?

To have a tariff system, you need to decide what it is you are paying for – what is the unit of healthcare? This unit of healthcare is often referred to as the currency. The currency used for admitted patient care (covering a spell of care from admission to discharge) – procedures undertaken in outpatients and accident and emergency attendances – is known as the healthcare resource group (HRG). The currency for outpatient attendances is the attendance itself, split between the first and follow-up attendances and the broad medical area (defined by a treatment function code).

HRGs – which are similar to diagnosis-related groups used in other countries, such as the USA – group services that are clinically similar and require similar resources for treatment and care. We'll find out more about how this actually works in practice later in the briefing.

What does an HRG look like?

We've looked at what the currency is, but it's important to understand what an HRG looks like as it is likely that the commissioning information received by each consortium and its constituent practices will be based on activity by HRG. An HRG is an alphanumeric code describing a unit of healthcare. Each part of the code has a purpose, as you can see from the diagram above.

The name of this HRG is 'major hip procedures for non-trauma category 1 with CC'. The first letter denotes the HRG chapter and relates to a body system – there are 21 chapters in total. The number represents the intervention or diagnosis, while the last letter gives the split for age, complications and co-morbidities – the presence of one or more condition/disorder/disease in addition to a primary disease – or length of stay. So HRGs recognise the type, mix and severity of the treatment provided to each patient.

How is an HRG assigned?

Clinicians do not write HRGs on patient notes. Instead specialist staff, known as clinical coders, assign clinical codes to patients based on the notes made by clinicians when seeing or treating patients. There are codes to represent the diagnosis made for a particular patient (ICD-10) and for any procedures or interventions undertaken (OPCS-4). To find out more about

CLINICAL CODING

For PBR to work as it is designed, it relies on good clinical coding by healthcare providers. Clinical coders translate what has happened to a patient during their time in hospital into codes using the following:

- **OPCS-4 is version 4 of the Office of Population, Censuses and Surveys' classification of surgical operations and Interventions**
- **ICD-10 is the 10th edition of the international statistical classification of diseases and related health problems.**

With about 28,000 of these codes in use, no payment system could operate at this level of detail while being timely and useful to the organisations reliant on the data generated.

Therefore the codes are grouped into 1,400 services that are clinically similar and require similar resources to provide the treatment and care – healthcare resource groups.

these alphanumeric codes and the link to HRGs, see the box on the facing page, below left.

A piece of software known as a grouper then assigns the care given to a particular patient to an HRG based on the combination of clinical codes.

The grouper then re-examines all the codes to produce an overall HRG for the patient spell (the whole time in hospital). This could be the same as one of the episode-based HRGs or could be a separate HRG altogether, as shown in the diagram below. Here, FCE refers to finished consultant episode, which can be defined as a period of care under one consultant during a hospital stay.

For example, proteinuria, painful micturitian and glycosuria would all group to the HRG root *LB37 miscellaneous urinary tract findings* (with a further split for with or without complications or co-morbidities). Polycystic ovarian syndrome, ovarian cysts, pelvic inflammatory disorder would group to *MB04 ovary, fallopian tube or pelvic disorders*.

For organisations providing healthcare, the accurate recording of patient activity is paramount. As the amount they are paid each month depends on the coding of patient activity, it is important that data records are accurate, up to date and that all activity is properly recorded. Clinical coders have a crucial role to play!

How are prices set?

The national set of prices is published annually by the Department and is mainly based on national average costs derived using information provided by NHS organisations, as discussed below.

Reference cost submission

Each summer, all NHS providers must submit details of their patient activity, costed locally, to the Department for all their provided services; this is known as the reference cost submission. Organisations submit costs for all HRGs, split by those undertaken as planned interventions (elective), emergency admissions (non-elective), day cases and procedures undertaken in outpatients.

They also provide costs for a range of other activity, such as outpatient attendances and community nursing services. The costs submitted for elective and non-elective treatments or interventions exclude the costs of inpatient days spent beyond nationally set lengths of stay, known as trim points. The costs of these 'excess bed days' are submitted separately.

