PAYMENT BY RESULTS TECHNICAL WORKING GROUP
MINUTES OF MEETING ON WEDNESDAY 28 MARCH 2012
QUARRY HOUSE, LEEDS

Present:
Jonathan Storey (JSt), North East SHA (chair)
Andy Eames (AE), Sheffield PCT
John Shepherd (JSh), Ramsay Health
Julie Speller (JSp), NHS Information Centre
Alex Wilson (AW), NHS Kirklees
Helen Maguire (HM), Royal Brompton & Harefield NHS FT
Richard Oldham (RO), NHS Connecting for Health
Petra Scantlebury (PS), Royal Free and Hampstead NHS Trust
Howard Davis (HD), Audit Commission
Lorraine Battle (LB), York and District Hospitals NHS FT
James Barker (JB), West Midlands HCS
Mark Chidgey (MC), Stockport PCT
Kevin Brett (KB), Gloucestershire PCT
Paul Athey (PA), The Royal Orthopaedic Hospital NHS FT Birmingham

Sarah Butler (SB), PbR
Eileen Robertson (ER), PbR
Simon Tither (ST), PbR
Henry Forster (HF), PbR
Stephen Fenton (SF), PbR
Chris Foster-McBride (CFM), PbR
Lorna Sinclair (LS), PbR
Ian Newton (IN), PbR
Tongtong Qian (TQ), PbR
James Lamb (minutes), PbR

Apologies:
Jane Hazelgrave (JH), Bradford & Airedale PCT
Paula Monteith, NHS Information Centre
Tina Lovelock, NHS Information Centre (SUS)
Nick Molle, Cambridge University Hospital NHS FT
Martin Campbell, PbR

1 Welcome and introductions

1.1 JSt welcomed all to the meeting and received apologies.

2 Minutes of the meeting held on 19 October 2011, and matters arising

2.1 Members agreed the minutes of 19 October 2011 were an accurate record of the meeting.

2.2 Paragraph 4.6 – TWG members had provided feedback on the pre-road test guidance.

2.3 Paragraph 9.2 – Paul Follet had circulated the reference costs data quality presentation.

3 2012-13 PbR Update

3.1 SF explained that the final 2012-13 package had been released on 16 February, and that the guidance had been amended to reflect the feedback received as part of the road test process. The Step by Step Guide to Tariff Calculation had recently been published.

3.2 The PbR team were in the process of pulling together a Q&A document, this was being derived from the queries that the team had received since the publication of the final package. SF asked TWG members if there were any topics that would benefit from being included in the Q&A document. PS asked who should be contacted with queries on CQUIN. SF said that the team was attempting to establish a contact for CQUIN queries but as it was not part of PbR, the team were not in a position to offer guidance on the subject.

3.3 JSp reported that the NHS Information Centre had received a large number of queries relating to the update of ICD10, and they were in contact with the PbR team with a view to the issue being covered in the Q&A.

3.4 SF asked TWG members to pass on any further suggestions for the Q&A, and said that he would share a draft of the document for comment prior to publication. **Action: TWG members and Stephen Fenton**

4 PbR in 2013-14

4.1 ER gave a presentation. The 2013-14 tariff would be developed by the current PbR team before responsibility passes to Monitor and the NHS Commissioning Board for the 2014-15 tariff. Both organisations would be consulted on the development of the 2013-14 tariff to aid the transition of work.

4.2 Given the changes in organisational responsibility, the intention was to retain as much stability with the tariff as possible whilst still delivering further progress with initiatives such as the best practice tariff programme. ER explained that it was planned to further expand the scope of PbR to include currencies for specialist rehabilitation, HIV outpatients and sexual health and there would be transition to a mandatory national tariff for cystic fibrosis. The implementation of PbR for adult mental health would continue and tariffs for chemotherapy delivery and external beam radiotherapy may be mandated.

4.3 There may be a small number of changes to the tariff structure and the PbR team is working with the DH policy team that is leading on the rehabilitation, recovery and reablement (RRR) programme.

4.4 MC felt that as there would be changes to commissioning arrangements in 2013-14 and given the planned changes to the tariff, this could be difficult to manage. SB explained that there is likely to be no change to the structure of mandatory tariffs.

