

## Diabetes and Payment by Results

### Why healthcare professionals should get involved

This factsheet explains Payment by Results and the national tariff. The aim is to help those most affected by the new system understand how it will work, and ensure that at both local and national level the system works in the best possible way for people with diabetes.

### Why Payment by Results?

Payment by Results is one of a number of linked changes designed to make the NHS fit for purpose for the 21<sup>st</sup> century. These changes have the dual aim of ensuring that care is of the highest quality whilst also providing good value for money.

For patients, the new system will support their decisions about where and when they receive treatment, as funds will literally follow patients as they choose from the wide range of services they need to help them manage their diabetes. These decisions will usually be made in discussion with their GP and primary care team. Payment by Results will also help encourage an increasingly diverse range of services which might be in both the public and independent sectors.<sup>1</sup>

Payment by Results will provide commissioners with a national currency (the tariff) to enable providers to be paid for the services they provide rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

Payment by Results provides a transparent, rules-based system for paying for NHS care, rewarding efficiency and enabling money to move fairly and openly around the system.

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<sup>1</sup> Payment by Results currently only applies to NHS providers,

The current expectation is that Payment by Results will cover 89% of Trust income in 08/09 – or some 46% of PCT budgets.

The Department of Health recognises the need to look closely at how the tariff supports care for people with long term conditions such as diabetes. Conditions such as diabetes have intricacies that a patient attending hospital for a “one-off” procedure wouldn’t necessarily generate, and it is important to ensure that the system supports patients being given appropriate care in the appropriate setting. The tariff may need to evolve over time in order to get the system right for people with long term conditions.

Payment by Results won’t be the only mechanism of change within the NHS. Although Payment by Results can encourage certain behaviours, other mechanisms may also be needed to bring about changes to the system and improve quality. This will include setting standards/National Service Frameworks (NSFs), commissioning processes etc.

The Diabetes NSF is based on the idea that it is how well organised the care is, not where it is delivered that is most important. Most routine diabetes care will be delivered in primary care, and is therefore not currently covered by the tariff. But the tariff will impact on many services provided for people with diabetes in hospital settings, which may have knock-on effects for the care delivered in other settings such as primary care.

Thus it is critical that professionals get together locally to ensure that there are mechanisms, including support and training from specialists, to ensure that primary care remains of the highest quality.

### Where are we now?

As in any new and very different approach, the system is still being developed and has not yet got things completely right.

The initial thinking and experiments on Payment by Results took place in acute and elective care.

It has been designed to support financial flows between PCTs and acute Trusts, so it is not surprising that some healthcare professionals feel that the new system does not address the needs of patients with long term conditions like diabetes.

The Department of Health recognises that further work may be needed to ensure that the system supports commissioning for people with long term conditions where care is provided in a range of different settings. It is important to remember that the tariff is not the only way for money to move around the system. Other important aspects of delivering and supporting delivery of care will need to be negotiated directly with PCTs.

## The tariff

The tariff that will be used to pay providers for in-patient and certain outpatients has been published for 2005/06. It applies across the NHS for elective hospital activity this year. For non-elective activity, outpatients and A&E the tariff applies only to Foundation Trusts this year, but will be used by everyone from April 2006.

## Health Related Group

The tariff for in-patients is based on Health Related Group (HRG). These provide the cost for all the parts of an episode of care that should be included together. It is obviously easier to work this out for a standard operation than for the complex situation like diabetes. There are HRGs for certain treatments and for special treatments and for children. The next version (Version 4) of HRGs will cover care wherever it is provided. There is an Expert Working Group including senior diabetes specialists (Chaired by Dr Nick Vaughan) who are advising on what the HRGs for diabetes should look like in the future.