The Department then uses these national average costs as the basis for the national tariff. But there is a time delay to enable the tariff to be checked before being put into operation. For example, costs submitted to the Department in July 2011 for the financial year 2010/11 will form the basis of the national tariff for 2013/14.The tariff is recalculated annually in this way based on each year's reference cost submission.

From reference costs to tariff

Several technical adjustments are needed before the national average costs can be turned into tariff prices. But as the tariff is based on historical costs, an adjustment is also needed to reflect the cost of inflation in the NHS. This includes traditional inflationary prices (pay and non-pay) and the costs of using new drugs, technology and techniques – for example, the cost of recommendations by NICE. The inflationary uplift is then offset by an efficiency requirement – the Department in effect sets the level of efficiency providers will have to achieve if they are to meet their financial targets at the new tariff prices.

Because of the three-year lag between reference costs and their use in the national tariff, three years of uplift need to be applied to the relevant reference costs to create tariff prices.

ASSIGNING AN HRG

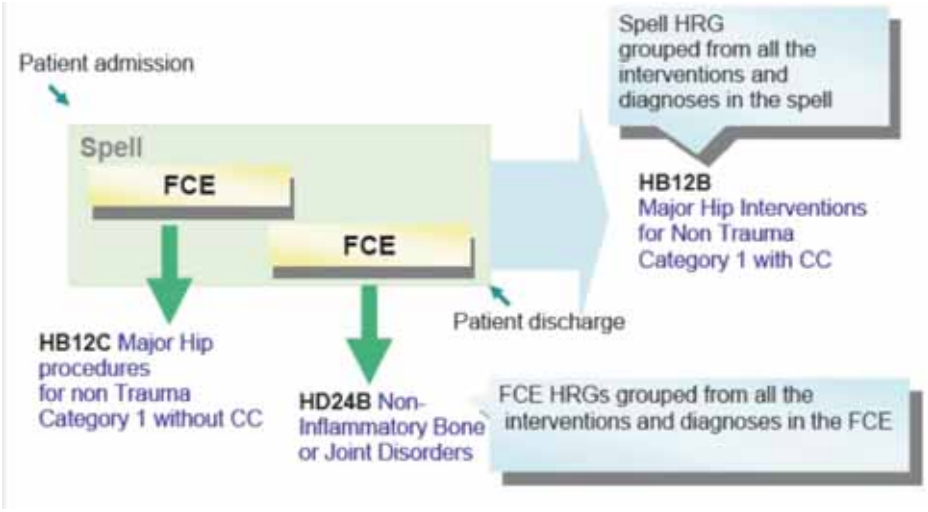


Table 1			
HRG	HRG name	Tariff (£) 2010/11	Tariff (£) 2011/12
CZ01Y	Minor mouth or throat procedures 19 yrs and over without CC	436	476
HA26B	Minor knee procedures category 1 for trauma with CC	1,620	1,253
LA07A	Acute kidney injury with major CC	3,554	5,009

Table 2			
HRG	HRG name	Tariff (£) 2010/11	Tariff (£) 2011/12
HA11C	Major hip procedures category 2 for trauma without CC	9,038	6,292

For 2011/12, inflationary pressures of 2.5% are offset by a 4% efficiency requirement, effectively equating to an overall 1.5% reduction in tariff prices. This means providers may be paid less for treating a patient than they were for carrying out the same procedure in 2010/11 – as you can see in the examples above.

Tariff examples

Table 1 shows some examples of the admitted patient care tariff for 2010/11 and 2011/12. The tariff is based on spells – the time from a patient's entry to discharge – and is used as the basic denominator for PBR as a patient can pass from one consultant to another during a hospital stay (as we saw in the last diagram).

The differences in price between the two years are a result of three key influencing factors:

- The efficiency included within the tariff for 2011/12 through setting the price below the average, as described above
- The adjustment for cost increases, as mentioned above
- The use of a more recent set of reference costs.

It's worth remembering that changes between years can also reflect changes of casemix within a particular HRG, changes in activity levels (meaning fixed costs are spread across a different denominator), improvements in costing practice and changes in clinical practice. It's clear from Table 2 that such other factors do influence the tariff between years so that providers can be paid significantly more or less than they were for the same procedure in the previous year.

