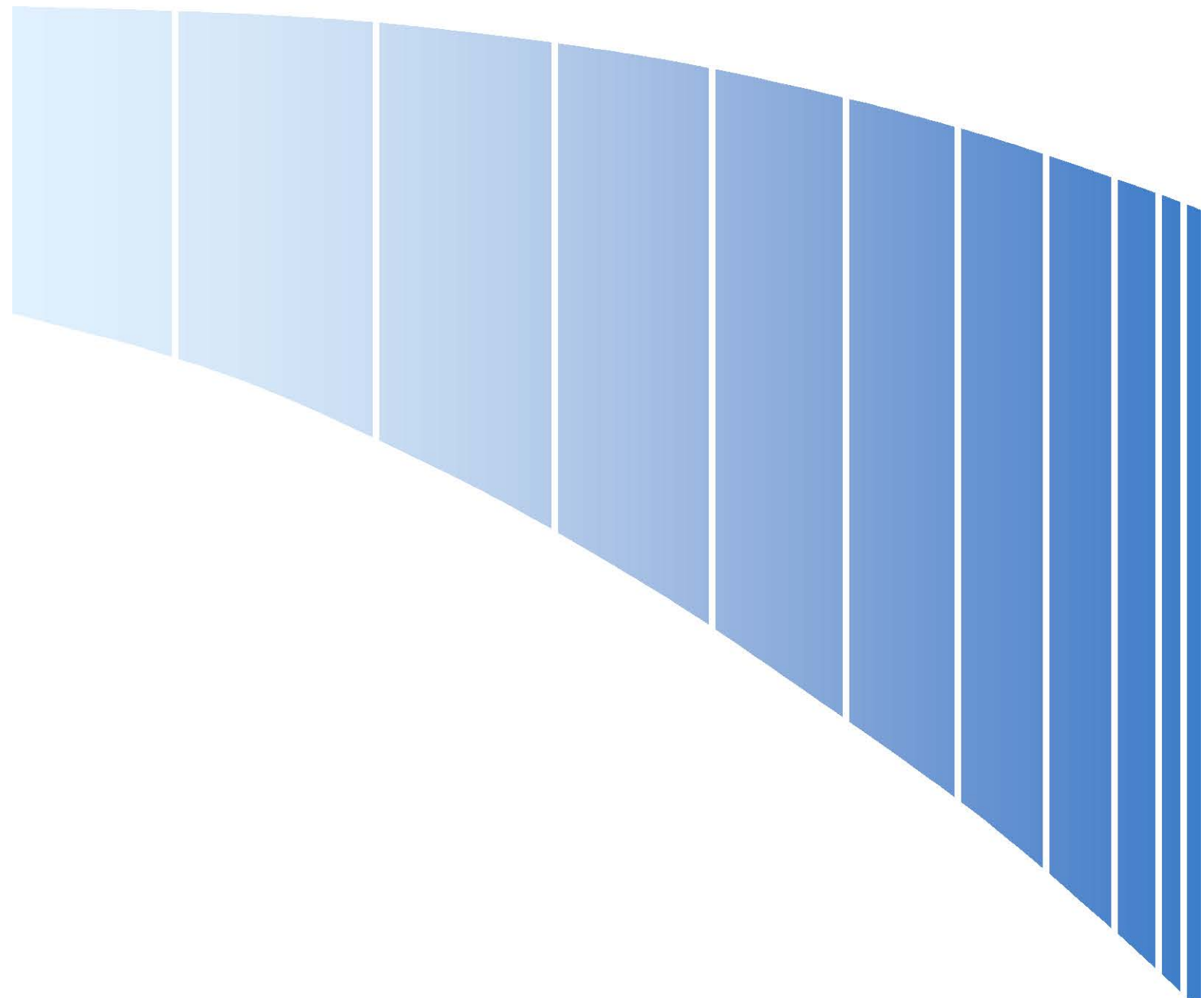


Equality Impact Assessment of the Payment by Results national tariff



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1. Introduction

- 1.1 The public sector equality duty ensures public bodies, such as the Department of Health, are specifically acting to eliminate discrimination, harassment and victimisation; advance equality of opportunity; and promote good relations.
- 1.2 This report provides a background into Payment by Results and shows evidence that equality is considered throughout the tariff development process.

