



THE CHARTERED SOCIETY OF PHYSIOTHERAPY



PAYMENT BY RESULTS

The new funding system for the NHS in England:
practical support for Allied Health Professionals

Acknowledgements

The Chartered Society of Physiotherapy (CSP) wishes to thank Noel Plumridge CPFA for his expertise and enthusiasm in developing this workbook. We also particularly wish to acknowledge the time and effort freely given by the following therapy managers during the preparation of this workbook:

Alison Balkas

East Lancashire Hospitals NHS Trust

Enid Feather

Airedale NHS Trust

Angela Karck

Sheffield Children's NHS Trust

Val Steele

Bradford Teaching Hospitals NHS Foundation Trust

© 2005 Chartered Society of Physiotherapy.
Any part of this publication may be freely reproduced for non-commercial purposes and with appropriate acknowledgement.

PAYMENT BY RESULTS

The new funding system for the NHS in England

Practical Support for Allied Health Professionals

A workbook

May 2005

i

About this workbook

Payment by results is still a relatively new policy initiative. It is not yet three years since the Department of Health (DH) originally proposed the introduction of tariff-based funding in the NHS in England. At first it seemed to be largely intended for accountants and finance departments: the title of the first DH publication, *Reforming NHS Financial Flows*, perhaps encouraged this.

The Chartered Society of Physiotherapy (CSP) has however recognised for some time that therapists need to understand, and work with, this new approach to NHS funding. In May 2004 we organised, for the Allied Health Professionals Federation (AHPF), a major conference that explored its likely impact on the allied health professions. The conclusions from that day led us to the present publication.

We believe that we need simultaneously:

- to support allied health professionals (AHPs) and AHP managers in the NHS, who are increasingly working within the payment by results regime, with practical guidance and information about the new funding system
- to influence the way payment by results develops, so that the contribution of the allied health professions to modern health care is properly and appropriately reflected.

This publication seeks to address the first of these needs.

However, we assure members and colleagues that we are also active in the second area, and intend to remain so. We are particularly keen to support the Department of Health as it tries to design meaningful healthcare resource groups, and ways of measuring activity, that reflect what we actually do from day to day.

Finally, this is a workbook, not an essay. Although it can be read from cover to cover in one sitting, we would strongly encourage readers to use it as a training resource, and take time to undertake the tasks printed in *blue italics* along the way. Many of these ask the reader to follow internet links, so we would also urge readers, wherever possible, to use this workbook alongside a computer.

Our main examples are taken from the world of physiotherapy. However, it is entirely possible to replace them

with relevant examples from any of the other AHP-led professions. We would encourage anyone using this workbook as a training tool to identify suitable examples from within their own professional sphere.

We do not believe that this workbook contains anything that a capable AHP manager will find overly daunting. The skills and knowledge that it calls upon are those that tomorrow's allied health professionals will need and expect.

Contents

- 1 Payment by results – what is it?
- 2 Key elements of payment by results
- 3 The policy context
- 4 Reference costs
- 5 What does payment by results mean for allied health professionals?
- 6 Where should allied health professionals begin?

Annexe one

Summary of useful Department of Health guidance and information.

1

Payment by results – what is it?

A new approach to NHS funding

Payment by Results is a radically different way of funding NHS services in England. Following trials in first wave foundation trusts during 2004-05, it has been extended from April 2005 to cover elective activity, across a broad range of specialities, in all NHS hospitals in England.

In 2005-06 about 27 per cent of hospital income will come via payment by results. This is expected to rise to around 70 per cent in 2006-07, when the system will be extended again to cover non-elective activity, out-patient appointments, accident and emergency departments, and adult critical care services.

There are also plans to include primary care and mental health care, probably from 2008.

At first, payment by results received less publicity than the other major structural changes – including the creation of foundation trusts, independent sector treatment centres and the introduction of “choose and book” and structured patient choice – that are transforming the NHS in England. It is, however, an essential building block for those changes. In recent months the true importance of this new approach to funding NHS care has become widely recognised.

For practical purposes the old method of funding NHS trusts, and by extension the AHP services within them, is already disappearing. Negotiations for 2005-06 have followed a significantly different pattern. In the past we typically started from the previous year’s funding “baseline”. This would be adjusted for inflation, agreed cost pressures and a savings (“efficiency”) target. The final agreement commonly took the form of a “block” agreement between the trust and its commissioner: an agreed cash sum in return for a defined level of activity. In 2005-06, however, around 27 per cent of trust income – more in foundation trusts – is determined by the national tariff.

How does it work?

(a) a price for a hospital in-patient procedure

For each of about 530 “healthcare resource groups” (HRGs), the Department of Health publishes a price for an in-patient spell in hospital. In fact, in most cases, it publishes two prices: one for an elective-spell, and one for a non-elective spell. (A “spell” refers to a spell in hospital, from admission to discharge). For instance, the national tariff for 2005-06 includes:

HRG code	HRG name	Elective spell tariff £	Non-elective spell tariff £
H01	Bilateral primary hip replacement	6362	6362
H03	Bilateral primary knee replacement	7211	7211
H04	Primary knee replacement	5376	5412
H07	Primary or Revision Shoulder Elbow or Ankle Replacement	4326	4834
H08	Joint Replacements or Revisions, Site Unspecified	3612	6149

These prices are the national average NHS costs for the procedure in question in 2003-04, adjusted for inflation. They are derived from the “reference costs” that all NHS providers calculate and submit to the Department of Health as part of their annual accounting process. They therefore reflect the **actual** cost of procedures – or as close to the actual cost as our systems allow – rather than a budgeted cost.

These actual costs include a share of all the support functions and overheads of the trust: from diagnostics to building maintenance, from the cost of cleaners to the cost of the chair and chief executive. Each of the five sample HRGs includes AHP costs.

Additional payments are made for patients with an extended length of stay. For instance, after 23 days in hospital a patient

with a bilateral primary hip replacement earns the trust a further £115 per day.

Go to:

<http://www.dh.gov.uk/assetRoot/04/09/15/32/04091532.xls> which holds the tariff for 2005-06, and locate the "admitted patient care tariff". Spend a few minutes browsing through the list of HRGs and their prices.

