A Brief Review of NHS Payment Systems

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Types of Payment System

- Block contract
  - fixed sum, no adjustment for changes in activity
  - focus mainly on inputs, little focus on outcomes
  - very few good performance indicators
- Cost and volume
  - price set for agreed volume of activity
  - payment can vary for (step) changes in levels of activity
  - greater focus on activity, but mainly on work done, not results
- Cost per case
  - set payment for each patient treated (not necessarily related to quantum of treatment required)
  - contract values will vary in proportion to activity
  - basic principle underlying Payment by Results

Types of Payment System (cont'd)

- Acute PbR using HRGs (Healthcare Resource Groups)
  - development work in 1990s?
  - introduced in 2003/4 for a limited number of treatments
  - gradually developed over time – now HRG4 (since 2006/7)
- MH PbR using Clusters (adult and older adult services)
  - development commenced in 2001 to improve care provision
  - clusters made available for use for MH PbR in April 2010
  - clusters mandated for use April 2012 (use in contracts)

HRG Characteristics

- HRGs are based on completed episodes of care – known as Finished Consultant Episodes (FCEs)
- Spells:
  - cover all treatment from admission as an inpatient to discharge
  - comprise one or more FCEs
  - HRG Grouper will determine dominant HRG for pricing purposes
- Payment based on HRG for each completed patient spell
- HRGs are based on an analysis of the ICD10* diagnosis and the OPCS-4** procedure
- HRGs are coded (by specially trained clinical coders) at the end of treatment (hence the 'F' in FCE)
- There are around 1,500 HRGs with a coding structure of AANNA grouped into chapters denoted by the first letter
- There are exemptions from PbR – mainly high cost low volume (high financial risk)

* International Statistical Classification of Diseases and Related Health Problems 10th Revision

** Office of Population Censuses and Surveys Classification of Surgical Operations and Procedures (4th revision)

Categories of HRG Tariff

- Outpatient procedure tariff (£)
- Combined day case / ordinary elective spell tariff (£)
- Day case spell tariff (£)
- Ordinary elective spell tariff (£)
- Ordinary elective long stay trimpoint (days)
- Non-elective spell tariff (£)
- Non-elective long stay trimpoint (days)
- Per day long stay payment (for days exceeding trimpoint) (£)
- Reduced short stay emergency tariff
- Per day long stay payment (for days exceeding trimpoint) (£)
- There are also around 170 BPTs covering 18 categories of treatment

Outpatient Tariffs

- 56 treatment functions
- 4 payment levels:
  - 1st and follow up appointments
  - split between single professional and multi-professional
- Paediatric diabetes

		CONSULTANT-LED (£)			
Treatment function	Treatment function name	WF01B First Attendance - Single Professional	WF02B First Attendance - Multi Professional	WF01A Follow Up Attendance - Single Professional	WF02A Follow Up Attendance - Multi Professional
263	Paediatric Diabetic Medicine	225	227	128	128

NB: BPT (£2,764) is equivalent to approx. 1 first appointment and 20 follow up appointments.

Best Practice Tariffs

- A best practice tariff (BPT) is a national tariff that has been structured and priced to adequately reimburse and incentivise care that is high quality and cost effective. The aim is to reduce unexplained variation in clinical quality and universalise best practice. A specific approach has been developed for each BPT, tailored to the clinical characteristics of best practice and the availability and quality of data.

- The service areas covered by BPTs have all been selected using the following criteria:
  a) high impact (ie high volumes, significant variation in practice, or significant impact on outcomes);
  b) a strong evidence base on what constitutes best practice; and
  c) clinical consensus on the characteristics of best practice.

Other Tariff Issues

- 184 non-mandatory tariff HRGs (with suggested prices)
- Trimpoint relates to the maximum length of stay that the HRG will pay for (HRG price is based on average LOS)
- Marginal rate for emergency tariff at 30% where cases exceed threshold
- Post-discharge tariffs
  - Cardiac rehabilitation
  - Pulmonary rehabilitation
  - Hip replacement
  - Knee replacement
- Avoidable readmissions – no reimbursement over agreed thresholds, but savings to be reinvested

The Mental Health Currency

- MH and PbR key issue: in many cases diagnosis and severity of the illness do not predict resource use accurately
- MH currency is based on need and resources: Care Clusters ("iso-resource")
- Each care cluster is associated with a care package(s) to be delivered over the cluster review period
- The tariff will be based on the packages of care and their related interventions
- PbR initially encompasses Adult and Older Adult services only
- Projects are underway to extend MH PbR to CAMHS, LD, Forensics, IAPT, Alcohol services, Quality & Outcomes