The Department may also make a number of 'normative' changes to specific tariffs to correct known problems or to provide an incentive to drive a specific behaviour between commissioners and providers as we'll see later in the briefing.

Emergency versus elective admission

HRGs do not differentiate between patients admitted for planned operations or emergencies, so the same HRG could be paid for at different rates depending on the way in which the patient was admitted to hospital, reflecting the different costs incurred. There are separate tariffs for:

- Admitted patient care (a single tariff for all elective admissions, be they inpatient or day case). This single tariff price is based on the average of day case and ordinary elective costs, as collected in reference costs, weighted according to the proportion of activity in each. This single tariff price incentivises the move to day case settings where appropriate.
- Emergency or non-elective admissions.

It's worth noting that there are a number of day case specific best practice tariffs which will apply in 2011/12 – we'll find out more about both these and best practice tariffs later in the briefing.

Tariffs have also been introduced to reimburse providers where procedures are undertaken in outpatient settings. This tariff would be paid instead of the lower outpatient attendance tariff and ensures there are no financial disincentives to providing care in the best setting for patients.

There are some other adjustments that can be made to the tariff and affect the final payment made. To find out more, see the box left.

ADJUSTMENTS TO TARIFF PRICES

A number of adjustments to tariff prices and additional payments can be made:

- **Marginal rate emergency tariff – A marginal rate of 30% of the tariff price is paid for emergency admissions above a set threshold (see section on influencing behaviour later in the briefing).**
- **Short-stay emergency adjustment – For patients admitted as emergencies who stay in less than two days, the tariff is adjusted depending on the average length of stay for the relevant HRG. It can be as little as 25% of the full tariff.**
- **Long-stay payment – Tariff payments are only intended to cover costs up to a nationally set length of stay for a particular HRG. For patients whose stay exceeds these 'trim points', providers receive excess bed day or long-stay payments.**
- **Specialised service top-up payment – Some HRGs will include both specialised and non-specialised activity. These top-up payments recognise the extra costs of undertaking specialised activity. Top-ups for children's services, neurosciences and spinal surgery are restricted to specialist providers.**

What are market forces and how are they dealt with?

As we've seen, the tariff sets a national price for all activity covered by PBR. As discussed earlier, one of the aims of setting national prices is to encourage less efficient, high-cost providers to improve their efficiency and reduce costs, while also rewarding efficient providers.

However, some providers will face unavoidable cost differences in delivering the same care as a result of where they are located. In particular, they may face higher costs of labour, land and buildings. (Although pay rates are mostly set nationally, labour market conditions in different areas can mean organisations have higher turnover rates or rely more heavily on expensive agency staff.)

To ensure equity across England, a compensating adjustment is made. This adjustment is called the market forces factor or MFF. The most obvious area affected is London and the South East.

The actual price paid to a provider for a spell of care is the tariff price adjusted by a market forces factor to take account of such unavoidable cost differences associated with a particular geographical area.

In 2011/12 the MFFs for different providers ranged from 1.00 to nearly 1.30, meaning the organisation with the highest MFF would receive a nearly 30% top-up to tariff for all its PBR activity to reflect its higher unavoidable costs.

The same MFF is used within the resource allocation mechanism to adjust commissioners' allocations, ensuring PCTs have broadly equal purchasing power irrespective of where they are located.

You can find out more about MFF and how individual providers are affected from the box below.

Some providers will face unavoidable cost differences in delivering the same care as a result of where they are located

MARKET FORCES FACTOR

Under the old system of block contracts, the underlying assumption was that the local prices paid by commissioners would reflect local cost differences. To continue to reflect this disparity when the system changed to PBR, an adjustment needed to be made to the fixed schedule of prices used.

Each organisation has a market forces factor (MFF) value determined by the Department of Health to reflect relative cost differences. The example below illustrates the extent to which this affects different provider organisations for 2011/12:

Barts and the London NHS Trust has an MFF value of 1.227398 whereas Bradford Teaching Hospitals NHS Foundation Trust has an MFF value of 1.033692. Therefore for every £1000 of PBR income, Barts will be paid £1,227 and Bradford £1,034.