(b) a regional adjustment

The cost of running a hospital varies from one part of the country to another, and an adjustment is made to reflect this differential. This is a regional adjustment: it does not attempt to reflect the actual local costs (for instance, the buildings) of each individual hospital. This adjustment is known as the "market forces factor", and takes the form of a multiplier. For instance:

RTV	5 BOROUGH PARTNERSHIP NHS TRUST	1.086207
5L8	ADUR, ARUN AND WORTHING	1.119265
REM	AINTREE HOSPITALS NHS TRUST	1.061669
5AW	AIREDALE	1.062248
RCF	AIREDALE NHS TRUST	1.057801

Note that the list includes both NHS trusts and primary care trusts.

Go to:

<http://www.dh.gov.uk/assetRoot/04/09/78/89/04097889.xls> and find the market forces factor for your own organisation. Also look up the market forces factors for some neighbouring trusts and decide whether they seem reasonable.

(c) income calculation

The price multiplied by the market forces factor represents the amount of income an NHS trust can expect to receive for each procedure it undertakes, up to the total volume agreed with its commissioners. Thus a bilateral primary hip replacement undertaken at Aintree Hospitals NHS Trust earns:

$$\frac{\text{National tariff}}{\text{£6,362}} \times \frac{\text{market forces factor}}{1.061669} = \text{Income of } \text{£6,754}$$

while the same procedure at Airedale NHS Trust earns:

$$\frac{\text{National tariff}}{\text{£6,362}} \times \frac{\text{market forces factor}}{1.057801} = \text{Income of } \text{£6,730}$$

Using the national tariff for 2005-06 and your local market forces factor, calculate what the following procedures would earn for your trust:

- intracapsular neck of femur fracture with fixation, without complications (H85) – length of stay 32 days
- head injury without brain injury (P31) – length of stay 14 days

(d) out-patients and accident and emergency

Tariffs are also published:

- for out-patient attendances. For instance, the 2005-06 tariff includes:

Outpatient Specialty code	Outpatient specialty name	Adult first attendance tariff £	Adult follow-up attendance tariff £
100	General surgery	146	77
110	Trauma and Orthopaedics	133	67
340	Thoracic Medicine	214	109
430	Geriatric medicine	267	122

with higher prices for a first out-patient attendance reflecting the longer duration of first appointments. Some 40 specialties are identified, and separate (higher) prices are listed for out-patient attendances by children aged under 17.

- for accident and emergency attendances. There are only three prices in 2005-06:

A&E tariff name	A&E tariff (£)
High cost attendance	93
Standard attendance	61
Minor injury unit attendance	35

In 2005-06 the tariffs for non-elective in-patient care, out-patient attendances and accident and emergency attendances apply to foundation trusts and some early implementers only.

Further guidance

In essence the new system is simple. It is, however, very different to the funding regime the NHS has known for much of its existence, and we are still trying to come to terms with its full ramifications. Complexities that have already emerged include:

- should activity in excess of that agreed in advance by commissioners be paid for at full tariff rate?

8 Payment by Results The new funding system for the NHS in England

- what if hospitals deliberately change their procedures to increase the number of chargeable “spells”? (There has, for instance, been an increase in the number of admissions via accident and emergency with very short lengths of stay).
- what if hospitals are simply counting their activity better?
- what if the HRG definitions are not precise enough? The examples given above are for well-defined and relatively finite procedures, but we could equally cite:

HRG code	HRG name	Elective spell tariff £	Non-elective spell tariff £
A11	Muscular disorders	996	3354
D21	Asthma w cc	1939	1975
E35	Chest pain >69 or w cc	912	797

There is a growing body of DH guidance on the detailed operation of payment by results. This small publication cannot attempt to cover all the subtleties of the new system. A summary of the principal DH links appear in Annexe 1.

Go to:

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en> and spend a few minutes familiarising yourself with the range of guidance that is available on the DH website. There is no need to download all the documents, but now you will know where to look for it, and where to find updates.

Does the tariff apply to the independent sector too?

Eventually the national tariff is expected to apply equally to independent sector and NHS providers. Indeed, one of the main reasons for introducing this system of funding was to encourage independent sector providers, who needed reasonable confidence about what they might be able to earn before they would commit to long-term investment.

In the short term, however, most agreements with the independent sector treatment centres have been negotiated separately.

What about non-acute care?

For the time being, the payment by results system does not cover non-acute care. The DH is currently working on a set of healthcare resource groups (or similar classifications), and methods of counting, that are suitable for primary care and for the management of long term conditions outside of hospitals. The intention is that the payment by results system will then be

extended to cover non-acute care. This is not expected to happen before 2008.

It is not yet clear whether the system will in time be extended to cover the care of people with learning disabilities.

There are, however, some immediate implications for clinicians working in primary care.

Firstly, there is already evidence that acute hospitals are responding to the new tariff-based funding system by increasing their levels of in-patient activity, and then demanding extra payment. In some ways this is a reasonable response to the financial prompts within the new funding system, which are often reinforced by DH targets. However, within a cash-limited system this can only squeeze the resources available for other parts of the NHS. Some primary care trusts are being forced to limit their funding for non-acute care, including their own “provider arms”, to balance their books.

Secondly, AHPs know as well as anyone that the boundaries between primary and secondary care are not rigid. This is particularly true of care arrangements for children and for older people. With acute hospitals being driven to make efficiency savings, there may well be a tendency to ask primary care to do more – but without a matching transfer of funding. There are likely to be particular pressures on AHPs working in paediatric care, as it is already clear that specialist children’s hospitals, in common with other specialist hospitals, face particular difficulties under the tariff system.

What about the rest of the United Kingdom?

At present there are no plans to introduce payment by results in Wales, Scotland or Northern Ireland, although the basic building blocks it uses for costing activity within the NHS – the healthcare resource groups – have been used across the UK since the early 1990s

However, there are signs that the national tariff for England is starting to be used as a benchmark for examining the cost-efficiency of health services in the remainder of the United Kingdom. Since the tariff:

- is easily accessible via the internet
- is the average of actual costs from a large number of NHS providers

it is not surprising that commissioners and managers outside England are already finding it useful when examining their local costs and activity levels.

