

HIV Adult Outpatients Pathway Clinical Factsheet No 1



1. Where can we find a copy of the pathway?

Go to:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH133365>

and you can download version 10 of the pathway as well as a whole raft of other information about the new currency.

2. How was the pathway developed?

The National Reference Group, a consortium of NHS providers and commissioners from London (through the London SCG), Heart of England, and Greater Manchester (through the Greater Manchester Sexual Health Network), including BHIVA and BASSH representation developed a clinically designed clinical pathway for each of three groupings of patients that supports an annual year of care tariff approach.

3. What does the pathway cover? Is it just outpatients in a clinical setting?

The clinical pathway is described as an Outpatient based pathway however during the course of the currency development we have been made aware that there can be alternative settings for elements of the pathway. For example, psychological support provided in the community or a greater involvement by GPs.

Rather than trying to be prescriptive using existing national guidance around unbundling a flexible approach can be adopted to allow a provider to deliver the pathway and co-ordinate where and how the inputs are delivered.

4. What goes into the pathway?

The pathway deliberately steers away from documenting the level of resource that would be expected to be delivered as part of an HIV Adult Outpatient service however it does document how patients might typically access care.

It also demonstrates how the pathway fits across the 3 category of patients.

5. What is excluded?

The standard Payment by Result exclusions apply so, for example, ARV drugs are excluded.

In addition this is an Adult tariff and so care delivered to Children (as per Payment by Results definition of 18 and under) whether it be in a Children's clinic, a transitioning clinic or an Adult clinic are excluded.

Non HIV care is excluded from this pathway approach. Whilst a pregnant lady with HIV will generate a complex category of patient the increased payment is to cover the increased complexity of HIV care and not for the maternity care.

HIV screening and/or diagnosis is also excluded from the pathway. This pathway is for patients already diagnosed with HIV.

6. Who categorises patients?

Patients are assigned to a category based on the coding in the patient record by the Health Protection Agency as part of their dataset processing.

It is therefore important to make sure that the dataset submitted to the Health Protection Agency

is complete and accurate to ensure that patients are categorised correctly.

7. How are patients that require more care but are not one of the medically complex categories accounted for?

Being a category 2 Stable patient does not mean that the delivery of care will be simple. There will be some patients in this category that require more intensive care than the average and there will be others that require less.

During the development of the categories we have tested them against real patient data across a range of providers and on more than one occasion.

This resulted in the published list of complexities that require significantly more resource and affect a significant number of patients.

If you feel that there are other medical complexities that should be recognised as category 3 then please email us at pbrcomms@dh.gsi.gov.uk.

It would be helpful if you could provide some background as to why you think the condition should be category 3 and indicate the percentage of patients that you think would be affected.

8. What are the medical complexities that result in a patient being Category 3?

- Current TB co-infection on anti-tuberculosis treatment
- On treatment for chronic viral liver disease
- Receiving oncological treatment
- Active AIDS diagnosis requiring active management in addition to ART (not inpatient care)
- HIV-related advanced end-organ disease
- Persistent viraemia on treatment (> 6 months on ART)
- Mental illness under active consultant psychiatric care
- HIV during current pregnancy

9. What does this mean for my service delivery?

The introduction of a new currency has no direct impact on how you choose to run your service.

Compared to a price per attendance payment system moving to a year of care system will no longer have a financial link between the number of times a patient is seen (and by whom) and the amount of money received which could lead to more efficient and effective models of delivery.

Compared to a block contract payment system moving to a year of care system will reward efficient providers and ensure the money follows the patient.

It may be worth discussing this new year of care approach with your finance department so they can reflect on your local situation.

There is however an administrative impact in terms of improved information requirements for patients.

10. What does this mean for how I am paid?

For 2012/13 there is no impact as the annual year of care approach is a shadow year for the testing of the currency.

In 2013/14 there may need to be local discussions about moving to a year of care price per patient, differentiating between where they are 1 New, 2 Stable or 3 Medically Complex and this has not already happened.

We are not setting any prices nationally in 2013/14 so these will all be for local discussions.

However, this is dependant on the currency being mandated for use in 2013/14 and will make it important to ensure that your information recording systems are robust enough to generate the data needed to support putting patients in the right category and hence being paid the correct price.

11. If I become more efficient will my financial reports improve?

If you find ways to still meet clinical guidelines, meet local quality, and outcome requirements, but at a lower cost, then your organisation will benefit.

Whether your financial reports will improve or not will depend on how your organisation reports their income against their costs for your service.

12. What if I don't deliver the entire pathway?

Where you don't deliver the entire pathway then there will need to be a local discussion between you organisation and your commissioner as to what this means.

During the development of this pathway we have seen one scenario where elements of the pathway were delivered in the community rather than by the acute trust.

In this scenario one option may be for the commissioner to divide up the year of care payment between the acute and the community provider i.e. unbundling.

The other option, consistent with other pathway based currencies, is for the acute provider to receive the whole of the year of care payment and for them to then sub-contract elements of the pathway as required.

13. Can this approach help me drive innovation in my service?

There is nothing currently to stop you driving through innovation in your service however it may require local discussions to ensure you are not financially penalised for doing so.

This new system will give you the certainty around how your organisation is paid and thus make it easier to ensure that innovation is incentivised rather than prevented.

14. What if I only delivery part of the pathway for patients as tertiary referrals?

Where you don't deliver the entire pathway then there will need to be a local discussion between you organisation and your commissioner as to what this means.

If you are only delivering elements of the pathway then one solution is for the main provider to be paid the whole pathway payment and for them to sub contract with you for the elements of the pathway you deliver.

Commissioners will need to understand how providers are meeting BHIVA guidelines (upon which the pathway is based) and where this is not occurring consider the implications of this. It is important where multiple providers are involved in delivering the pathway that the BHIVA guidelines are still fully being met.

15. Which drugs are included in the pathway?

The standard Payment by Results guidance on which drugs are excluded or not continues to apply.

So High Cost Drugs such as ARV drugs within BNF chapter 5.3.1 are excluded from the scope of Payment by Results and require local agreement as to how they are reimbursed.

If the drugs are not listed as being excluded from Payment by Results then they are paid for by the tariff.

16. What is happening with high cost ARVs?

There have been a number of discussions at the National Reference Group as to what is the best approach to commissioning high cost ARVs.

For now no conclusion has been reached and so they continue to require local agreement as to how they are commissioned.

Further information

More information on the Adult HIV Outpatient Pathway PbR system can be found on the DH website including the clinical pathway, currency guidance, dataset documentation, coding guidance and data validation rules.

The simple guide in particular is an excellent starting point.

There are also supporting FAQs tailored to different audiences of which this is one.

If you have any specific queries about Adult HIV Outpatient Services and PbR that are not answered here or on the website, please email pbrcomms@dh.gsi.gov.uk

In addition the Health Protection Agency have published the full dataset, HIV and AIDS Reporting System (HARS) which will ultimately replace SOPHID, and supporting FAQ at <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVAndAIDSReportingSystem/>

