Gateway reference: 17828

HIV Adult Outpatients Pathway Commissioner Factsheet No 2

Please note that this factsheet should be read in the context that a commissioning rules set of guidance is currently under development and a pricing methodology has yet to be agreed. As a result aspects of the following could change as feedback is received.

1. What is Payment by Results

Payment by Results (PbR) is a payment per patient funding method.

It replaces other funding methods such as block contracts, which often provided fixed budgets irrespective of patient numbers or differences in patient complexity.

PbR was first introduced in 2003 for some elements of elective care. Since then, PbR has expanded to cover many other healthcare services, and is now the main funding mechanism between providers and commissioners of NHS care in England.

For further details on PbR, there is more information available on the DH website[1].

2. Why the move away from 'episodic' PBR?

The episodic payment system provides payment for each outpatient attendance and so the more clinical interventions, the more a hospital is paid. Hospitals supporting developments in primary care and more efficient pathways would in fact be worse off financially.

The new pathway payment system – in conjunction with choice and local contracts that focus on outcomes, quality and patient's experiences – removes these perverse incentives and frees up providers to develop the right services for their patients without the prospect of losing income.

The pathway payment system is still a PbR payment system. It retains the important principle of 'money following the patient' while providing an incentive for prevention, and care closer to home

3. What is different about this new payment system?

Under the new system, a commissioner will pay a provider for all the non admitted care a patient may need in relation to their HIV care based on a year of care.

A provider retains full responsibility for how they deliver care for their patients, while commissioners will judge providers solely on how well they have delivered their overall service. The aim is to encourage proactive care and prevention.

Where a provider does not delivery the entire pathway then there will need to be a local discussion between the provider and commissioner as to what this means.

One option is for the commissioner to unbundle the pathway and essentially share the pathway payment between each provider in some way.

The other option, consistent with other pathway based currencies, is for one provider to receive the full pathway payment and then subcontract with other providers as required.

This 'single payment' approach differs from the current PbR mechanism, where each intervention or hospital attendance triggers additional payments.

[1] http://www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/payment-by-results/

4. How do we separate GUM payments from HIV payments?

GUM is already covered by Payment by Results with an attendance tariff mandated for use.

The scope of the HIV currency excludes initial diagnosis and access to GUM services and so there is no overlap in terms of payments for services.

If the concern is that for a joint clinic HIV attendances could be recorded as GUM attendances then the NHS standard contract already contains clauses for you to locally address that concern.

5. What does it mean practically to have a mandated currency but not price?

For both providers and commissioners 2012-13 is a chance to understand how the new currency operates, work through any local nuances and to start operating the pathway in shadow form.

It also gives both parties the opportunity to plan for the proposed activity against the required categories and establish the conditions for the new dataset.

6. Will commissioners need to do an impact assessment?

Yes. There will be a national impact assessment as part of the tariff calculation process but commissioners will also need to do a local impact assessment as they do each year as Payment by Result prices are updated and its' scope changes.

7. What do commissioners need to do to implement it?

The detailed answer to this will depend on how HIV services are to be commissioned post April 2013.

As a minimum they will need to get used to the new dataset and the new categories of patients and understand what the information means.

This will come with the need to agree with providers how the performance monitoring information will flow and potentially new quality indicators.

It is entirely possible that a national service specification will be written for Adult HIV Outpatient but essentially commissioners need to understand if their existing providers fully meet BHIVA guidelines (upon which the pathway is based) and service specification and if not consider the implications of this.

Ultimately as finances are affected by the new currency and impact assessment may be required.

8. 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.

9. What if I want care delivered outside of the acute setting?

Where the entire pathway is not delivered by one organisation then there will need to be a local discussion between providers and commissioners.

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.

10. How do we deal with "shared care" arrangements?

Where the entire pathway is not delivered by one organisation then there will need to be a local discussion between the providers and commissioner .

If two organisations are equally delivering the care then one option is for the providers and commissioner can unbundle the pathway payment between them.

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

11. What about joint clinics?

The Adult HIV Outpatient tariff only covers HIV care with non HIV care being excluded from this pathway approach.

If there is a joint clinic e.g. HIV and maternity then the HIV element of the clinic is covered via the pathway approach.
Commissioners will need to discuss with providers how the non HIV element of the joint clinic is then funded.

12. What data system changes are required as part of this?

The Information Standards Board (ISB) for Health and Social Care published the advance notification[2] of the HIV and AIDS reporting System (HARS) on 21 May 2012. This is essentially an alert to information system providers to start updating their solutions with the new data fields.

We have been working with software providers for some time to ensure the changes are reasonable and to give them the opportunity to plan for the changes.

In the future commissioners will need to access HARS to obtain their validated HIV activity although there will still be the option to have local data flows if required.

13. How do commissioners verify the data?

One difficulty is that currently NHS Number for HIV patients cannot be shared. So the Health Protection Agency will use their existing approach to validate activity and de-duplicate where required so that commissioners are only billed once per patient.

If there are concerns about the coding of patients then the NHS standard contract already allows for the auditing of this.

14. What additional resource is required to implement and manage this?

For commissioners it depends on how you currently understand your providers' case mix of patients and validate it etc.

Depending on current local approaches this may require less effort as there will be nationally standardised data flows, grouping and data validation.
Also with an improved granularity of information it should give commissioners the opportunity to improve how HIV services are commissioned without needing to do adhoc data collections etc.

[2] See http://www.isb.nhs.uk/news-folder/nsfs-an/

15. What is the implementation timescale?

2012/13 is a period of shadowing the currency, giving providers and commissioners time to prepare for its introduction.

During 2012/13 we are carrying out a series of stake holder engagement events, the feedback from which will help inform the decision on whether to mandate the currency for 2013/14.

Currently we would advise providers and commissioners to plan on 2013/14 being the introduction of the mandatory currency but with pricing still being for local negotiation.

Further information

More information on the Adult HIV Outpatient Pathway PbR system can be found on the DH website[3] 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/

3 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133365