2. Background

- 2.1 Payment by Results (PbR) is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. The two fundamental features of PbR are nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.
- 2.2 PbR currently covers the majority of acute healthcare in hospitals, with national tariffs for admitted patient care, outpatient attendances, accident and emergency (A&E), and some outpatient procedures.
- 2.3 Before PbR, commissioners tended to have block contracts with hospitals where the amount of money received by the hospital was fixed irrespective of the number of patients treated. PbR was introduced to:
 - (a) support patient choice by allowing the money to follow the patient to different types of provider
 - (b) reward efficiency and quality by allowing providers to retain the difference if they could provide the required standard of care at a lower cost than the national price
 - (c) reduce waiting times by paying providers for the volume of work done
 - (d) refocus discussions between commissioner and provider away from price and towards quality and innovation.
- 2.4 PbR was introduced to support healthcare policy and the strategic aims of the NHS. As these change and develop over time, so will PbR. The tariff is now seen increasingly as a vital means of supporting quality outcomes for patients and delivering additional efficiency in the NHS.
- 2.5 PbR is not unique to England. Many other countries in Europe, North America and Australasia operate similar payment systems.

Healthcare Resource Groups HRGs

- 2.6 The currency for admitted patient care and A&E is the healthcare resource group (HRG). HRGs are clinically meaningful groups of diagnoses and interventions that consume similar levels of NHS resources. With some 26,000 codes to describe specific diagnoses and interventions, grouping these into HRGs allows tariffs to be set at a sensible and workable level. Under the latest version, HRG4, there are over 1,100 tariffs. Each HRG covers a spell of care, from admission to discharge. The currency for outpatient attendances is the attendance itself, divided into broad medical areas known as treatment function codes (TFCs).
- 2.7 The NHS Information Centre, working with NHS clinicians, is responsible for developing groupings of healthcare treatments (HRGs) to which prices can be attached.

Classification systems and clinical coding

- 2.8 When a patient is discharged, a clinical coder working in the hospital translates their care into codes using two classification systems, ICD-10 for diagnoses and OPCS-4 for interventions. When a patient attends an outpatient clinic, their TFC is similarly recorded. This information, together with other information about the patient such as age and length of stay, is sent from the hospital's computer system to a national database called the Secondary Uses Service (SUS). Reports from SUS allow commissioners and providers to make adjustments to monthly contract values agreed in the NHS standard contract to reflect what has actually happened to patients.
- 2.9 NHS Connecting for Health has responsibility for developing and maintaining classification systems and clinical coding.
- 2.10 Further information on PbR can be found in the Simple Guide to Payment by Results, Gateway ref 16300:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128862

3. Developing the tariff

- 3.1 PbR began in a small way in 2003-04, covering about £100 million of activity, but from the outset there were ambitious plans for it to ultimately cover as much secondary care expenditure (about £60 billion) as possible. Primary care expenditure on GPs, dentists, opticians and prescribing (about £20 billion) is already covered by separate national contracting and funding arrangements.
- 3.2 By 2006-07, PbR had expanded rapidly to cover most acute activity, initially applying only to the NHS but extended to the independent sector in 2008-09. However, the original aim of covering most secondary care had not been achieved and a number of services – notably mental health and community health – remained outside the scope of PbR. For these services, the price paid still has to be worked out by negotiation between commissioners and providers each year. *Equity and Excellence :Liberating the NHS* set out the Government's renewed ambition to extend the benefits of PbR into these and other areas.
- 3.3 The timescale for bringing services into the scope of PbR can be quite lengthy and reflects the processes that have to be followed when introducing new data flows and collecting the information needed to introduce PbR without destabilising services or organisations. As new services are brought into the scope of PbR, they do not automatically have both a national currency and a national tariff. Many are introduced initially as a national currency with local prices. This helps create a common contracting unit for benchmarking and comparison, whilst providing the flexibility to fit with the financial situation of local health economies. Such an approach may be part of a phased transition with a national tariff introduced in subsequent years.

4. Tariff calculation

- 4.1 Tariff prices have traditionally been based on the average cost of services reported by NHS providers in the mandatory reference costs collection. In practice, various adjustments are made to the average of reference costs, so that final tariff prices may not reflect published national averages. The DH PbR team collects costing data from suppliers of NHS services and calculates the national tariff.
- 4.2 Because the reference costs from which the tariff is produced are three years in arrears, an adjustment is applied which reflects pay and price pressures in the NHS, and includes an efficiency requirement. There may also be other adjustments to the tariff for long or short stays, for specialised services, or to support particular policy goals. The introduction of best practice tariffs in 2010-11 means that increasingly tariffs are determined by best clinical practice rather than average cost.
- 4.3 In order that tariff calculation is transparent, DH is committed to publishing a guide that describes the stages involved in calculating the PbR national tariff each year. The step-by-step guide to calculating the 2012-13 national tariff can be found under the following link:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132654

Mandatory tariffs

- 4.4 The mandatory national tariff is payable by commissioners for day cases, ordinary elective and non-elective admitted patient care, outpatient attendances, some outpatient procedures, and A&E attendances carried out by NHS trusts, NHS foundation trusts or independent sector providers.

Non-mandatory tariffs

- 4.5 In addition to mandatory tariffs, which must be used by all commissioners when commissioning services, we also publish non-mandatory currencies and prices. Examples include non face-to-face outpatient contacts and hearing aid fitting and maintenance. Non-mandatory currencies can be used as a contracting unit and the prices can be used as a guide or starting point for local negotiation. We sometimes use non-mandatory prices to send a signal to the service that we anticipate being able to bring the service within the mandatory list in due course.

Exclusions

- 4.6 Some activity is excluded from PbR and remains subject to local payment rather than mandatory tariff. There are various reasons for this:
- (a) services outside the scope of reference costs are, by default outside the scope of PbR

- (b) some services either have not yet had currencies developed for them, or do have currencies but the costs associated with them are not considered robust
- (c) some drugs are typically specialist, and their use concentrated in a relatively small number of centres rather than evenly spread across all providers that carry out activity in the relevant HRGs. They would not be fairly reimbursed if funded through the tariff
- (d) some medical devices represent a high and disproportionate cost relative to the cost covered under the relevant HRG.

4.7 Each year, alongside the tariff, we publish an exclusions list which covers activity, drugs and devices. Local arrangements are then needed to agree funding for excluded items.

Flexibilities

4.8 PbR is meant to be a tool and it should never be seen as a barrier to providing the best care for patients. Flexibilities allow for deviation from tariff rules where the patient and the NHS benefits. For example, 'innovation payments' give commissioners the flexibility to make an additional payment for a new device, drug or technology that gives better care than is provided for in the tariff. The guidance published alongside the tariff each year lists the full range of flexibilities that are available and the principles that govern their use.

Market Forces Factor (MFF)

- 4.9 The tariff received by the provider is multiplied by a nationally determined MFF. This is unique to each provider and reflects the fact that it is more expensive to provide services in some parts of the country than in others. MFF compensates for the unavoidable cost differences of providing healthcare in different parts of the country, eg organisations in some parts of the country have higher costs because labour, land and buildings cost more in these areas.
- 4.10 The MFF originated in the weighted capitation formula used to allocate funding to PCTs and the mechanism used to produce it is the responsibility of the advisory committee on resource allocation. Prior to PbR, the assumption was that the local prices paid by commissioners to providers would reflect cost differences. With the introduction of PbR, there was a need to include a pricing adjustment to the tariff. The MFF is in the form of an index which allows for a comparison of each organisation's unavoidable costs relative to every other organisation.
- 4.11 The MFF payment index operates as a multiplier to each unit of activity. For an organisation with an index of 1.10, each £1,000 of PbR income is worth an additional £100. The index always has a lowest value of 1.00 and currently has a highest value of 1.30. London and the south east of England are the highest cost areas. On average, the MFF adds about 8% to the value of the tariff.

5. Protected characteristics

- 5.1 The public sector equality duty covers the 'protected characteristics' of age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex, and sexual orientation.
- 5.2 Any potential impact of PbR on people sharing the different protected characteristics has been considered during the tariff development process.