5 Best practice tariffs

5.1 IN gave a presentation and explained the process for developing new Best Practice Tariffs (BPTs). Invitations for new areas were invited from stakeholders in January using a standard form. Twenty-nine areas were nominated, which was fewer than in previous years. These nominations were then considered against the criteria and grouped into categories. When considering new areas for development, the following factors were considered:

- Affordability
- Feasibility
- Administrative burden
- Potential to make links to clinical audits

5.2 IN explained the nomination for avoiding hospital admissions for long term conditions. This aim of this potential BPT area would be to encourage the better management of patients. MC asked if the BPT compliance would be recorded though SUS. IN explained that the BPT would not flow though SUS and is likely to be picked up through accurate clinical coding. TWG members felt that it was too early in the development process for them to give an informed view but were concerned that the timescales may be too tight for organisations to be able to implement in 2013-14.

5.3 IN explained the proposed BPT area for delivering care in appropriate settings would build on what has already been implemented through some existing BPTs that incentivise a shift to less acute settings. JSt felt that it would be useful to have more clinical detail on the areas, and specific HRG information. HD stressed the importance of it being relatively easy to identify when best practice has been met.

5.4 IN told the group that a BPT for less invasive interventions was being explored, with the nomination for this being endometrial ablation.

5.5 IN reported that nominations to improve the quality of interventions had been received. The areas suggested were endoscopy, distal radial fractures and hip and knee replacements. The knee replacement BPT would be designed so that the commissioner would not have to pay for revisions within a given time period.

5.6 IN told the group that BPTs for telemedicine and pre-emptive kidney transplant would be looked at. TWG members were concerned that there could be high capital costs for the set up of telemedicine which may be difficult to establish.

5.7 HD asked if there had been any analysis carried out of the existing BPTs that were designed to encourage day case procedures. ER reported that an evaluation had been carried out on the first tranche of BPTs and the findings will be released shortly.

5.8 JSh felt that there is sometimes confusion over what outcomes BPTs are designed to achieve and that commissioners have been stipulating that six months' notice be given for any counting or coding changes that arise from the introduction of new BPTs and could increase costs to them. The group discussed this at length and felt this may be due to organisations not applying the guidance as it had been intended. SB asked TWG members to email examples of this if they had experience of it, so that the PbR team could consider whether clarification of the PbR Guidance or Code of Conduct was needed. **Action: TWG members**

5.9 IN told the group that the list of new BPT areas for 2013-14 would be finalised in April and more detail would be shared at a future TWG meeting.

5.10 IN explained that the National Clinical Directors had discussed the possibility of linking some BPTs to clinical audits.

5.11 JSp asked if the current BPT areas will be updated for 2013-14. IN said that this was likely, but was unable to give more detail as work had not yet begun. JSp asked TWG members if they were content with the current methodology of using flags in the grouper to identify BPTs. TWG members did not have any concerns with this methodology.

6 Tariff price volatility

6.1 HF gave a presentation, explaining that the issue of price volatility had been raised in the recent report produced by PwC for Monitor evaluation payment mechanisms. HF noted that as part of the sense check and road test of the tariff in previous years, some stakeholders had raised price volatility as a potential concern.

6.2 HF asked if TWG members felt that tariff price volatility was a significant issue which needed to be addressed. TWG members discussed this and concluded that as there are often changes to underpinning HRG structures, it is not always easy to determine the reason behind any price changes or whether these are justified.

6.3 Overall TWG members were not concerned about volatility at HRG level, as they will always look to manage tariff changes at an

organisational level. The general view was that volatility is an inevitable consequence of the current approach to calculating the tariff based on underlying Reference Costs on an annual basis. The advice from TWG was therefore not to systematically try to manage volatility at an individual tariff price level.

7 Specialist rehabilitation currency proposal

7.1 CFM introduced the paper and explained the proposal. The hierarchical model being proposed has been subject to robust development over some time. Costs have been collected at a patient-level, and the UKROC database is well-established. CFM set out plans to move this work to the next stage. This was noted by TWG members.

8 Options for payment of diagnostic imaging in outpatients

8.1 LS presented the paper. Diagnostic imaging has been reimbursed as part of the outpatient tariff since 2010-11. LS explained that there was growing feedback that this is becoming difficult to manage and could be contributing to a reduction in direct access imaging. The reduction in direct access imaging could be due to commissioners not wanting to pay for imaging when this was already being paid for though the outpatient tariff.

8.2 LS explained the two options that were set out in the paper designed to address these concerns:

- Option 1 - Full unbundling of diagnostic imaging. This would be relatively simple to do from a tariff calculation perspective but would have several disadvantages. It would be a large change for the NHS to implement in a short period of time.

- Option 2 – Keep the costs of diagnostic imaging bundled but have clearer rules on the payment of outpatient tariffs following a direct access scan. There was a technical solution proposed by EMPACT for how to identify when a direct access scan was followed by an outpatient attendance.