2

Key elements of payment by results

The national tariff

The national tariff has already been outlined in chapter 1 above. Note that each tariff line has three important components:

- **a definition.** For in-patient activity this is the healthcare resource group or HRG, which is itself backed up by a detailed clinical definition. One of the tests of the robustness of proposed new HRGs will be whether the definition is clear enough to distinguish it from other HRGs.
- **a currency.** For in-patient activity this is now the spell: that is, a spell in hospital. This has replaced the finished consultant episode (FCE), largely because of suspicion that some NHS trusts might be transferring patients internally, without clear clinical cause, in order to increase their numbers of recorded FCEs.
- **a cash amount.** This has so far been based on the NHS's average cost.

Healthcare resource groups

The DH defines HRGs as groupings of treatment episodes that are similar in resource use and clinical response. They are a standard method of analysing clinical procedures, and therefore of classifying hospital activity.

The groupings are set nationally, and are widely accepted and understood. They have not, however, been designed with funds flow in mind, and in non-acute areas they remain relatively undeveloped. Therapists in general do not classify their clinical activity by HRG.

Current HRG definitions can be found at:
www.icservices.nhs.uk/casemix/pages/tools/asp

You may wish to obtain advice from your organisation's information specialists on how these definitions are currently being interpreted in practice.

The Department of Health is working on a new and more

comprehensive set of HRGs (or similar) to support the extension of payment by results. It is expected to be ready by 2008.

The market forces factor

The market forces factor is an adjustment to the tariff that reflects the different costs of providing healthcare in different parts of the country.

The original market forces factor was the index used within the NHS resource allocation system to adjust for unavoidable variations in input costs. Its components are staff costs, London weighting, land, buildings and equipment. This has now been replaced by an index constructed specifically to support payment by results.

NHS reference costs

NHS reference costs are an analysis of what the NHS actually spent, HRG by HRG, in the financial year that recently finished. They are a standardised presentation of the costs of NHS services, prepared and published annually.

The *NHS Costing Manual*, a detailed guide to costing healthcare provision, specifies how they are to be calculated. The underlying intention is to allow comparisons between services through the use of a consistent approach to costing.

Reference costs also form the basis of the national tariff under payment by results. However, while reference costs apply to the whole cost of an NHS organisation, the payment by results tariff only currently covers part of the cost.

The 2005 reference cost returns, which cover financial year 2004-05, are due at the Department of Health on 30 June 2005. We are strongly encouraging AHP managers to contribute actively to this process. Chapter four suggests how you might do so.

What is the difference between reference costs and the tariff?

There are two essential differences:

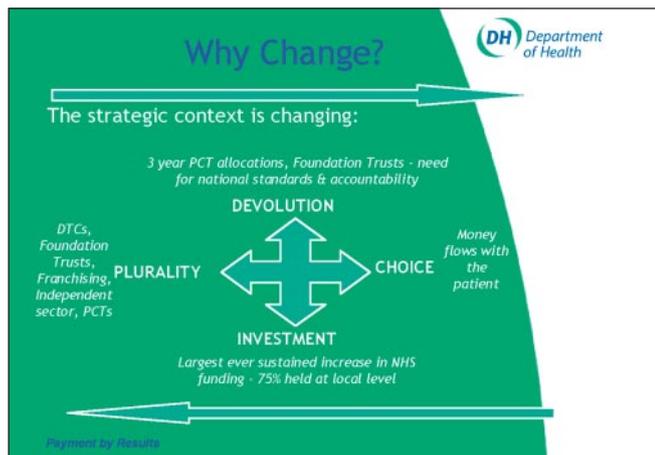
- Reference costs are retrospective; the tariff is prospective. In practice this means that the reference costs for 2004-05, plus two years' inflation, will form the tariff for 2006-07. (Some data cleansing and other adjustments also take place).
- The tariff only covers covers part of NHS activity. Reference costs cover a larger proportion of the activity undertaken by an NHS provider.

3 The policy context

Policy initiatives

Payment by results has never been an end in itself. It is, however, a vital building block for a number of important health policy initiatives that are in the process of being implemented.

In its autumn 2003 consultation on some technical aspects of the new funding system, the DH identified four principal policy directions that payment by results was intended to underpin. They are shown on the following diagram, reproduced from that consultation document:



- **devolution**: the belief that important decisions should be taken as close as possible to the patient, though within a national framework of standards and accountability. Practice based commissioning, which gives GP practices direct financial control of the way health care is organised and provided, is the latest manifestation of this policy.
- **choice**: the belief that patients should be able to take key decisions about the care they receive from the NHS. Thus far the national choice initiatives, such as "choose and book", have focussed mainly on where care is given: from December 2005 patients are to be given a choice of four or five hospitals for elective procedures.

Using a national tariff makes such choices (almost) cost-neutral for NHS commissioners. However, choice brings markedly increased financial risk for NHS providers, as their income is no longer predictable.

Go to:

http://www.dh.gov.uk/PolicyAndGuidance/PatientChoice/Choice/ChoiceArticle/fs/en?CONTENT_ID=4081958&chk=%2BS%2BHWz

and browse the DH's current plans for strengthening patient choice. Consider how, as choice becomes as much about the manner of treatment as its location, allied health professions might be affected – and might market their services.

- **plurality**: the belief in a "mixed economy" of public and private sector healthcare provision. AHPs have for many years worked in independent practice and private hospitals as well as within the NHS, so the concept of provider plurality is nothing new. However, the last two years have seen very rapid growth in independent sector hospital provision in England, mainly in the form of treatment centres. Payment by results makes the price of each procedure transparent to all.

Foundation trusts, which are required to operate as if they were free-standing businesses, can be seen as part of this transition to a mixed economy.

Spend a few minutes taking stock of how "mixed" your local health economy currently is. Which NHS trusts have become, or are becoming, foundation trusts? Are there any independent sector treatment centres, and if so, in which specialities?

- **investment**: the huge investment that the NHS has seen in recent years comes with a condition that the NHS must spend the money wisely and efficiently. The national tariff is not only the new basis of funding for the NHS; it also provides a series of benchmarks against which we can measure our relative costs. It is now common for trust boards, when faced with

12 Payment by Results The new funding system for the NHS in England

financial difficulties, to compare the trust's own reference costs with the national tariff, specialty by specialty, and ask for savings in those specialties where the trust is an outlier.

