

**PAYMENT BY RESULTS TECHNICAL WORKING GROUP
MINUTES OF MEETING ON WEDNESDAY 8 JUNE 2011
QUARRY HOUSE, LEEDS**

Present:

Jane Hazelgrave, Bradford & Airedale PCT (Chair) (JH)
Richard Oldham, CfH (RO)
Jill Cockrill, NHS Information Centre (JC)
Siobhan Keable, Cambridge University Hospitals NHS FT (SK)
Verity Hinde, Cambridge University Hospitals NHS FT (VH)
Wendy Allott, Leeds Teaching Hospitals NHS Trust (WA)
Lorraine Battle, York & District Hospitals NHS FT (LB)
Petra Scantlebury, Royal Free and Hampstead NHS Trust (PS)
Kevin Brett, Gloucestershire PCT (KB)
James Barker, West Midlands HCS (JB)
Howard Davis, Audit Commission (HD)
Jonathan Storey, North East SHA (JS)
Paul Athey, Royal Orthopaedic Hospital NHS FT (PA)
Robyn Rukavina, South East Coast SHA (RR)
Andy Eames, Sheffield PCT (AE)
Sarah Butler (SJB)
Martin Campbell (MC)
Jake Gommon (JG)
Eileen Robertson (ER)
Adiba Enwonwu (AEn)
Simon Tither (ST)
Nathan Abbotts (NA)
Stephen Fenton (minutes) (SF)

Apologies:

Paula Monteith, NHS IC
Julie Speller, NHS IC
Nathalie Verin, Boston Scientific
Tom Fellows, Nuffield Health
Neil Brent, South West Specialist Commissioning Group
Mark Chidgey, Stockport PCT
Tina Lovelock, NHS Information Centre

1 Welcome and introductions

1.1 Jane Hazelgrave welcomed all to the meeting and received apologies.

2 Minutes of the meeting held on 30 March 2011, and matters arising

2.1 Members agreed the minutes of 30 March were an accurate record of the meeting, subject to a number of amendments being made:

- Jonathan Storey is from North East SHA, not North West
 - At para 5.8, 'ambulance' should read 'ambulatory'
- 2.2 Action at paragraph 5.17 – ER had taken back the suggestion of a best practice tariff for macular degeneration.
- 2.3 Action at paragraph 5.18 – some comments had been received from TWG members on the best practice tariff proposals.
- 2.4 Action at paragraph 7.3 – Bulwinder Singh had provided a template of what would be required in a diagnostic image mapping collection.

3 Best practice tariffs

- 3.1 JG gave a presentation covering the evaluation of best practice tariffs (BPTs) and plans for 2012-13, and sought views from the group on a number of issues including possible outcome metrics and implementation options.
- 3.2 RR asked what proportion of a BPT might be linked to outcome. JG said that the proportion would probably be quite small. SK raised the issue of the subjective nature of PROMS data, and WA asked about the time lag in collecting this data and how that might affect payment timescales. JH asked what proportion of patients respond to PROMS, JG said that it is between 70 and 80 per cent, with coverage currently limited to hips, knees, hernias and varicose veins.
- 3.3 JG and ER confirmed that any use of PROMS for BPTs would be based on the trust average score, and that there would need to be some adjustment for factors such as patient deaths. PA said that use of the trust average was important, but there were difficulties around timing of information and financial flows. In principle he was in favour of the direction of travel, but asked that any BPT arrangements using PROMS data do not cross financial years.
- 3.4 KB said that what was being proposed might lend itself more to a CQUIN-style approach. SK said that many trust boards are very focused on CQUIN goals, and that an increased focus on BPTs would be beneficial. SJB said that the policy of better linking payment to quality and outcomes was now set, so the issue is how to operationalise. MC and JG said that the PbR team is trying to act on feedback to keep complexity to a minimum, though JS raised the concern that the proposed approach may compound unintended consequences and add complexity. JH said that whilst the principle of linking payment to quality in this way is worthy of support, the devil is in the detail.
- 3.5 JH asked if there were any changes planned to the cataracts BPT, which AE said was helpful for commissioners as it defined a pathway

approach. JG said that the challenge was to make it worthwhile financially but without causing undue volatility.

