

## Payment by Results (PbR)

### URGENT ACTION!

**From when your clinic opens on Monday 3 April, your coding for PbR needs to be in place – every attendance accurately logged as new or follow-up (according to PbR criteria) and every patient attributed accurately to a PCT area.**

*Please ensure that your office manager is aware of this, and make contact with your finance department if you have not already done so.*

From 1 April 2006, Payment by Results (PbR) will be operational for Genitourinary Medicine **in England**. For Foundation Trusts, this is nothing new. PbR changes the arrangements for funding providers of care. For detail, go to:~  
<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en>

### Implications for Genitourinary Medicine

Service leads will need to provide accurate data in respect of clinical activity and do this on a monthly basis. This will have to be in a timely fashion (for example, data for April may be required on 15 May, depending on local arrangements). This is so that your Trust can charge the relevant PCT for the work undertaken. It is, therefore, imperative that your service does record the PCT. Attendances must be mapped to the GP or home residence if the GP is unknown or if neither, the patient should point to a map and a PCT code entered. **Entry of the FULL POSTCODE on your system is strongly recommended for all patients attending.** This is for your audit trail – it is not for sharing outside your service (although you could share the first 3 or 4 digits which identify PCT). By one mechanism or another, those patients who attend your service must be accurately mapped to the relevant PCT (and you will be audited to check the accuracy).

PbR is a fairer system because:~

- It rewards providers for the work undertaken and encourages efficiency.
- It supports patient choice.
- It increases transparency of hospital funding.
- PCTs pay the same tariff wherever the activity is undertaken under PbR

All clinics should at least be aware of the following tariffs for GUM:

New	£142
Follow-up	£79

### Definitions of New and Follow-up

#### **New**

- Never attended the service before or
- First time referred to consultant or
- Discharged last time the patient attended or

- Attendance is not related to previous visit or
- More than 26 weeks since last visit to clinic

### **Follow up**

- This is a face to face consultation (non-face to face consultations do not attract payment for 2006/7 - Dept of Health will review in future).

### **Work with your Finance Departments**

It is very important that you contact your Director of Finance to ensure that you are clear about the local reporting arrangements that will apply to your service. It is most likely that your finance/contracts department will require the above information on a MONTHLY basis. It is likely that they will need the information by 15<sup>th</sup> of the each month (for example, information relating to the activity in May 2006 may be needed by 15 June 2006 in order to ensure payment by the end of June).

There are a number of mechanisms in place to facilitate full implementation of PbR and also even out the current local variances in costs in different parts of the country (e.g. Market Forces Factor).

### **Code of Conduct**

All bodies operating PbR are required to comply with the Code of Conduct and Assurance Framework (the implementation of which will be managed by the Audit Commission).

### **Working out Trust Revenue**

For **every PCT** from which your patients attend, your finance department will calculate as follows:-

#### New

- £142 x MFF x total number of PCT new attendances from that PCT

#### Follow-up

- £79 x MFF x total number of PCT follow up attendances from that PCT

*(MFF is Market Forces Factor, which is paid directly to Trusts from DH, so PCTs pay the same tariff for the same activity to all providers they commission with, regardless of where they are located).*

### **Host funding and cross charging**

Some GUM services are host-funded (where the funding for the service comes directly to and then from, the host PCT). Others are funded through a PCT consortium.

Where GUM services are host-funded, the 'non-hosting' PCTs would not have received the central allocations for their patients attending the host-funded GUM clinic. If they then receive a request for payment from a provider trust, they would not be in a position to pay. Thus, for the exceptional patient attending a host-funded GUM clinic for whom there is no PCT of GP or PCT of residence data, it would be fair to charge this to the host PCT.

Where funding has been through a consortium, I believe some local negotiations will need to take place to ensure that all GUM attendances are funded – even if the patient is resident outside the consortia PCT area.

Clinics vary greatly as regards their current data collection systems, but from 1 April 06, the collection of appropriate data to support PbR is a must do for your service. Under paragraph 3.1.2 of the 'Operation of the Secondary Uses Service (SUS) to Support Payment by Results' (July 2005) GUM services are specifically excluded from the otherwise mandatory requirement to provide named patient data for PbR. However, procedures need to be in place to ensure accuracy of this information and the information should be anonymised by the time it leaves the GUM service. However, an audit trail must be in place and ***you will be required to provide the evidence*** – if the data are on your system, the evidence is there.

### **Services currently excluded from PbR**

- Independent & voluntary services
- Outpatient HIV/AIDS
- Contraception services

Services will need to differentiate between HIV/AIDS workload from GUM workload and collect data on new and follow-up HIV/AIDS attendances.

### **Opportunities**

For those offering an accessible, quality service that patients wish to attend, the advantages of PbR are clear-cut.

### **Risks of PbR**

Complicated (and costly) cases that require several extra interventions may attract the same income under PbR as the relatively simple (and inexpensive) asymptomatic screens. Thus, the viability of some services may depend on the ratio of complicated to uncomplicated cases.