As long as governments hold these values dear, they are likely to insist on payment by results – or something like it – as the financial building block for the NHS. Moreover, most European governments have now moved, or are rapidly moving, to some form of tariff-based, casemix-adjusted funding.

We can reasonably assume that, for the foreseeable future, payment by results is here to stay. And these values are as strong in respect of primary care as they are for hospitals.

Pressures and speed of implementation

Although many nations now operate some form of tariff-based funding, few have tried to introduce it as quickly as the DH in England. Indeed, when it was announced in January 2005 that non-elective in-patient care would not be covered by the tariff in 2005-06, other than in foundation trusts, many felt that a real risk of destabilisation had been removed. This (temporary) delay reduced the proportion of acute hospital income covered by payment by results from 70 per cent to around 30 per cent.

The reasons for the accelerated implementation, followed by a late application of the brakes, lie in the DH's high-priority drive to improve access to acute care. In 2002, when tariff-based funding was first announced, the NHS still did not have the capacity to offer hospital appointments within nine months to all. Payment by results, it was hoped, would address this in two ways:

- by promoting greater efficiency amongst existing NHS hospitals, as part of an environment that encourages competition and choice
- by encouraging the independent sector to introduce new capacity

Arguably it has already worked. The NHS, for practical purposes, had achieved a nine-month maximum wait for all by the summer of 2004, and is now pursuing further improvements in access. However, during 2004-05 the NHS experienced a degree of associated turbulence:

- reported activity levels amongst the new foundation trusts, which were piloting the new funding system, were significantly higher for procedures covered by the tariff – and commissioners had not set aside funds to pay for it
- this led in turn to conflict between commissioners and foundation trusts, both of which were required under the new regime to stay in financial balance.

Meanwhile, it has become apparent that while a relatively simple tariff-based system might work well for in-patient care, a more sophisticated approach is needed for the more complex care

pathways to be found:

- amongst the long term ill. Payment by results offers a perverse incentive to admit chronically ill patients to hospital, whereas in clinical terms unplanned hospital admission often represents a breakdown of care.
- in mental health. Starting in April 2005, 18 mental health trusts are piloting new methods of patient data analysis that will hopefully lead to a meaningful HRG set in mental health. Up to now, this has not been done successfully anywhere in the world.
- in primary care, where there are long-acknowledged difficulties in measuring clinical activity and where information systems are generally less well developed.

We can probably now expect the introduction of payment by results in these areas to be a little slower and more measured.

4

Reference costs

Familiarisation – the 2004 national reference costs

The latest published edition of reference costs is for financial year 2003-04.

(a) the reference cost index

The National Reference Cost Index gives a single figure for each NHS provider. This compares the actual cost of its activity in 2003-04 with the cost of the same activity at national average costs.

Go to:

<http://www.dh.gov.uk/assetRoot/04/10/55/52/04105552.xls> which is the national reference cost index for 2004, and look up for your own organisation:

- column D (organisation-wide index including excess bed days)
 - column E (organisation-wide index excluding excess bed days)
- On a scale where 100 represents the national average, this shows whether your organisation cost more or less, overall, than the national average. Thus a score of 115 shows costs that are, overall, 15 per cent above the national average; a score of 80 shows costs that are, overall, 20 per cent below the national average.

Now scroll through columns F to L and note the relative contributions of elective and day case care, non-elective inpatient care, critical care, outpatient services, community services and mental health.

Disregard the "market forces factor" index on this table: it is out of date. Note that information is available for GP practices operating under PMS plus as well as NHS trusts and primary care trusts.

(b) the schedule of reference costs

The National Schedule of Reference Costs shows, for each HRG:

- the total number of reported procedures (in finished consultant episodes)
- the national average unit cost

- the range of unit costs submitted (excluding some extreme high and low costs, to avoid data distortion)
 - the average length of stay, in days, for the HRG.
- This information is found within a sequence of tables in spreadsheet format, the first of which covers NHS trust activity. For example, for H04 (primary knee replacement):
- 46,199 FCEs were reported in 2003-04
 - the national average unit cost was £5,313 – slightly less than the 2005-06 elective spell tariff of £5,376
 - the range of costs ran from £4,704 to £5,938
 - the average length of stay was 9 days.

Go to:

<http://www.dh.gov.uk/assetRoot/04/10/55/53/04105553.xls> and find the five orthopaedic procedures (H01, H03, H04, H07, H08) for which the 2005 tariff was listed in chapter 1. Then scroll up and down the list of HRGs, looking particularly at the number of FCEs reported. Identify five other HRGs:

* where you would expect there to be significant input to patient treatment from your own profession

* where the volume of activity is relatively large

Note that selecting print preview will provide details of the type of data in each schedule, eg day case

Although the initial focus of payment by results has been hospital activity, the annual reference cost collection covers the full range of AHP activity. This information is spread throughout the NHS trust tables, which we have just been using, and further tables that cover primary care trusts and PMS-plus pilots.

Go to:

<http://www.dh.gov.uk/assetRoot/04/10/55/57/04105557.xls> which is the appendix for PCTs, and find the national average unit costs, and related data, for direct access physiotherapy, occupational therapy and speech and language therapy.

14 Payment by Results The new funding system for the NHS in England

They are summarised as follows:

Direct Access Therapy Services Data	No. of First Contacts in Financial Year	National Average Unit Cost (£)
Direct Access Physiotherapy Services : Adult	338,950	107
Direct Access Physiotherapy Services : Child	17,025	134
Direct Access Occupational Therapy Services : Adult	53,162	202
Direct Access Occupational Therapy Services : Child	3,294	244
Direct Access Speech Therapy Services : Adult	18,981	327
Direct Access Speech Therapy Services : Child	17,395	290

The equivalent data for NHS trust direct access therapy services can be found back at: <http://www.dh.gov.uk/assetRoot/04/10/55/53/04105553.xls>. It reads as follows:

Direct Access Therapy Services Data	No. of First Contacts in Financial Year	National Average Unit Cost (£)
Direct Access Physiotherapy Services : Adult	475,405	87
Direct Access Physiotherapy Services : Child	33,311	87
Direct Access Occupational Therapy Services : Adult	54,805	75
Direct Access Occupational Therapy Services : Child	13,441	85
Direct Access Speech Therapy Services : Adult	12,620	141
Direct Access Speech Therapy Services : Child	19,914	212

Note that there are marked cost differences. In a hospital, for instance, direct access adult physiotherapy cost, on average, £87 for each first contact. Within a PCT the equivalent amount was £107, nearly a quarter as much more. Why might this be?