## Setting the tariff

The tariff is based on the average 'reference' costs for a package of care in England (see text box below). The Finance Director for each Trust has been asked to calculate the costs for each in-patient and outpatient condition in their hospital and submit it centrally. These reference costs are then averaged, and other factors are applied. This includes an uplift for inflation, and an additional weighting for certain high-cost situations such as some children's specialities. There are separate costs assigned to first and follow-up appointments for outpatients. A weighting of 10% is applied to increase the payment for a first visit compared to a follow up visits in order to provide an incentive to discharge people sooner. This creates the final tariff, which will be used to purchase care across England.

The way the tariff is set means that those providers whose costs are below average will benefit. This could be because they are very efficient, or perhaps because they have been providing an inadequate service and so will be able to use the extra money to improve quality of care following discussion within the Trust. Trusts whose costs are above the tariff will have to look for savings and ways to become more efficient.

In 2004/05, the returns that made up the reference costs from which the tariff was calculated came from only 63 Trusts for diabetes and 74 Trusts for endocrinology. It is therefore difficult to know how true a picture they reflect. The tariff for 2005/06 may be different next year as it will be dependent on the number and accuracy of the reference costs submitted by Trusts. **It is crucial that all Trusts submit accurate reference costs for their diabetes service in order to ensure that the tariff reflects the real cost of diabetes care across the country.**

## Deriving the national tariff

The national tariff is based on the average cost of providing care or treatment in the NHS, derived from the reference costs from two years earlier. (For example the 05/06 tariff is based on 03/04 reference costs). However, a number of changes are required to turn reference costs into tariff, which includes:

A limited **cleaning** of the reference cost data to take account of data quality issues.

- Costs are **standardised** using the Market Forces Factor, so that the tariff is based on the area with the lowest MFF score.
- A **tariff uplift** is applied to take account of changes in cost over the two years. The uplift covers pay and price changes (abated by expected efficiency improvements); investment in quality and reform that does not result in increased volumes; and any technical changes in NHS funding and accounting
- A **spell uplift** to take account of the fact that reference costs are based on Finished Consultant Episodes (FCEs) whereas HRGs are based on spells (which can include more than one FCE)
- There is an adjustment to account of **NICE technology appraisals** that will have material impact on costs.

## Issues for diabetes

Many diabetes professionals will argue that, for a complex long term condition like diabetes, it is appropriate for patients to be followed up long term by specialists, and most diabetes clinics have a high ratio of follow up to new patients for this reason. However, the size and scope of this need is not yet known by the diabetes community.

Because the tariff is based on consultant episodes, it isn't known whether the multidisciplinary costs were included.

It isn't yet known by the diabetes community which part of the care package delivered by different professional members of the team, over different timescales and in different locations has been included.

It is difficult to know how to cost all the follow up work, telephone calls, emails etc which are an increasing part of supporting patients to self manage, and the extent to which these should be covered by the tariff or form part of separate negotiations between commissioners and providers.

An increasing amount of care will be provided out of hospital in the community or in the home. There are currently no national packages or currencies to pay for this and so payment will need to be negotiated locally with the PCT.

## Other ways to receive payment

The cost of providing care varies around the country and a supplement is available everywhere, except in the South West where the costs are the lowest, to take account of this. Most specialist services will therefore receive an additional supplement for each episode of care on top of the tariff paid by the PCT. This supplement is paid direct to the Trust by the Department of Health and is called Market Forces Factor (MFF).

Trusts will also need to negotiate separate payments from PCTs for all the other services they provide that aren't yet covered by the tariff. This will be important for specialist diabetes teams who increasingly provide services in the community or at home, indirect services like group patient education, and advice, training and mentoring to primary care providers. Specialist teams need to ensure that their Trust Chief Executives and Medical Directors understand the scope and importance of this work and ensure that the Trust is being paid for it.

## What's happening now?

Discussions are on-going to see if the additional cost of outpatient specialist services for complex patients can be better recognised in 2006/07 and beyond.