Age

- 5.3 Age can have a major impact on length of stay and the costs of an intervention. Development of the HRG currency and PbR tariffs takes into consideration additional costs that may be associated with younger or older people. Where procedures have additional costs associated with age, HRGs include an age split, which reflects these costs. HRG Chapter P is dedicated to diseases associated with childhood and neonates.
- 5.4 Patients who receive specialised care may be more expensive than those allocated to the same HRG who do not require specialised care. Top-up payments recognise these additional costs and are applied as a percentage increase to the tariff price. For example, in 2012-13 a 50% top-up was applied to specialised children's services.
- 5.5 Top-ups are triggered when an ICD-10 or OPCS-4 code, from a list based on the latest editions of the specialised services national definition sets (SSNDS) produced by the National Commissioning Group (NCG), is present in the spell. Some top-ups are limited to eligible providers. The methodology underpinning these payments is described in *Estimating the costs of specialised care* (February 2011), a research paper commissioned from the Centre for Health Economics (CHE) at York University.

Disability

- 5.6 Many HRGs differentiate between care provided to a patient with or without complications and comorbidities¹ (CCs) in order to reflect the higher expected resource use of treating the latter. CCs may be deemed to be major, intermediate or insignificant in terms of requiring additional resource use to treat.
- 5.7 ICD codes have been developed in order to recognise patients who have problems related to care-provider dependency (eg mobility problems, or a lack of care at home). They are also able to recognise mental health issues.

¹ additional conditions that the patient might come into hospital with that increase the complexity of the primary intervention

Sex

- 5.8 Certain procedures are, by nature, distinctive for male and female patients and for this reason, those HRGs are classified by gender.

Table 1: HRGs classified by Gender

LB21Z	Bladder Neck Open Procedures - Male
LB22Z	Laparoscopic Bladder Neck Procedures - Male
LB23Z	Bladder Neck Open Procedures - Female
LB24Z	Laparoscopic Bladder Neck Procedures - Female
LB27Z	Prostate or Bladder Neck Minor Endoscopic Procedure – Male
LB44Z	Non-Operative Interventions of Genital Organs and Perineum - Male

- 5.9 There are three HRG Chapters dedicated to gender specific procedures:

Table 2: Gender specific HRG chapters

Chapter M	Female Reproductive System Disorders and Assisted Reproduction
Chapter N	Obstetrics

- 5.10 The PbR tariff is based on the average cost of all services reported by NHS providers through the annual reference costs collection, and so reflects the costs incurred in providing gender-specific procedures.

Gender Reassignment

- 5.11 Procedures for gender reassignment attract the relevant HRG tariff price, based on reported costs, and so the reimbursement for these procedures reflects the costs incurred.

Pregnancy and maternity

- 5.12 The 2012-13 tariff introduced, in shadow form, a pathway payment system for maternity care. The shadow year of operation will allow the PbR team to gather feedback from the NHS on whether any element of it would impact negatively on our equality duty and to resolve any issues prior to full implementation, which is planned for 2013-14.
- 5.13 The pathway system assesses a woman's characteristics and factors that may affect the resource required to care for them during their pregnancy. The factors and characteristics have been chosen in line with both NICE Guidelines and NHS stakeholders to ensure that all relevant factors are taken into account, and where a woman does exhibit specific factors, the organisations caring for that woman will receive a higher level of funding to care for her.

- 5.14 The pathway will impact positively on:
- a) inequality – payment will be enhanced to give improved care for women who have complex social and other factors (social care and safeguarding issues, women under the age of 20, mental health issues, recent immigrants and refugees, women who require an interpreter, domestic violence sufferers, substance misuse and dependency)
 - b) disability – payment will be enhanced for women who have a physical disability
 - c) vulnerable groups – payment will be enhanced for women who have HIV, sickle cell disease or thalassaemia (particularly prevalent in certain ethnic groups) and other autoimmune diseases, women who reach specific levels of obesity or are particularly underweight, and those with a genetic or inherited disorder.

Race, sexual orientation, religion or belief

- 5.15 The tariff does not distinguish between procedures that are carried out on patients of different race, sexual orientation, religion or belief. Reimbursement is based on reported costs incurred for patients from all backgrounds.