Since April 2009 the MFF for PBR activity is included within each PCT's allocation, leaving commissioners to pay the relevant MFF directly to providers with whom they contract. It is not yet clear how this will transfer to GP consortia when PCTs cease to exist but clearly some adjustment will continue to be needed.

SECONDARY USES SYSTEM

The Secondary Uses System (SUS) is part of the National Programme for IT, delivered by NHS Connecting for Health. It is a national data warehouse and provides anonymised patient-based data for purposes other than direct patient care.

These 'secondary uses' include functions such as healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance.

Although its use isn't mandatory at present, reports from SUS allow commissioners and providers to make adjustments to monthly contract values agreed in the NHS standard contract.

PCTs agree monthly contract payments to providers at the start of the financial year and any adjustments can then be made for the actual value of patient activity undertaken based on the monthly SUS report.

Every time a patient receives treatment or diagnosis, it is recorded by the healthcare provider in their electronic patient record

How does payment by results work?

From patient to HRG

We've examined the currency used for healthcare in detail, but it's also important to understand how the currency is assigned to individual patients and how payment reaches the organisation that has provided the service.

Every time a patient receives an intervention, treatment or diagnosis, it is recorded by the healthcare provider in their electronic patient record and can be assigned a classification based on national standards.

Secondary Uses Service

For the purposes of payment, this clinical data is submitted each month to a national data system known as the Secondary Uses Service (SUS, see the box above) which groups the data into HRGs and sets the PBR payments due to and from each organisation.

In order for commissioners and providers to monitor healthcare contracts during the year, and agree payments and variations from what was originally planned, this data needs to be studied in detail and then agreed by the organisations involved.

It is important to note that the data described above covers all patient activity, whether or not it is covered by PBR.

Although local health organisations may share activity data on a regular or quicker basis, all official financial data comes directly from SUS to individual commissioners.

There is an inherent time delay in the process, but the data is accurate and reflects what providers are actually paid by commissioners for the patients they have treated. It is this data that will need to form the basis of financial reporting within consortia, both in terms of individual budgets and monthly board reports.

If you want to know more about how budgeting and budgetary control might work for GP consortia, the HFMA has produced a separate briefing entitled *Budgeting and budgetary control for GP consortia*, which is available on the HFMA's website, www.hfma.org.uk.

Scope and currency development

Scope and GP budgets

Under the plans for the NHS set out in the *Health and Social Care Bill*, the government intends to give GPs direct responsibility for much of the service's budget to commission the majority of NHS services for their patients including:

- Planned hospital care
- Rehabilitative care
- Urgent and emergency services including out-of-hours services
- Maternity services
- Community health services
- Mental health services
- Learning disabilities services.

However, PBR doesn't yet cover all the services for which consortia will be funded. At present the proportion of total NHS spending driven by PBR is about £26bn, just under half of the expected £60bn commissioning budget for consortia. A number of key areas of PCT and future consortia spend are currently outside the scope of PBR, although there are plans to change this.

Currency development

At this point in time, community health, mental health, learning disabilities and ambulance services are outside the PBR system. But steps are being taken to pave the way for the introduction of a tariff to these services. New currencies will increasingly feature in contract discussions involving GP consortia as they move towards assuming full responsibility for commissioning.

To find out about the process for extending PBR to mental health services, see the box below left.

Currencies will be introduced for a number of other services during 2011/12 to increase the coverage of PBR, although prices will still be down to local negotiations between commissioners and providers.

The introduction of a national currency provides a common basis for agreeing contracts alongside local flexibility to fit with the financial situation of individual local health economies. This model of national currency, local price, currently covers:

- Adult and neonatal critical care
- Cystic fibrosis
- Smoking cessation.

An example of how this might work for adult critical care is given in the box below right.

Progress has also been made in relation to the development of a currency for ambulance services. The collection of ambulance service reference cost data based on the outcome of calls made to the service will facilitate the introduction of a national tariff in 2013/14.