Staying within the tables for primary care trusts (<http://www.dh.gov.uk/assetRoot/04/10/55/57/04105557.xls>) locate the national average unit costs for community therapy services. They are:

Service Code	Direct Access Therapy Services Data	No. of First Contacts in Financial Year	National Average Unit Cost (£)
N5A	Direct Access Physiotherapy Services : Adult	1,015,433	118
N5C	Direct Access Physiotherapy Services : Child	89,890	274
N6A	Direct Access Occupational Therapy Services : Adult	290,722	198
N6C	Direct Access Occupational Therapy Services : Child	54,068	323
N7A	Direct Access Speech Therapy Services : Adult	150,691	233
N7C	Direct Access Speech Therapy Services : Child	285,821	289

Next go to

<http://www.dh.gov.uk/assetRoot/04/10/55/55/04105555.xls>

which is the table for PMS-plus pilots, and locate the equivalent data for community physiotherapy. It reads as follows

Service Code	Direct Access Therapy Services Data	No. of First Contacts in Financial Year	National Average Unit Cost (£)
N5A	Direct Access Physiotherapy Services : Adult	4,753	32
N5C	Direct Access Physiotherapy Services : Child	72	21

but is based upon a much smaller data source.

What conclusions, if any, can be drawn from these sometimes marked differences between therapy unit costs? Are they more likely to reflect differing clinical activity or data collection issues?

Your organisation's own reference costs

Reference costs combine:

- cost data, which is taken from the accounting system after year end; and
- activity data, which is collected through the year.

The costs and activity associated with physiotherapy, occupational therapy, speech and language therapy and indeed nearly all the allied health professions – along with many other important areas of NHS activity – do not fit neatly into the current set of healthcare resource groups. In addition, analysing the costs of AHP staff between specialties, or even between hospital and community, is sometimes far from straightforward.

The reference cost information on the Department of Health's website:

- shows the relative cost of whole organisations, with some rudimentary sub-division
- shows the national average cost for a long list of activity categories

but does not reveal the actual cost of each HRG for your own organisation. Yet somehow the whole cost of each allied health profession in 2003-04 was absorbed into the reference cost return and spread across specialties, and then into individual HRGs.

Details of individual unit costs by HRG and specialty are available for your own organisation on CD-ROM. Your finance department will have a copy of this.

In practice the finance department will have apportioned all costs on some – hopefully reasonable – basis.

Identify who within your finance department prepared and submitted the 2003-04 reference cost return. (This work is commonly done by a management accountant or a cost accountant). Ask:

- what the organisation's total spend on your profession or department was in 2003-04
- how it was apportioned for the purpose of the reference cost return

If you believe a more accurate basis of apportionment could have been used, resolve to provide that data for the 2005 collection!

The 2005 reference cost collection

(a) general

For the 2005 reference cost collection, the costs of the allied health professions are to be reported in one of five categories:

- as part of a composite inpatient cost, where care is provided during an inpatient stay
- as part of a composite outpatient cost, where care forms part of an outpatient attendance or where the patient remains under the care of an outpatient consultant
- as outpatient therapy services, where treatment takes place in a hospital setting, the patient has been discharged from the care of a hospital consultant, and a clinical professional other than a GP has referred the patient for treatment
- as direct access therapy services, where treatment is carried out in a hospital setting, the patient is not under the care of a hospital consultant, and a GP has referred the patient for treatment
- as community-based therapy services, where treatment is carried out in a community setting, regardless of the source of referral.

This analysis is important. It is likely to determine the future tariff for AHP-led care.

(b) outpatient therapy services

For the 2005 reference cost collection, new outpatient categories have been introduced for physiotherapy, occupational therapy and speech and language therapy. These are for use "where the patient has been discharged from the care of a hospital consultant, and where referral for treatment carried out in a hospital setting has been made by a clinical professional other than a GP." For other AHPs there is no change in 2005. (2005 Guidance, p31).

(c) direct access and community therapy

For the 2005 reference cost collection, an important change is being made to the currency for direct access and community-based therapy services. Data must be reported for the total number of contacts in the financial year (not first contacts).

Because of the volume of data involved, and the general weakness of recording systems, organisations are allowed to use:

- "appropriate and reflective sample data" instead of data covering the whole of 2004-05. This reflects a practical reality that some organisations will not have kept full contact data in an accessible form during the current year.
- or, if this is not feasible, "informed clinical estimates".

Where care is provided by a team that includes a number of health care professionals, the activity for the year is the total number of team contacts.

The full DH guidance for the 2005 reference cost collection is to be found at:

<http://www.dh.gov.uk/assetRoot/04/09/75/94/04097594.pdf>

Action needed

There are concerns that the 2005 analysis of AHP activity, in spite of the changes mentioned above, still lacks subtlety. There is, for instance, still no attempt to differentiate patient casemix, other than between adults and children. Within a hospital setting, a brief physiotherapist appointment with a mother and baby and a much longer involvement with a stroke or head injury patient each count as a single contact. The cost implications are very different.

It is also widely acknowledged that first contacts always take longer, although this is not generally reflected in the costing system.

The use of contacts as the currency for AHP activity outside hospitals would not seem to be especially useful for measuring what we do. We are particularly concerned that AHPs have, in effect, been asked to change the currency for recording direct access and community activity during the year, and to a currency that does not match the standard data collection systems that are a legacy of the Körner years.) As a result we simply may not have good enough information for meaningful samples, or even for informed estimates.