### **What about integrated services?**

Where the purpose of the visit is predominantly GUM related, it would appear sensible to charge under PbR and to apply the usual practice of PCT funding of contraceptive services for contraceptive consultations.

My personal view is that PbR enables those Trusts that house accessible services to be rewarded for the work they undertake and PbR provides incentives to see more patients (and the means to employ extra staff). PbR thus supports improvements in 48-hour access.

We all know what patients want:-

- To be seen quickly by people with the skills
- To be seen where they choose to attend (and this is generally locally)
- To have their confidentiality respected

Clinicians should continue to improve access to their clinics, improve efficiency and improve quality. Clinicians are not Directors of Finance, but they certainly need to be in contact with their finance departments.

In order to improve the quality of your service, attract staff (or at least avoid losing them) you need to provide your finance department with the relevant information to code the activity and indicate the relevant PCT.

To put this in context, assume for now that in one morning you see 6 new patients and 3 follow ups per clinic (ignore the MFF for the moment and any considerations around your baselines). If you fail to inform your finance department with the PbR and PCT information they need (see definitions above) the income that your trust would lose for your session is **£1,089**.

If we assume that 5 people in your clinic work at the same rate and these five people undertake 8 sessions a week each, the loss of income per week is **£43,560** and, for a 50 week year, **£2,178,000**.

Thus, at long last, your trust has an interest in ensuring that you are enabled to see as many patients as possible. Under PbR, if your basic administration systems are weak this will result in a major loss of income for your trust. So, if before 1 April 2006 you have struggled to persuade your trust of the need for a new IT system, printers, extra rooms in which to see patients etc, you may find that doors do now open.

### **Costs of Locally Enhanced Service (LES) or Nationally Enhanced Service (NES)**

PbR does not apply in all settings. For example, some activity will take place in primary care in the context of a LES or a NES. This provides patients with more choice and, if part of additional capacity building, will improve access.

Although cost is not the only consideration, it is an important exercise to undertake a cost analysis for the provision of sexual health services in various settings outside the PbR structure in order to demonstrate cost efficiency and effectiveness. To illustrate this, take two hypothetical examples:~

#### **Example 1: a LES for £120**

If all diagnostic and therapeutic costs are taken into account within the LES, this is cost effective. It would be cost effective to support this service. Such services would, of course, need the appropriate support and training to ensure quality. Also, the potential to de-stabilise existing services funded through PbR should be considered.

#### **Example 2: a NES for £105**

In this example, a national rate of payment is indicated (£105)

Diagnostic costs of, say, £50 may not be included

Incentives for other tests of, say, £30 may not be included

This example would actually cost £185 and would not be cost-efficient as the total cost is above the PbR rate. In addition, the potential effect on PbR funded services should, again, be taken into consideration. Clearly, it is not cost-efficient for a PCT to support a NES costing

more than the PbR rate (although other considerations such as local access might apply). It is therefore critical to **include all the direct and indirect diagnostic, therapeutic and other costs** in calculating the cost efficiency of the NES.

If all relevant costs are included, the true cost is apparent. The consequences of a miscalculation are that one service may appear relatively expensive when, in fact, it is not. This is how services can close under PbR. Also, apples are not pears – services that cost the same may be very different in other respects.

### **Tariffs will probably change**

And when they do, this will again affect the interface between the various providers (if cost were the only consideration).

### **Top slicing**

The extent of top slicing by trusts for capital charges, laboratory costs, other overheads associated with (or unrelated to) running the service will affect how much additional funding from PbR actually reaches the service providers. PbR is paid to trusts, not directly to services.

### **Clinical Governance**

It is imperative that service provision, whether at levels 1, 2 or 3 is of high quality and subject to proper clinical governance processes. Training, support and networks are essential. It is not in the interests of those providing services within the context of a LES or NES (or those commissioning them) to de-stabilise the level 3 service. Likewise, those working in level 3 services have a pivotal role in supporting levels 1 and 2. Wherever we, as individuals, are based, we share a duty to work with colleagues in ways that best serve patients' interests.

### **Open access**

Open access to Genitourinary Medicine services is key. PbR provides a mechanism that enables Trusts, in partnership with others, to support increasing capacity in order to meet the 48-hour access target.

This letter follows the Clinical Governance Meeting on Friday 31 March at which PbR was discussed. At the meeting, it was clear that an urgent communication along these lines (intended to get to your office manager & reception staff on Monday morning) was in order. For any misunderstandings or miscalculations on my part, I can only apologise – this is a hurried response and I am not an expert on PbR. Apologies for the delay - the letter became more complicated than I had originally intended.

Far more authoritative guidance on PbR will come from others such as Immy Ahmed, Vanessa Griffiths and the BASHH IT Group in due course. This will come to you via the chair of your BASHH Regional Branch or will be posted on the BASHH website.

**Mike Abbott**

Chair, BASHH Clinical Governance Committee

5 April 2006