Care clusters – some characteristics

- The Care Clusters are based primarily on the needs and characteristics of a service user (with some reference to contextual matters)
- Expected diagnoses are given for each cluster, but the same diagnosis can appear in multiple clusters
- The clusters are mutually exclusive in that a service user can be allocated to only one cluster at a time
- Clinicians allocate patients to clusters using the Mental Health Clustering Tool (MHCT)*
- Each cluster has a review period at the end of which a decision should be taken as to how continuing care should be provided or whether the patient is fit for discharge

* (incorporates items from the Health of the Nations Outcome Scales (HoNOS) and the Summary of Assessments of Risk and Need (SARN))

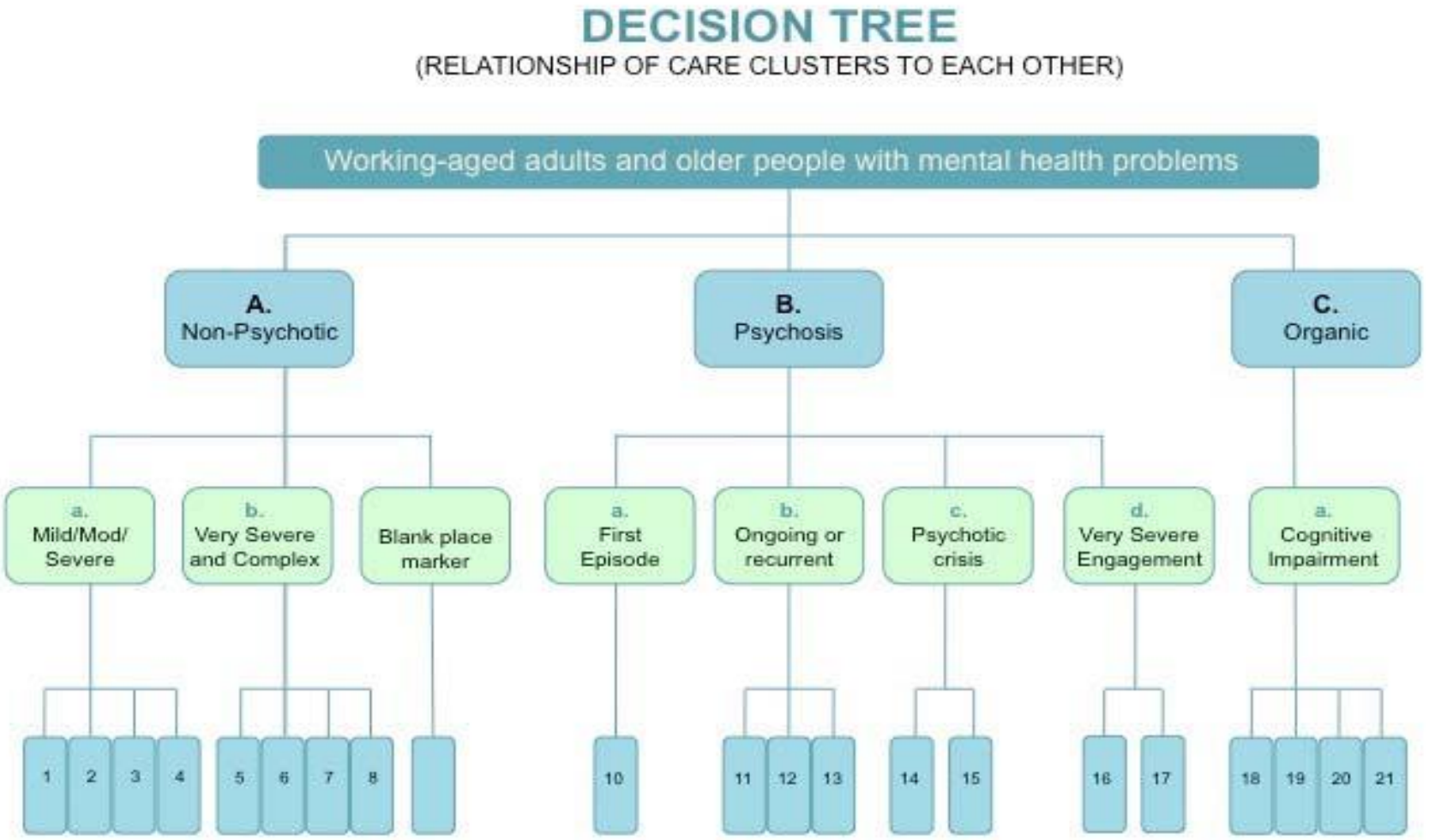
Care clusters – some characteristics (cont'd)