Nevertheless we are urging AHP managers to do their best to make the 2005 reference costs as accurate as possible, not least because it is likely to form the basis for future payment by results tariffs. We suggest the following course of action:

1. Identify, if you do not already know, how AHP activity is recorded within your own organisation, and whether the information on contacts needed to complete the 2005 reference cost collection is readily available.
2. Plan how the information for direct access and community contacts will be found. If you plan to use a sample for a particular period of the year, try and choose it as soon as possible. If you plan to make an estimate, decide now how it will be based.
3. Identify and contact the person in the finance department who is coordinating the reference cost submission as early as possible. Agree:
 - how therapy in-patient costs will be identified as a share of total therapy costs
 - how costs will be allocated (apportioned) to specialties and then to individual HRGs
4. If this requires additional information for use as a basis of apportionment, clarify who will supply it, and by when. Finance departments often tend to leave the apportionment of

complex clinical areas, like the AHPs, until relatively late in the annual reference cost cycle.

5. Request that when the reference cost cycle is complete, the finance department provides an analysis showing:

- how AHP in-patient costs were spread across HRGs
- and what proportion of the trust's cost on each HRG was attributable to each allied health profession

If necessary, the latter request could be limited to a small range of HRGs – say fifteen or twenty – where there is significant therapy input. But this is an important piece of management information, and should be pursued energetically. It identifies the share of any additional income, generated by extra activity under payment by results, that has been earned by your service. This will increasingly be seen as essential knowledge as we move into the payment by results funding system.

5

What does payment by results mean for allied health professionals?

General

“Stick with what you have got and build on it. There are no magic solutions”.

This was one of the key conclusions from the AHPF’s workshop on payment by results in May 2004, and it remains a sound piece of advice. Financial systems in the NHS are changing rapidly, but our professional clinical practice is based on knowledge and values that have been built over many years. Our approach needs to be built upwards and outwards from our existing systems and knowledge.

To make this a reality, we need to develop:

- budget and cost awareness, so that we know and understand the real costs of what we do
- awareness of how our service integrates with the remainder of the patient care pathway in the new context of payment by results
- knowledge of the balance between capacity and demand for our service
- a real understanding of our organisations’ data recording and analysis processes as they relate to the allied health professions
- an understanding of how and where our professions bring genuine financial rewards to the organisation as well as clinical benefits to our patients

This chapter develops each of these five themes in turn.

Budgeting and cost awareness under payment by results

Most AHPs who hold budgets have a very keen awareness of the amount of money that is available, what expenditure it is meant to cover, and where the pressure points are. To manage successfully under payment by results, however, we also need a reasonable awareness of the actual costs of what we do.

Locate, if you do not already have it to hand, the annual budget for your service, and last year’s actual (“outturn”) expenditure. (For the latter you may have to ask finance for a

“month 13” report). Note any major differences between budget and actual.

Now locate, if you do not already have it to hand, the actual activity – in whatever currency it is recorded – for your service, for the same financial year as the actual expenditure.

Begin to compare the two documents Do they appear consistent? Can you produce any meaningful statistics: how much does an “average” member of the team cost? how many contacts does an “average” clinician make in a year? and so on.

Eventually the tariff will, we hope, provide unit cost information on a uniform basis. For the time being – and especially given the data weaknesses we currently recognise – it seems also sensible to begin some approximate “bottom up” costing of the main types of treatment and care we offer.

One trust physiotherapy department approaches the task this way:

(a) identify the main things we do.

It isn’t necessary to cover the entire spread of activity, but ensure that all the main areas are included. Using 2002-03 activity data the trust identified the 50 most significant HRGs, and comparing them with their clinical knowledge concluded that:

- in orthopaedics, hip and knee procedures, fractured neck of femur and other fractures together account for about 80 per cent of physiotherapy time
- patients with respiratory conditions such as COPD, post-surgical and intensive care are big users of physiotherapy
- head injury is relatively infrequent but can use a lot of physiotherapy time
- stroke care and care of the elderly are also important categories
- obstetric care accounts for a lot of recorded contacts but relatively little time in total.

(b) for the main areas of activity, calculate the cost of the relevant staff team.

This need not be absolutely accurate. The trust’s calculation for its orthopaedic team was:

	£
Actual cost – staff	93,311
Actual cost – non-staff	2,103
All other costs, including allowance for overheads	24,109
Total actual cost	119,523

(c) calculate approximate unit costs. Thus:

- total orthopaedic team activity for the year was 8,027 contacts, so the cost per contact (£119,523 / 8027) is around £14.90.
- but a first contact takes about twice as long, and the team saw 1,210 new patients in the year. By double-weighting the first contact, the team’s total activity was 9,237 units at around £12.90 per unit.
- a knee replacement requires, on average, 6.7 physiotherapy contacts. If the first is double-weighted, giving 7.7 units, the total cost of the physiotherapy input, including overheads, is £99.30: say £100.

Using the same methodology:

- total physiotherapy outpatient costs for the year, including overheads, were £640,260. The total team activity was 48,044 contacts, of which 10,665 were new patients. So the outpatient team’s total activity was 58,709 units at around £10.90 per unit.
- based on typical numbers of contacts, a knee replacement cost around £106 in physiotherapy out-patient time, and an arthroscopy cost around £74 for patients who needed to be seen.

This is a pragmatic approach to building cost awareness, based on clinicians’ practical knowledge of the number of contacts associated with their normal work. The arithmetic is not especially complex, and it quickly brings a better appreciation of the relative costs of what we do.

If you were to try this approach for your own therapy, which HRGs or interventions would you choose first? If you feel confident, assemble the basic data and have a go!

Remember that the national tariff can offer a useful benchmark when assessing one’s own costs.

One essential building block is an estimate, however approximate, of the level of AHP input that different procedures and conditions need. In due course this can become more sophisticated. Some trusts already record clinician time by grade, and in relatively small blocks of time. But we should not let

excellence be the enemy of good practice. It is better to begin simply.

AHP managers are finding this type of cost awareness invaluable as NHS commissioners begin to use the independent sector for orthopaedic surgery. In one recent instance commissioners purchased knee replacement surgery from a treatment centre at the full HRG tariff, without considering provision for pre- or post-op physiotherapy. For clinical reasons the treatment centre could not offer rehabilitation, not least because of the distances involved and the contra-indications of post-op travel. The local NHS physiotherapy service needed, at short notice, to supply an estimate of the level of physiotherapy input, and its cost.