More fundamentally, diabetes is a long term condition where lessons could be learned and applied more widely. A number of options are under consideration. Perhaps care could be purchased in different ways, for example through a Year of Care for those with complex feet or renal problems or the duration of a diabetes pregnancy. Similarly, a year of support for lifestyle change in a community food and exercise programme might attract a specific tariff based on clear quality standards and outcomes.

These packages clearly need to be based on the patient's journey through the system, not on traditional habits of providers. It is therefore essential that professionals and patients get involved in these discussions.

## Actions for diabetes teams

Make sure that you and/or your local service or team are part of an effective and functioning network which has authority to plan and deliver local diabetes services.

Make sure that there is a clearly understood model of care in your network based on the patient's journey, the Diabetes NSF Standards and NICE guidelines and appraisals. Ensure that the roles of the various players, specialists, generalists, community, and social care are clearly defined and agreed by the institutions involved.

Find out the numbers of patients who would get care in the various parts of your service in your ideal world and where they get care now.

Ask your Trust Finance Director how the reference costs for diabetes services have been calculated and if they have been submitted nationally and come to an agreement about all the things that should be included.

For consultants, ensure that your job plan reflects all the work that you do that can be included in the reference costs. Ensure that the costs of endocrinology are separated out and for consultants ensure that your contribution to general medicine is recorded separately.

Start discussions with the CEO and Medical Director in your Trust about how they see the value of the work of the specialist diabetes team, including their contribution to inpatient work for people with diabetes.

Where there is specialist work that cannot be included such as home visits, teaching and training (that is essential to the agreed model of care), ensure that it is documented and have discussions both within your Trust to ensure it is recognised and within the network to ensure it is valued.

Consider sharing your experiences nationally or joining one of the groups that are helping to define the role of the specialist in the new world or work on the new packages of care.

## Further information

More information about the Payment by Results system is available on the Department of Health website at:

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en>

A number of worked examples have been developed to illustrate what services will be included under Payment by Results (and what the tariff for these services will be) and what services will need to be negotiated locally with the PCT. These slides are available in Appendix A.

Appendix A

Work in Progress – October 2005

Pathway and payments for child, newly diagnosed with Type 1 diabetes		PbR £	Local £
7 year-old Jack referred to A&E by GP. Saw consultant in casualty. Diagnosed with diabetes.	PbR payment for A&E applicable – standard cost	61	
* Attends diabetes unit (open access) for 1st insulin injection, 2 hours education by specialist nurse and dietician, future care plan organised.	PbR payment for 1st child outpatient appointment (diabetic medicine).	205	
Mother accessed the 24 hour helpline on first night after discharge	No PbR tariff for telephone contact. Local price negotiation needed.		
Specialist nurse visits Jack at home before breakfast and evening meals over next four days to deliver education package and train Jack and parents in injecting insulin.	No PbR tariff for community services. Local price negotiation needed.		
Jack attends outpatient clinic one week after diagnosis.	PbR payment for follow-up child outpatient appointment (diabetic medicine).	82	
Specialist nurse visits Jack's school and GP	No tariff for community services. Local negotiation required.		
Jack attends outpatient clinic for 3 follow-up appointments.	PbR payment for 3 child outpatient follow-up appointments applicable (diabetic medicine).	246	
Specialist nurse visits Jack at home twice during the year, dietician in attendance during one of these.	No PbR tariff for community services. Local price negotiation needed.		
Mother accessed the 24 hour helpline 15 times further during the year.	No PbR tariff for telephone contact. Local price negotiation needed.		
* The treatment of open access clinics under PbR is likely to vary from Trust to Trust as it does not fit the standard definition of an outpatient appointment in the PbR technical guidance. If the attendance at the open access unit did not attract the tariff for an outpatient appointment, then the outpatient appointment one week after diagnosis would attract a first appointment outpatient tariff.		£594	+ £X