- 3.6 PA highlighted the need to engage with clinicians and demonstrate the benefits of increased quality.

4 PbR in 2011-12: update

- 4.1 SF gave a presentation which invited comments on how a number of aspects of the PbR regime for 2011-12 are being operated, mostly in relation to the policy of non-payment for some emergency readmissions.
- 4.2 SK said that disagreement over payment for clearly unrelated readmissions had caused a delay in signing off contracts. PS said that her trust had modelled the potential impact, using 'same admission and readmission HRG chapter' as a basis for this. PS noted that a large number of readmissions related to dialysis patients, and that her trust has fortnightly clinical review meetings with the PCT to monitor the operation of the policy. SK said that her trust had been unable to reach agreement with the commissioner on paying for readmissions where the readmission HRG was in a different chapter to the admission. RR said that there were a number of disputes relating to individual patients in her region.
- 4.3 On the potential for 'year of care' tariffs to be agreed for named patients, AE said that six to eight months planning work would be needed before implementation, suggesting that uptake in 2011-12 might be low. JH suggested that the PbR team raise this with SHAs to identify any local best practice. **Action – Stephen Fenton.**
- 4.4 MC asked the group whether clinical audit had been used to set the threshold rate for emergency readmissions following a non-elective admission. PS said that her trust had tried but had been unable to make use of this information, and so were using previous years' activity as a basis.
- 4.5 There was a discussion on the use of savings arising from non-payment, and there are a number of approaches being taken, such as PCTs investing the savings with providers to deliver some specific improvements designed to reduce the risk of readmission. JH stressed that the objective of the policy has to be reduce readmissions. AE said that the ongoing transformation of community services meant that the policy had to be viewed in the round and not in isolation, and KB agreed with this.
- 4.6 On the issue of the flexibility which permits additional payment for complex diagnostic imaging, one suggestion was that having more granular TFCs might help, or some form of specialist top-up for this

activity. Another option suggested was mentioned, that being taking the cost of certain complex diagnostics out of the outpatient tariff and adding them to specific inpatient HRGs, thereby targeting certain groups of activity more accurately.

5 PbR in 2012-13: post discharge support

- 5.1 ST introduced an information paper, which updated TWG members on developments since the last meeting, and invited comments.
- 5.2 ST gave an overview of the ongoing data collection work, and the significant challenges the team faces in collecting data to underpin a potential tariff. Few of the early implementer sites have been able to provide data, apart from Torbay. The current focus of this work is on possible post discharge payments which relate to age and length of stay.
- 5.3 ST set out issues around affordability and impact, and the links to the existing emergency readmissions policy. SK asked whether the PbR team is attempting to obtain more data. ST said that this work was ongoing, and that it might be possible to use the sense check exercise to test the robustness of the data collected. PS raised the issue of the community minimum dataset, which is not yet available.
- 5.4 JH said that a key issue to be considered was the potential for financial instability as a result of any new payment arrangement. KB said that moving to a casemix approach for paying for these services would make it more difficult to link payment to the quality or appropriateness of service.

6 PbR in 2012-13: Cystic fibrosis

- 6.1 AEn set out the background to the issues discussed in the paper and the current situation whereby there is a mandatory currency for cystic fibrosis (CF) services. The three main issues on which comments from TWG members were invited were:
 - Maintenance of the registry by the CF Trust
 - Costs underpinning a tariff (currently based on 2007 data)
 - The scope of the year of care tariff
- 6.2 The CF Trust currently maintains the register and assigns patients to bands. This has a cost which could be covered by adding £15 to the tariff price. Feedback received from the CF Trust indicated that this was not a desirable approach and as such TWG were asked to feedback any other potential suggestions regarding funding.