8.3 The group discussed the proposed options and concluded that there were arguments for unbundling the costs but also arguments for retaining the current arrangements. Representatives from specialist hospitals and from the independent sector were in favour of unbundling, and though that this would be straight forward to implement. Others were concerned that introducing instability at a time when a lot of change will be happening, and were not necessarily convinced that unbundling would have an influence on the use of direct access services.

9 Analysis of outpatient procedure activity

9.1 LS introduced the paper. Since the 2010-11 tariff there have been a number of tariffs for procedure-driven HRGs in outpatients. This number has increased to 79 for the 2012-13 tariff. The plan is to not fundamentally change the approach to setting outpatient procedure tariffs for 2013-14, but it is becoming clear that there are issues in relation to the relative tariffs for some HRGs in outpatients compared to other settings, and compared to the tariffs of other HRGs in outpatients, and the relevant outpatient attendance tariffs.

9.2 To inform options for the 2013-14 tariff an analysis will be carried out comparing reference costs data and SUS data to enable a comparison of procedure-level activity between SUS outpatient data and HES admitted patient care data. There will also be comparison of reference costs data between outpatients and admitted patient care.

9.3 TWG members did not raise any issues with the proposals set out in the paper. LS requested that any issues or suggestions be emailed to her. **Action: TWG members**

10 Spells costs collection

10.1 ST updated the group on the decision to mandate the collection of spell level costs for the 2011-12 reference costs collection. A pilot spell collection had been carried out during the 2010-11 reference costs collection (building on the cost collection in 2009-10). This collection had helped to identify that all organisations should be able to collect costs on this basis and that a tariff could be produced from spell-level costs. TWG members did not raise any issues with the decision to mandate the collection of spell level costs.

11 Cherry picking

11.1 LS explained that some analysis work had been done to investigate a number of HRGs to determine whether some providers are carrying out a less complex subset of activity within those HRGs. This work is at an early stage and more details on this will be brought to a future TWG meeting.

11.2 It was suggested that some independent sector providers may treat a less complex mix of patients, sometimes due to contractual requirements. JSh said that many independent sector providers have a very similar casemix to that of district general hospitals and that he had some analysis to confirm this. ER said that it would be helpful for the PbR team to have sight of this, and JSh agreed to look into the possibility of sharing the data. **Action: John Shepherd and Eileen Robertson**

12 Any other business

12.1 No issues were raised.

Date of next meeting – The next meeting will be held on 13 June 2012.

Action log

Para ref	Action	Owner
3.4	Pass on any topics to be included in the Q&A document Share draft Q&A document for comment	TWG members Stephen Fenton
5.8	Provide examples of where the PbR Guidance or Code of Conduct could be clarified in relation to changes to counting or coding practice	TWG members
9.3	Provide feedback on the options for analysing outpatient activity	TWG members
11.2	Look into sharing the data relating to 'cherry picking' discussion	John Shepherd and Eileen Robertson

TWG attendance grid [1]

Y	Attended[2]	A	Apologies	N	Not a member

First name	Surname	Organisation	30/03/11	08/06/11	19/10/11	28/03/12				
James	Barker	West Midlands Commissioning Business Support Agency	A	Y	Y	Y				
Lorraine	Battle	York and District Hospitals NHS FT	Y	Y	A	Y				
Stephen	Bloomer	Royal Orthopaedic Hospital NHS FT	Y	Y	A	Y				
Kevin	Brett	Gloucestershire PCT	Y	Y	Y	Y				
Mark	Chidgey	Stockport PCT	Y	A	Y	Y				
Howard	Davis	Audit Commission	Y	Y	Y	Y				
Andrew	Eames	Sheffield PCT	Y	Y	Y	Y				
Jane	Hazelgrave	Bradford & Airedale PCT (Chair)	Y	A	Y	A				
Christina	Lovelock	NHS Information Centre	N	A	A	A				
Helen	Maguire	Royal Brompton and Harefield NHS FT	A	A	A	Y				
Nick	Molle	Cambridge University Hospitals NHS FT	A	Y	A	A				
Paula	Monteith	NHS Information Centre	A	Y	Y	Y				
Richard	Oldham	Connecting for Health	Y	Y	A	Y				
Petra	Scantlebury	Royal Free and Hampstead NHS Trust	Y	Y	Y	Y				
John	Shepherd	Ramsay Health	A	A	Y	Y				
Edward	Smith	Cambridge University Hospitals NHS FT	Y	Y	A	A				
Jonathan	Storey	North East SHA	Y	Y	Y	Y				
Alex	Wilson	Kirklees PCT	Y	A	Y	Y				

[1] The table takes account of changes to individuals representing member organisations.
[2] Including sent a deputy.