It is envisaged the speed with which new currencies are developed – as a route to expanding the scope of PBR – will increase in the coming years. It is likely that, as GP consortia become established, more and more of the activity they commission will fall under PBR.

Establishing local prices

To be able to contract for healthcare services currently outside the scope of PBR, consortia will

EXTENDING PBR TO MENTAL HEALTH

A new currency for adult mental health services was made available for local use in 2010/11. The government is mandating these currencies, based on care clusters, from 2012/13, although prices will still be set locally.

This year (2011/12) is a crucial preparatory year, with mental health organisations required to allocate all service users to a cluster and to agree local prices to be used next year.

Care clusters reflect a patient's needs over a given period of time. The clusters have been developed following clinical guidance and successful pilots across England.

CURRENCY FOR ADULT CRITICAL CARE

A PCT needs to contract for adult critical care services from its local hospital. In order to make the new national currency work, the hospital must count and classify all patients admitted to the critical care unit based on the national minimum dataset requirements. This means it will count adult critical care activity in exactly the same way as all other hospitals with this service in England.

The hospital and PCT need to agree how the PCT will pay for adult critical care services this year. The number of patients has fluctuated over the past few years, so the PCT agrees to pay 80% up front of what they spent on this service with the hospital last year. This means the hospital will have enough money to run the unit for the whole year, irrespective of the number of patients admitted.

The rest of the money will be paid at a price they agree for each patient admitted based on which unit of the new currency applies.

PBR is more than just a funding mechanism. It aims to incentivise the right behaviours and actions and to support policy

need to negotiate the price to be paid with healthcare providers, as described in the example on the previous page for critical care. Any local price will need to take account of the costs incurred by the provider to deliver the service, meaning providers can afford to deliver the agreed level and quality of care.

Drawing on the guidance issued to organisations when agreeing contracts for the financial year 2010/11, local prices must be formally agreed, reviewed annually and established under the *Code of conduct for PBR* – commissioners and providers must apply the same approach to agreeing local prices as is applied to services covered by PBR.

The Department is currently developing guidance on how to establish local prices.

What does PBR aim to achieve?

PBR is more than just a funding mechanism. It aims to incentivise the right behaviours and actions and to support healthcare policy and the strategic aims of the NHS. As policy and objectives develop and change over time, so must PBR.

Focus on quality

The way in which the payment mechanism is being adapted to further healthcare policy can be seen clearly with the introduction of best practice tariffs in 2010/11. Initially, one of the key aims of PBR was to incentivise increased activity as the NHS targeted a reduction in waiting times and lists. But more recently the focus has been on driving quality.

This was reinforced with the introduction of four best practice tariffs from 1 April 2010. Initially they were introduced for two elective and two emergency high volume areas of service, namely:

- Cataracts
- Cholecystectomy (gall bladder removal)
- Fragility hip fracture
- Stroke.

Best practice tariffs aim to bring together quality and efficiency by rewarding high-quality care. Rather than being set at the national average cost of delivering the procedures, tariffs reflect the costs of delivering best practice – for example, by undertaking cholecystectomies as a day case procedure or admitting stroke patients directly to a dedicated stroke unit. Tariffs could in theory be higher or lower than national average costs. For example, if it is best practice to treat a particular condition as a day case, this is likely to cost less than national average costs, based on activity that includes perhaps significant levels of inpatient cases. On the other hand, best practice could involve extra steps in the treatment or the use of more expensive technology or drugs and require a tariff that is higher than national average costs.

The standard tariff – not best practice – is set below the best practice tariff. Consequently, there is a financial incentive for providers to adopt best practice patient pathways and treatments as those providers failing to deliver this best practice will attract a lower payment for the patients they treat.

As this approach is applied across the NHS in England, national improvements in the quality of care in these areas should be seen.

This approach has been extended for 2011/12 with best practice tariffs increased to include:

- Interventional radiology
- Primary hip and knee replacements
- Transient ischaemic attacks (mini-strokes)
- Paediatric diabetes
- Adult renal dialysis.

In addition, tariff prices will support the overall policy of increasing the number of patients treated in a day case setting rather than being admitted to hospital for an inpatient stay. To that end, best practice tariffs for 2011/12 will include 12 day case procedures in five specialties:

- Breast surgery
- General surgery – for the treatment of hernias
- Gynaecology/urology
- Orthopaedic surgery
- Urology.