- All mental health care should be covered by the clusters
- The clusters are designed to be setting independent, on the premise that people should be treated in the least restrictive care setting possible
- They should cover care provided by social care staff of integrated services (Section 75 Agreements)
- The varied contributions of different local authorities and the voluntary sector can make it hard to make quick comparisons between providers about the costs and scope of services

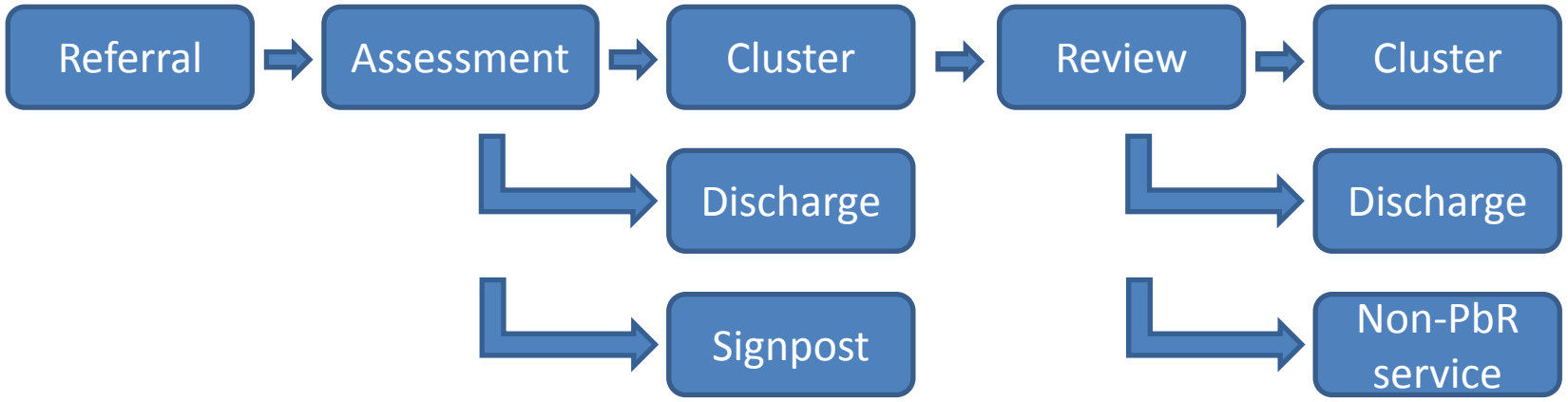
Description of Clusters

Cluster no.	Cluster label	Review period
0	Variance	6 months
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	6 months
6	Non-psychotic disorders of overvalued Ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
9	Blank cluster	N/A
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	Annual
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical or engagement)	6 months

Decision tree for clustering



Cluster process



Notes

- Assessments are done using the MHCT, with recommended completion after two consultations or two inpatient days
- Assessments are for clustering purposes, not full clinical assessment
- There is a separate price / charge for assessments
- Review process uses MHCT and also transition protocols which could result in the patient remaining in the same cluster, or moving to another cluster with higher or lower needs, or discharge

Mental Health Clustering Booklet (V3.0) (2013/14)

CARE CLUSTER 1: Common Mental Health Problems (Low Severity)

Description:
This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms.

Likely primary diagnosis:
May not attract a formal diagnosis but may include mild symptoms of: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F50 Eating Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31 Bipolar Disorder, F33Major depressive disorder, recurrent.

Impairment:
Disorder unlikely to cause disruption to wider functioning.

Risk:
Unlikely to be an issue.

Course:
The problem is likely to be short term and related to life events.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Anxiety CG113, Depression in adults CG90, Depression with Chronic Health Problems CG91, Common mental health disorders CG123, OCD CG31, Eating Disorders CG9.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score		Unlikely to score	
Expected to score		No data available	
May score			

*Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.