There has also been some evidence of PCT commissioners being reluctant to fund their share of AHP overheads where clinicians are working in primary care. Practice-based commissioning may reinforce this trend. However, overheads need to be funded somehow, and one solution has been to agree to recover all overheads on a pre-set, and clearly stated, level of activity. Challenges of this sort make it all the more important that AHP managers can analyse their unit costs between staff, non-staff and overhead elements.

Integration with the care pathway under payment by results

As well as analysing how clinicians spend their time, we need to understand how each clinician and AHP service integrates with the whole care pathway, and in turn how the pathway is funded under payment by results.

Process mapping techniques, familiar to those with experience of “modernisation” and service improvement, can be a useful way to begin. Many find it useful to “map” the patient journey, typically using post-it notes on a table-top and re-arranging them until the “map” is accurate. For instance, one trust began to map the pathway for referral after a GP consultation as opposite, as a first step to understanding the levels of reimbursement under payment by results, which can simply be overlaid. Thus, using an example from non-elective in-patient treatment, say for a fractured neck of femur: and the original again please

Any physiotherapy input in this example would be funded from within the non-elective tariff (H85) for fractured neck of femur surgery. (For clarity the market forces factor adjustment has not been shown).

Take a set of post-it notes, clear some space on a desk-top and “map” one of the simpler care pathways that involve your profession. To test your knowledge of payment by results, consider which interventions will attract funding...and how much.

Capacity and demand awareness

AHPs are being asked to do more and more complex clinical work. In part this is because clinical assistants and junior grades are now undertaking more of the simpler clinical tasks. At the other end of the spectrum, extended scope practitioners and other senior clinicians are taking on work that would formerly have been done by doctors.

However, the volume of clinical work that can be undertaken by an individual clinician remains more or less constant. There are still only 24 hours in each day. With therapy teams being expected to work at full stretch for much of the time, it is all the more important that AHP managers assess what their actual capacity is, and plan to work within it.

This includes an assessment of the case mix, and the staff mix that is necessary to undertake it. Calculating Staffing Levels in Physiotherapy Services, by Joyce Williams, is an excellent guide to this task in physiotherapy. The CSP's own work on outpatient staff capacity is also useful for assessing the volume of work that can be expected from different grades of staff.

Data recording and analysis

AHPs resent the time that inputting activity data to centralised computer systems takes, especially when the system offers little by way of meaningful information in return. They particularly dislike entering the same data twice! But there are real risks that unless we take effective control of our local activity data, that is what will happen.

We typically collect data not according to funding criteria, such as healthcare resource groups, but according to what we actually need: patient identity, age, referrer (perhaps), procedure or diagnosis, where seen. We are also used to collecting data on contacts to satisfy local commissioner requirements.

In future, however, we must collect data on all contacts, not just new episodes. Now that contacts – with all their shortcomings – have been introduced for the 2005 reference cost collection, it is more than likely that they will form the currency for a future payment by results tariff.

An urgent need is to build our familiarity with the way data collection actually works within our organisation. This will entail:

- developing an increased awareness of data definitions. This is

tedious but essential. For instance, the precise difference between elective and non-elective care becomes crucial in an NHS trust where, in 2005-06, elective care earns the national tariff, but non-elective is still covered by a block contract.

- checking how AHP activity is actually being interpreted and recoded locally, and ensuring consistency with the national reference cost definitions. As has already been highlighted, this can be far from straightforward. Is a child with cerebral palsy, returning to a hospital site for therapy each month, under the care of a consultant neurologist or not? We cannot delegate this to the information function within our organisations, which in all probability understands little of what we do.
- insisting on clarity about patients' source of referral. The current definitions do not always help us: they are vague, for instance, about how referrals by social services, education, or patient and carer self-referrals, should be classed. But we in turn need to be specific.
- deciding where clinical coding can best be done. For hospital activity the coding determines how treatment is allocated to an HRG, and hence the income that it earns. It must be done well. For instance, comorbidity needs to be recognised: it often makes a procedure more complex and more expensive.
- auditing how well we are doing. Are we, for instance, up to date with data input? In organisations where the switch to direct palmtop data entry has still to happen, it is important not to allow a data entry backlog to accumulate.

Consider the above suggestions for action. Do they seem feasible in your local context? Prepare a short plan – a few bullet-points might suffice – for improving your own familiarity with, and control over, activity information.

Financial reality

During 2004-05 the first live trials of payment by results have reminded us that the NHS does not have a bottomless bag of gold with which to fund extra activity. In practice the new system does not simply reward additional activity. Commissioners, faced with bills for extra clinical activity, have been tightening the terms of agreements and challenging claims from trusts: they too have a duty to balance their books.

In this climate, a reasonable first response from allied health professionals may be to ensure that all activity is correctly classified, so that the organisation is properly rewarded for the activity it actually does. This requires a clear and thorough evaluation of how each type of intervention will be recorded, and places an additional importance on data management and on

clarity about discharge and admission.

For instance, when a patient is told to “come and see us whenever you need to”, should each return visit be funded separately under payment by results? We believe it should. This is not manipulation, but an accurate reflection of clinical reality.

List the main areas within your own practice that do not seem to fit easily with the definitions of out-patient, community and direct access in the 2005 reference cost guidance. Consider how you would propose to classify each of them in future.

Consider how would you justify your reasoning if faced with a challenge – say by a GP working under the new practice based commissioning arrangements – that you are manipulating data to increase your organisation’s income.

However, there are also real opportunities for innovation under the new funding system. We have long understood the clinical advantages of physiotherapy, for instance, for a lower back pain patient faced with a long wait for an outpatient appointment with an orthopaedic surgeon. We have also known that such appointments, with their low conversion rates to surgery, can be a real waste of a scarce medical resource. Now there is a genuine financial incentive for commissioners and trust managers to fund physiotherapy-based triage and similar service improvement strategies.

Similarly, where hospital costs are being driven up by extended in-patient length of stay, and the bottleneck on the care pathway is lack of AHP input prior to discharge, investment may well be self-financing. Especially in orthopaedic and stroke care, AHP input is clearly linked with earlier discharge from hospital.