The annual planning document issued by the Department, the *Operating framework*, makes clear that the expansion of best practice tariffs 'will accelerate in 2012/13 and beyond'.

Influencing behaviour

Increasingly, the tariff is being used to influence the behaviour of those commissioning and providing services and to support the strategic aims of the NHS. There are two clear examples of this in the way PBR has been developed to reduce emergency admissions to hospitals:

Emergency activity

In 2010/11, a change to the way in which

emergency inpatient activity was paid for by commissioners was introduced to:

- Facilitate closer working between PCTs and provider organisations
- Minimise the number of emergency admissions to hospital
- Support the movement of care out of hospitals into the community.

It involves providers of emergency services being paid at full tariff for the number of patients admitted to hospital as an emergency up to the value of the activity recorded for the financial year 2008/09 priced at the tariff for the current year.

Admissions above this baseline are only paid at a marginal or per patient rate of 30% of tariff. So health economies where the emergency admissions consistently exceed the baseline have an incentive to redesign services and manage patient demand for those services. The extra money the PCT would have spent on paying for all the activity at full tariff (70%) is handed over to the strategic health authority to fund changes in the way emergency services are provided. This strategy has continued in 2011/12.

Readmissions to hospital

An early change announced soon after the government came to power was that service providers would no longer receive any further payment for a patient admitted within 30 days of their discharge following a planned or elective admission. In other words, hospitals will be penalised if the patient is readmitted within 30 days if the readmission is related to the original reason for care.

This came into effect from 1 April 2011 and aims to reduce the number of emergency admissions to hospital by up to 25%. So, if the readmission rate was 10% last year, the threshold will be set at 7.5%. A number of patient groups will be excluded from the rule, including maternity, cancer and paediatric patients.

To support the policy, commissioners will not make a payment for patients readmitted to hospital following an emergency admission within 30 days, over and above a locally agreed threshold rate (the number of readmissions as a percentage of total emergency admissions).

Any savings made by commissioners as a result of these changes will need to be disclosed and will be used to support patients following discharge from hospital via a 'post-discharge fund'. An illustration of how this may work is given above. The PCT withholds payment of £500 from Provider A for the emergency admission and commits £500 to the post-discharge fund.

EXAMPLE OF POST-DISCHARGE FUND

Provider	Admission method	Admitted	Discharged	Tariff
A	Elective	20/03/2011	21/03/2011	£500
A	Emergency	30/03/2011	01/04/2011	£500

The 'rule' applies even if the patient is readmitted to a different hospital than the one where they received their original treatment.

What the future holds for PBR

Here to stay

As can be seen from the changes introduced for 2011/12 outlined above, the coalition government plans to retain PBR but with an increased focus on the quality of service delivery and the delivery of outcomes. It has set out four principles underpinning the tariff:

- Incentivising quality and better patient outcomes
- Embedding efficiency within the tariff
- Integration and patient responsiveness
- Expanding the scope of PBR .

As noted above, the government has already committed to an expansion of best practice tariffs, 'so that providers are paid according to the costs of excellent care rather than average price'.

Price flexibility

In its guidance for the operation of PBR in 2011/12, the Department has indicated that in exceptional circumstances, commissioners and providers will be able to agree a price for a treatment or service that is less than the preset national tariff. However, it has insisted that this is not an attempt to introduce price competition into the NHS.

Prior approval for reductions in tariff price will be needed from the relevant SHA and the variation to price cannot affect the quality of service provided, patient choice or competition. It is intended to create an opportunity for 'the provision of services to patients which would not otherwise be possible without some flexibility on price'.

Any such variation will be subject to the rules of the PBR framework and will be closely monitored.

MONITOR

Monitor was created in 2004 to authorise, monitor and regulate foundation trusts. To do this, it has established a 'risk-based compliance framework' that involves scoring each FT's level of financial and governance risk. Monitor assesses risk to ensure compliance with all aspects of an FT's terms of authorisation and intervenes where there is or is likely to be a significant breach of the terms of authorisation.