6. Payment by Results advisory arrangements

- 6.1 The delivery of PbR policy development and stakeholder engagement is managed through a number of advisory groups. The key groups that consider equality issues are the External Advisory Group (EAG), Clinical Advisory Panel (CAP), Children's sub-group and Technical Working Group (TWG).

External Advisory Group

- 6.2 The EAG is a large stakeholder representation group. This Group is chaired by John McIvor, Chief Executive of NHS Lincolnshire, and has a wide membership including NHS and independent sector organisations, regulators, professional associations and policy organisations.

Terms of reference

- To provide strategic advice to the NHS Chief Executive on the development and implementation of Payment by Results (PbR) policy
- To maintain an overview of the relationship between the developing and implemented policy and the stated policy objectives
- To monitor the tariff setting process ensuring that its construction is fair, transparent and objective
- To provide reports to the PbR Programme Board on issues considered and advice given

Clinical Advisory Panel

- 6.3 The CAP is chaired by Dr Ian Rutter, who has been a PCT chief executive and who currently acts as an adviser to the Department of Health. The membership is predominantly clinical with medical, nursing and allied health professional representation

Terms of reference

- To provide strategic clinical advice to the NHS Chief Executive on the development and implementation of Payment by Results (PbR) policy
- To provide advice on policy and pricing to ensure that PbR does not inappropriately affect clinical practice
- To provide strategic direction to the expert working groups (EWGs) developing healthcare resource groups (HRGs).
- To provide reports to the PbR Programme Board on issues considered and advice given.

Children's sub-group

- 6.4 The Clinical Advisory panel also has a children's sub-group, chaired by Dr. Sheila Shribman, National Clinical Director for Children, Young People and Maternity, that looks specifically at children's issues.

Technical Working Group

6.5 The TWG is chaired by Jane Hazelgrave, Director of Finance at Bradford and Airedale PCT, and includes representatives from NHS Trusts, NHS Foundation Trusts, PCTs and SHAs, who have expertise in fields such as finance and specialised services.

Terms of reference

- To provide technical and operational advice to the Department of Health Payment by Results team on the implementation of PbR policy
- To facilitate a shared understanding between the NHS and the DH of technical and operational issues relating to PbR and its impact on the NHS

6.6 CAP, EAG and TWG each meet on a quarterly basis. These meetings are scheduled to ensure that advice is sought in advance of key milestones in the tariff development process. The following paragraph is included on all policy papers submitted to CAP, EAG and TWG to ensure all policy proposals are considered in terms of equality.

Equality impact assessment

We are required to consider if these policy proposals would have an either negative or positive impact on equality in relation to age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation

Please let us know if you think the recommendations contained in this paper would:

- present or eliminate any problems or barriers to any particular community or group
- exclude any group of people
- worsen (or eliminate) existing discrimination or inequality
- have a negative or positive impact on community relations
- promote equal opportunity
- Promote positive attitudes towards or more favourable treatment of disabled people
- encourage the participation of disabled people
- promote and protect human rights

7. Sense check

- 7.1 In addition to ongoing engagement with advisory groups, each year the national tariff is subject to a 'sense check' which is a process established in response to the recommendations made in the Lawlor Report² which was commissioned following the setting of the 2006-07 tariff. The purpose of the sense check is to look at individual tariff prices and identify any potential perverse clinical incentives that may have been introduced by the draft tariffs.
- 7.2 The sense check of the draft 2012-13 PbR tariff took place from 6 October to 4 November 2011 and included three main strands:
- i) A 'clinical' sense check of tariff prices was carried out by members of the PbR Clinical Advisory Panel, PbR Children's sub-group and PbR External Advisory Group. In addition, the draft prices were shared with the NHS Information Centre's HRG Expert Working Group Chairs, National Clinical Directors and a number of trusts that provide specialist services. We asked these groups and individuals to review the draft tariffs and let us know of any anomalies or potential perverse clinical incentives.
 - ii) A 'local' element to the sense check through which we worked with a small number of providers and commissioners nominated by their SHAs, and some single-specialty providers, to help us better understand the potential financial impact of the new tariff and identify any unintended consequences.
 - iii) We undertook 'parallel' checking exercises with a number of individuals and organisations, which included a cystic fibrosis trust, to assess the impact of a number of specific tariff proposals.