- 6.3 Options for updating the costs, from their current 2007 basis, for a tariff include making an adjustment by using the MFF, or asking PwC to undertake a costing exercise at cost of £10k - £15k.
- 6.4 JH suggested that a clinical view would be needed on any changes since 2007 which might require a reassessment of costs. ER said that drug costs could be dealt with outside of the CF tariff. The issue is what activity would be covered by a year of care tariff. A review of HES data has identified 19,000 spells. ER posed the question as to whether the currencies are being used, and how easy it is to identify CF patients for which the year of care tariff might apply.
- 6.5 JC said that coding rules are clear in that if the primary diagnosis is CF, then it would fall within the year of care tariff. PS said that if CF was secondary, it would count as a complication or comorbidity. SK asked what guidance currently exists for reference cost collection in relation to CF services. MC said that future tariff guidance would need to make it clear that primary diagnosis would be the determining factor in whether a spell is covered by the year of care tariff.
- 6.6 SJB asked what definitions had been used in the collection of the 2007 cost data. NA said that some feedback has suggested that it has been done at a sub-episode level and as such there is a need to clarify which activity would be covered by the year of care tariff. MC clarified that the banding is based on the severity of the condition, not the number of attendances. MC emphasised that the development of pathway or year of care tariffs is a priority for the Department. AE highlighted the similarity with the previous agenda item discussion on year of care tariffs for named patients.
- 6.7 JH suggested that a review of costs / prices should be a priority, and ER said the PbR team would check costing methodologies from 2007 to determine the extent to which it matches the primary diagnosis approach. **Action – Adiba Enwonwu.**
- 6.8 AEn said that around ten per cent of CF patients are not on the registry. WA said that her trust had used to the banding, and both she and PS queried whether it is necessary for the CF Trust to do this rather than providers. ER said a consideration here was money moving with the patient. JH suggested that the PbR team should speak with major CF service providers to bottom out some of the issues discussed, and possibly flag these up at sense check. **Action – Adiba Enwonwu.**

7. Exclusions

- 7.1 ER introduced the paper which provided an update on the work to refresh the mapping of high cost drug and device exclusions to HRGs and TFCs. On devices, ER said that a lot of work has been done with

clinicians to refresh the mapping, with the result that the amount top-sliced will fall and the individual adjustments will increase. PS asked whether the PbR team will be top-slicing across the board, ER responded that the team is trying to target as far as is possible.

- 7.2 ER said that the impact on prices of the re-mapping work will be assessed as part of the sense check exercise, through the involvement of the HRG Expert Working Groups.

8. ICD-10

- 8.1 JC gave a presentation on the updated version of the ICD-10 diagnostic codes, due for implementation from April 2012.
- 8.2 160 new codes are being added to the 16,000 existing codes, and there are some changes to code meanings. There remains a possibility that the current draft list of changes could be further amended.
- 8.3 SK said that it would be difficult to plan ahead as the local payment grouper reflecting some of these changes won't be available until March 2012. JS said that the use of a Table Of Coding Equivalence (TOCE) will help smooth the impact and ensure that new codes will map back to existing codes.
- 8.4 PS said that richer/deeper coding could lead to complaints from commissioners about increased payment for no additional activity. KB asked whether there are capacity issues for coders, such as time and resource for training, which could have an impact on implementation. JC said that any problems with adherence to the revised codes would be highlighted by SUS generating 'U' code HRGs.

9. Reference cost audits

- 9.1 HD gave an update on the Audit Commission's reference cost audit work. All 167 trusts have been audited, and 30 independent sector providers.
- 9.2 Initial findings suggest that 2009-10 reference costs were broadly accurate, with problems such as inaccurate unit costs relating mainly to non-admitted care. Errors with reference cost / HES reconciliation also related mainly to non-admitted care. The final report on the audits is due to be published later in the summer.
- 9.3 JC said that the NHS Information Centre make use of reference cost data to see if HRG design is playing out as intended. Some issues had been identified with length-dependent spells being assigned to inappropriate HRGs.

10. Any other business

10.1 None was raised.

Date of next meeting – Wednesday 19 October, 11am

Action log

Para ref	Action	Owner
4.3	Ask SHA PbR leads about any local 'best practice' regarding year-of-care tariffs for named patients	Stephen Fenton
6.6	Check 2007 costing methodology for Cystic Fibrosis	Adiba Enwonwu
6.7	Liaise with CF providers to discuss some of the implementation issues raised at the meeting	Adiba Enwonwu