Because payment by results offers a standard tariff for a procedure, there is a powerful financial incentive to manage skill mix proactively. We can ensure that clinical work is undertaken by people with appropriate skills, and equally that scarce skills are not wasted. This is directly linked to the realities of the labour market. For example, the current availability of newly qualified physiotherapists makes a business case built around changing skill mix, and a re-emphasis of therapy within the ward environment, attractive to commissioners.

On one side of paper, prepare the main headings of a “business case” – based on payment by results – for introducing a change in clinical practice that extends the role of your profession. The main categories should be:

- cost – estimate the difference in cost that the change will involve
- income – calculated from the payment by results tariff!

- improvement in clinical outcomes and quality of care
- risk – what could go wrong?
- evidence to support the case – clinical outcomes, prior experience
- estimated patient numbers.

Finally, we must recognise that from time to time, the business ethic behind payment by results may hinder the development of new and better methods of treatment. One recent example has been non-invasive ventilation (NIV) for children with neuromuscular conditions who are at risk of death from respiratory failure. This new form of treatment is inherently expensive, with frequent admissions and 24-hour therapy input, but it is proving effective. There are, however, some flexibilities around service redevelopment, specified in the technical guidance available on the DH website, and scope for NHS staff to notify the DH directly of any concerns they have about new developments by using the HRG questionnaire, also available on the DH website.

One of our future challenges will be to work with finance colleagues to create business cases subtle enough to support this type of innovation; and to ensure that along the way our duty of care remains paramount.

6

Where should allied health professionals begin?

Congratulations

If you have reached this point via steady progress through the workbook, congratulations! We hope that you have found it useful, that you know a little more than you did at the outset, and that you have some ideas about next steps.

If you have turned straight to this section, we recommend that you build an appreciation of payment by results by simply reading this workbook through from start to finish. This should not take more than an hour, and you should then have a reasonable overview of the subject.

We see the immediate priorities as twofold: the 2005 reference cost collection, and steady familiarisation during 2005-06 with the new financial regime.

The 2005 reference cost collection

AHP managers must engage fully with this year's national reference cost collection. We have already suggested some tangible ways in which this process can begin, including retrospective requests for 2003-04 information and pre-emptive pleas for analysis of the 2005 return. However, perhaps the most pressing need is to identify who within the finance department is coordinating the process, and ensure that the allied health profession component of the return is a shared effort.

There is no hidden agenda, no reason for finance to resist our involvement. If we do not help – for instance, with the apportionment of AHP costs to specialties – we cannot blame finance colleagues afterwards for making flawed or outdated assumptions.

Payment by results in 2005-06

In chapter five we describe the main strands of work that will be useful during the months ahead. They combine:

- building a genuine awareness of the costs and activity measures associated with our professions;
- and developing our engagement with the business aspects of our organisations.

You will need to prioritise: the pressures of clinical practice will inevitably take precedence for many. We, meanwhile, will do our best to support your involvement in this new and demanding field.

i

Annexe one

Summary of useful Department of Health guidance and information

Payment by Results

National tariff 2005-06:

<http://www.dh.gov.uk/assetRoot/04/09/15/31/04091531.pdf>

National tariff 2005-06: technical guidance:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4097993&chk=JSLwVc

Healthcare Resource Groups

HRG definitions:

<http://www.icservices.nhs.uk/casemix/pages/tools/asp>

Reference Costs

NHS costing manual:

<http://www.dh.gov.uk/assetRoot/04/06/54/78/04065478.pdf>

Reference costs 2004: Introduction

<http://www.dh.gov.uk/assetRoot/04/10/63/91/04106391.pdf>

Reference Cost Index:

<http://www.dh.gov.uk/assetRoot/04/10/55/52/04105552.xls>

Schedule of Reference Costs:

<http://www.dh.gov.uk/assetRoot/04/10/55/53/04105553.xls>
(NHS trusts)

<http://www.dh.gov.uk/assetRoot/04/10/55/57/04105557.xls>
(PCTs)

<http://www.dh.gov.uk/assetRoot/04/10/55/55/04105555.xls>
(PMS-plus pilots)

Reference costs 2005: Guidance

<http://www.dh.gov.uk/assetRoot/04/09/75/94/04097594.pdf>

The following organisations make up the Allied Health Professions Federation and a copy of the workbook can be downloaded from each organisation's website.



Association of Professional Music Therapists (APMT)

www.apmt.org.uk

British Association of Art Therapists (BAAT)

www.baat.org

British Association of Dramatherapists (BADTh)

www.badth.org.uk

British Association of Prosthetists and Orthotists (BAPO)

www.bapo.org

The British Dietetic Association (BDA)

www.bda.uk.com

British and Irish Orthoptic Society (BIOS)

www.orthoptics.org.uk

British Association/College of Occupational Therapists (COT)

www.cot.co.uk

Chartered Society of Physiotherapy (CSP)

www.csp.org.uk

Royal College of Speech and Language Therapists (RCSLT)

www.rcslt.org

Society and College of Radiographers (SCoR)

www.sor.org

The Society of Chiropractors and Podiatrists

www.feetforlife.org

Alternative versions of this document are available for blind and partially sighted people through each of the above websites

CSP Headquarters

14 Bedford Row
London WC1R 4ED
Tel: 020 7306 6666
Fax: 020 7306 6611
Text phone: 020 7314 7890
Email: enquiries@csp.org.uk

CSP Northern Ireland

Merrion Business Centre
58 Howard Street
Belfast BT1 6PJ
Tel: 028 9050 1803
Fax: 028 9050 1804
Email: northernireland@csp.org.uk

CSP Scotland

21 Queen Street
Edinburgh EH2 1JX
Tel: 0131 226 1441
Fax: 0131 226 1551
Email: scotland@csp.org.uk

CSP Wales

Cymdeithas Siartredig Ffisiotherapi
1 Heol Yr Eglwys Gadeiriol
Caerdydd CF11 9SD

1 Cathedral Road
Cardiff CF11 9SD
Tel: 029 2038 2429
Fax: 029 2038 2428
Email: wales@csp.org.uk

www.csp.org.uk

ENVIRONMENTAL STATEMENT:

This document is fully recyclable and made from elemental chlorine-free pulps sourced from sustainable forests. The paper mill operates an environmental management system to internationally recognised ISO 14001 standard. When you have finished, please pass this document to another user or recycle responsibly.