Summary of sense check feedback on Equality

- 7.3 Organisations were asked: "Do any of these proposals have either a negative or positive impact on equality in relation to disability, ethnicity, gender, sexual orientation, age, religion or belief?"
- 7.4 Of the eighty-four organisations that took part in the sense check, one equality issue was raised regarding funding for women's services. As a result of this, the PbR team met with representatives from the women's hospitals. Further details can be found in the action plan in section 9.

² *Independent Review of the Tariff Setting Process for 2006/07* available on the DH website at: http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_4137253

8. Road test

- 8.1 Following pricing adjustments that are made as a result of feedback received from the sense check exercise, an annual road test exercise is carried out. The 2012-13 road test was carried out from 15 December 2011 to 20 January 2012.
- 8.2 The purpose of the road test exercise is to:
- i) Support early service and financial planning, by releasing information about the following year's tariff package as soon as possible
 - ii) Invite comments on the clarity and comprehensiveness of the draft PbR guidance and Code of Conduct
- 8.3 The validation carried out during sense check means that we do not use the road testing exercise to verify the accuracy of the tariff. The final tariff package is published once the tariff and guidance are finalised following any comments received during the road test.
- 8.4 The following question regarding equality was asked at road test: "What potential impacts on equality in relation to Disability, Race, Age, Sex, Sexual Orientation, Religion and Belief, Gender Reassignment, Pregnancy and Maternity and Socio-economic status, do the proposed PbR policies have (both negative and positive)?"
- 8.5 Of the 126 individuals and organisations that responded, two equality issues were raised:
- One correspondent was concerned about artificial urethral sphincter (AUS) exclusions, but had not noticed that AUS had received its own HRG.
 - The other issue was around the emergency readmissions policy and the potential to penalise those from lower socioeconomic backgrounds who are more likely to access non-elective services. However, the policy does not operate at individual patient level and is intended to release funds, which can be used by the commissioner to improve services in the community. The PbR team will be monitoring feedback on this policy and this has been included in the action plan found in section 9.

9. Action Plan for Payment by Results Equality Impact Assessment

9.1 Each year the DH PbR Team sets an action plan to ensure any potential equality issues are addressed during the following year's tariff development process. The action plan following the sense check and road test exercises for the 2012-13 tariff is set out below:

Action	Lead
<p>Further attention will be paid to the impact on specialist services for children. A joint work programme between DH and a number of representatives from children's hospitals has been agreed by David Flory and the children's hospitals Chief Executives which will:</p> <ul style="list-style-type: none"> • investigate further the characteristics of complex and high cost cases, where there is a disproportionate cost relative to the level of reimbursement • review the tariff structure and casemix design to determine how they can best support future models of care • assess how Infrastructure costs impact on the costs of delivering specialised children services <p>Conclusions from work programme will inform 2013-14 tariff design and beyond.</p>	PbR Team & the children's hospitals
<p>Further attention will be paid to the impact on women's health services. Following concerns raised by an organisation about a reduction in income, a meeting was held on 19 January 2012. A number of actions were arising from the meeting to inform a decision on whether any further work is required.</p>	PbR Team
<p>Monitor feedback regarding the introduction of the emergency readmissions policy through PbR advisory and stakeholder advisory groups.</p>	PbR Team
<p>We will continue to maintain the 'PbR Comms' mailbox through which NHS colleagues and members of the public can raise questions / concerns directly with the PbR team.</p>	PbR Team
<p>Feedback received during 2012-13 will help to inform the design of the tariff for 2013-14.</p>	PbR Team

10. Future of PbR

- 10.1 The Health and Social Care Act (2012) introduced changes in where responsibility rests for tariff design and price-setting. The Department of Health will lead on the development of the tariff and PbR arrangements for 2013-14, in consultation with Monitor and the NHS Commissioning Board. Beyond the 2013-14 tariff, Monitor and the NHS Commissioning Board will have responsibility for the tariff, currency design and price setting.

11. Conclusion

- 11.1 Payment by Results aims to provide a transparent, fair and consistent basis for hospital funding. This report presents evidence that equality is considered and stakeholders are consulted throughout the development of the national tariff. An action plan is created each year and reported on to the equalities team before the final tariff package is published.