

Need advice on how to implement Payment by Results? Christine Watkiss presents the findings of a case study of one of the first trusts to do so.



implementing payment by results

■ **Members of the ACCA Health Service Panel subgroup examining the practical implications of Payment by Results (PbR) visited the East Sussex Hospitals NHS Trust earlier this year to discuss the reforms.**

We met with Gary Bryant, the Trust's Deputy Director of Finance and Performance, who is the implementation lead and also a member of the subgroup.

The East Sussex Hospitals NHS Trust is a relatively new organisation, formed from the merger of two trusts in April 2002. The Trust provides a wide range of acute services from two district general hospitals, plus outpatient and maternity services from a range of sites.

As is common in mergers, obvious differences existed between the two partners. At a practical level there were different ledgers and patient information systems. Operationally the two hospitals had different approaches to medical coding, information and contract management and cost apportionment. The initial priorities were establishing a single corporate

management structure and transfer onto a single ledger and patient information system, complicated tasks only just now achieved.

new opportunities

Rather than a handicap, some of these issues have assisted in the implementation of PbR. The merger provided a driver and opportunity to review the current 'way of doing things' complementing the groundwork needed for PbR.

For example, the two predecessor trusts had very different reference costs. It was assumed that some of this was due to the differences described as much as comparative efficiencies. Like many trusts the existing apportionment tables and methodologies had been established for some time and a review of the original assumptions overdue. As a minimum, an update would be needed to reflect the post-merger organisation. Given the increasing importance of reference costs it was decided that this was an opportunity to do a complete overhaul.

technical support

Recognising the existing workload, an outside consultant was used to provide technical support. A desktop review was undertaken against the NHS costing manual to ensure costs were being dealt with in accordance with the guidance.

For example, this review caused the Trust to revisit its treatment around trim points and ensured that all eligible clinics (e.g. recently established nurse-led clinics) were being included.

All of this work could be undertaken within the finance and information departments and on its own resulted in improved reference cost performance in a number of areas.

For those areas where the Trust still appeared as an outlier a bottom-up costing review was initiated. In this exercise clinician involvement is crucial and discussions with clinicians included raising awareness of PbR and how it might affect them and their work – a simple message that accurate costs do matter.

issues identified

The bottom-up review identified a number of issues outside of simple apportionment and costing decisions. It highlighted that in future clinicians and managers will have to be much more proactive in predicting and managing the financial implications of any service change.

Currently the financial impact of simple changes in practice (e.g. changes in the preferred prosthesis or procedure) is often managed retrospectively and on a trust-wide basis (the global bottom line).

Frequently only costs are affected, not income, but this might not be true of the future. With PbR the relationship between cost, income and the specific service delivered will become much more transparent and important. A simple change in practice may move a HRG from profit into loss.

Differences in medical coding between the two hospitals were also part of the reason for differences in reference costs. It is obvious that accurate coding is critical and the Trust has recently reviewed this area. Although the level of un-coded activity is very low, the concerns were potential inaccuracies, inconsistencies and the delays in coding could result in a loss of income under PbR.

monitoring system

Understanding and refining reference costs is only one element of preparing for PbR. The Trust has also invested in the PSCAL SLA monitoring system (SLAM), which is designed as an activity and income modelling and monitoring tool as set out in the PbR/financial flows guidance.

For a relatively low investment this provided the Trust with a ready-made tool, producing a variety of reports including full price and

weighted activity schedules by PCT and by HRG. As with the use of an external consultant to review costing methodologies, the view was that the investment repaid itself as the internal finance team could focus on analysis and planning. An efficient use of skills and in-house knowledge.

SLAM reports clearly highlight the possible impact of PbR at specialty and HRG level and the sensitivity of different areas to changes in cost or activity levels. Added to the work on reference costs this has helped prioritise areas for further detailed work.

patient choice

PbR is the payment tool to deliver Patient Choice. Assessing the impact of choice is harder. Service level agreements will need to be more sophisticated than at present with contracting higher on the agenda.

With the introduction of cost-per-case arrangements within SLAs greater links between contract managers and medical colleagues will be required. The Trust felt that the national push on PbR was still focused within the finance agenda and needed to be a priority across the board.

feeling positive

Overall the Trust feels it may be a net gainer under PbR. The work discussed has improved reference cost performance and on a spells basis is below or around 100 in most specialties. In addition some service changes, including the closure of a long stay hospital, will also increase efficiency. ■

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The Health Service Network Panel would like to thank Gary Bryant for his time and efforts in compiling this article.

The key messages from our visit were:

- a desktop review of reference cost methodologies can significantly improve reference cost performance; saving resources for targeted bottom-up costing reviews
- costing expertise needs to be developed and valued as a core business skill
- using external sources to provide the basic tools, frees up internal resources for value-added analysis and interpretation
- coding is key to PbR – coding staff must be valued and trained
- mechanisms for assessing the business impact of changes in clinical practice will be a key element of cost management
- mechanisms for monitoring service level agreements will need to become more sophisticated not more bureaucratic
- PbR must be seen as a Trust-wide issue across all areas.