The government plans to extend Monitor's remit to that of 'economic regulator'. This will involve regulating all providers of NHS care from 2013, promoting competition among providers and setting the tariff prices used by commissioners to pay for the healthcare they purchase. It means a move away from setting prices based on average cost as happens at present.

All healthcare providers will need to be licensed by both Monitor and the Care Quality Commission, and GP consortia should only enter into contracts with licensed providers.

Pathway tariffs

The Department has already committed to the introduction of a tariff to reflect patient pathways. This is likely to apply initially to maternity services where the pathway combines care in both community and secondary settings.

At present, some elements of the pathway are paid for under the old style block contracts while hospital interventions are covered by PBR. Introducing a tariff to cover the whole patient pathway would facilitate the right care to patients in the right setting as cost-effectively as possible.

You can read more about this development in the March edition of the HFMA's monthly publication *Healthcare Finance,* available at www.hfma.org.uk.

Future roles and responsibilities

As far as the mechanics of PBR are concerned the government is proposing that future prices be set by Monitor in its role as economic regulator (see box left). The intention is that it will work with the new NHS Commissioning Board to decide which services should be subject to national tariffs. The development of currencies for pricing and payment will also be a joint responsibility, although the board will have primary responsibility for determining currencies.

Conclusion

PBR as a payment mechanism for the NHS in England is here to stay and will grow in influence, with a wider coverage and more levers to drive behaviours between commissioners and providers. It can be seen as hugely positive for GPs in their new roles as commissioners for their patients: nationally set prices mean the focus for contract negotiation is quality and volume of the services to be provided rather than price paid.
In addition, the cash payments made by GPs to providers of care for patients are linked to the activity and services provided.

But it means GPs will need to be familiar with PBR and its application, its rules, code of conduct and flexibilities, as well as the impact of what is being spent on care in relation to consortia budgets.

To find out more, the HFMA's e-learning module, *Introduction to payment by results,* can be found at www.hfma.org.uk. ■

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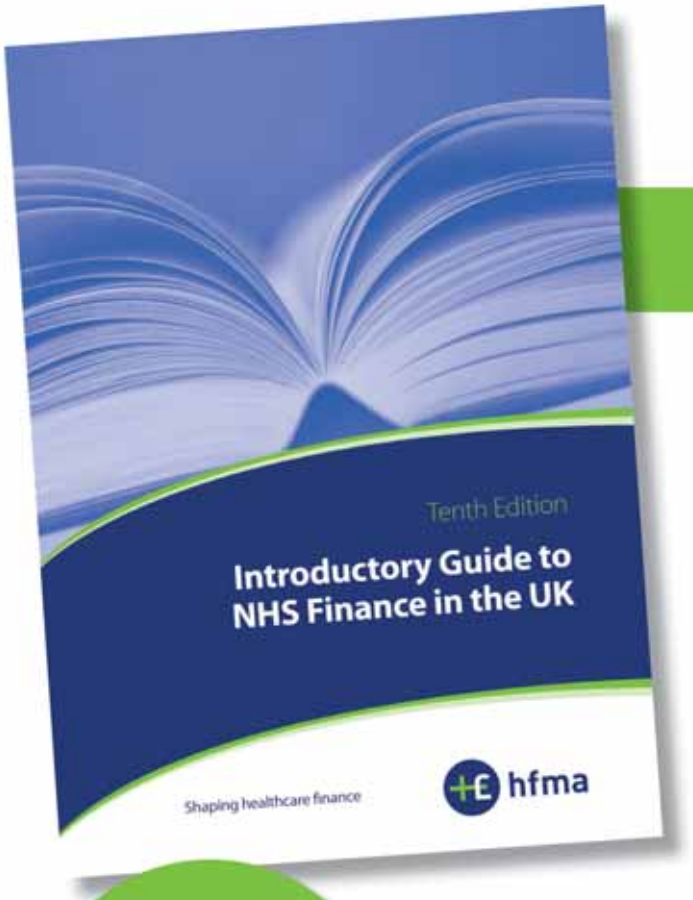

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