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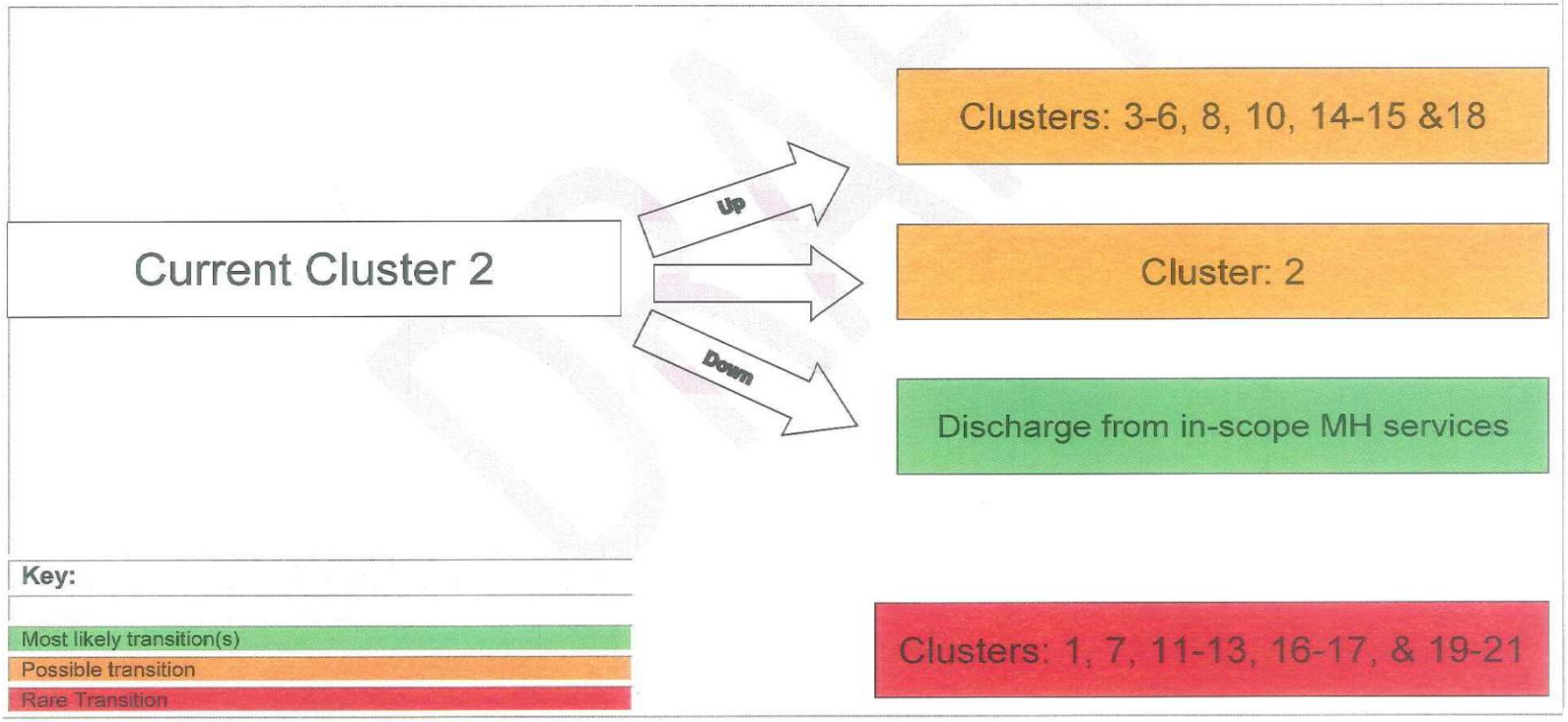
Mental Health Clustering Booklet (V3.0) (2013/14)

CARE TRANSITION PROTOCOLS - Cluster 2: Common Mental Health Problems

Indicative episode of care: 12 – 15 weeks

Cluster reviews at least every: 15 weeks

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
2	• Service User fits description and scoring profile of any listed 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 0 • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less	N/A



Calculating Prices

- Original principle was that price = cost (i.e. no cross-subsidisation between activities and no profit)
- Trusts now need to generate some profit, and price is now seen much more as a tool to deliver particular outcomes or changes in operating practice
- Traditionally, NHS prices are based on reference costs
  - costs for 2011-12 would inform tariff for 2014-15
- Reference costs are subject to a highly prescribed costing process, which basically involves allocating costs to all activities, with a lot of averaging, particularly of indirect costs and overheads
- PLICS being introduced to improve quality of costing information and related management information and control

Objectives of PbR

- Facilitate patient choice of provider
- Enable diversity of provision
- Introduce some of the benefits of a market without having to negotiate the cost. Reward quality more!
- Refocus discussions between commissioner and provider
- Promote efficiency at higher cost Trusts (because they have to reduce costs to a national tariff level) and there is more standardisation of pathways
- Allow lower cost trust to invest in service development

PbR is about providing better quality care tailored to the patient's need, using money as an enabler

Useful references

- Acute sector PbR documentation
  https://www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs
- Information on Best Practice tariffs can be found in chapter 8 of PbR Guidance 2013-14, with specific information on the paediatric diabetes BPT in paragraphs 482 – 489 (pages 97 – 100)
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214902/PbR-Guidance-2013-14.pdf
- MH PbR documentation
  https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14