Work in Progress – October 2005

Possible pathway and payments for recently diagnosed 16 year old Type 1 patient		PbR £	Local £
16 year old female goes to A&E with polyuria and vomiting associated with high blood sugars and ketones in the urine.	PbR payment for A&E applicable. Standard cost.	61	
Admitted to Medical Emergency Admissions Unit and stayed overnight.	PbR payment for non-elective admission (HRG K14) with 53% children's specialist supplement. Short stay tariff not applicable for this HRG.	1,646	
Attended young person's clinic for review by consultant, specialist Diabetes Nurse and Diabetes Liaison midwife	PbR payment for 1st outpatient appointment (diabetic medicine – child under 17)	205	
Fortnightly review with Diabetes Specialist Nurse over the phone.	No separate payment as assumed to fall within composite cost of patient care.		
Attends clinic for review by medical staff after 3 months.	PbR payment for follow-up outpatient appointment (diabetic medicine – child under 17)	82	
		£1,994	

### Work in Progress – October 2005

Pathway and payments for 72-year old with high risk foot problems newly identified to have proteinuria, renal failure and eye disease		PbR £	Local £
* Attend Diabetes Clinic as an outpatient. Seen by both a physician with an interest in diabetes and a physician with an interest in renal medicine (40 mins) and a diabetes specialist nurse (15 mins)	PbR payment adult outpatient (diabetic medicine) 1 <sup>st</sup> appt	152	
↳ If stable, referred to GP for follow up			
↳ If unstable, attend monthly multi-disciplinary pre-renal clinic	11 PbR payment adult outpatient (diabetic medicine) follow-up appt	671	
Appointment with consultant ophthalmologist	PbR payment adult outpatient (medical ophthalmology) 1st appointment	96	
Access same-day laser therapy	PbR payment adult outpatient (medical ophthalmology) follow-up appointment	47	
Outpatient follow-up at 6 weeks, 6 months and 1 year	3 x PbR payment adult outpatient (diabetic medicine) follow-up appt	183	
Monthly appointments at the foot clinic with state-registered podiatrist. Clinic is under supervision of a consultant diabetologist.	PbR payment adult outpatient first appointment and 11 follow-up appointments (podiatry falls within general medicine outpatient tariff)	1247	
OR – Monthly appointments at the easy-access community clinic, with a state-registered chiropodist	No tariff for community services. Local negotiations required.		
* Where a provider offers the services of a number of specialties in a single outpatient visit, they should receive the tariff for the highest-tariff specialty represented and half the tariff of the lowest-tariff specialty involved, as agreed with commissioners. But nephrology out-patients are excluded from tariff, therefore the only tariff payment shown here is for diabetic medicine. The costs for nephrology outpatients would need to be negotiated locally.		£2396	+ £X

### Work in Progress – October 2005

Antenatal care for a woman with diabetes		PbR £	Local £
Attend midwife led clinic. Glucose tolerance test shows an abnormal result and diabetes diagnosed.	Midwife episodes are excluded from the PbR tariff. Local negotiations required.		
* Clinic appointment with multi-disciplinary team, with diabetologist, obstetrician, dietician, midwife and diabetes specialist nurse.	PbR payment adult outpatient* (MDT payment 1 x diabetic medicine outpatient and 0.5 x obstetrics outpatient appointment)	224	
Monthly ultrasonography	No PbR tariff. Local negotiations required.		
Follow-up appointment with multi-disciplinary team, with diabetologist, obstetrician, dietician, midwife and diabetes specialist nurse.	PbR payment adult outpatient* follow-up Appointment (MDT payment 0.5 x diabetic medicine outpatient and 1 x obstetrics outpatient appointment)	97	
Weekly phone calls with diabetes specialist nurse.	No separate payment as assumed to fall within composite cost of patient care.		
* Where a provider offers the services of a number of specialties in a single outpatient visit, this will be recorded as just one outpatient attendance. The provider should receive the highest-tariff specialty tariff represented plus half the tariff of the lowest-tariff specialty involved. This approach should be agreed with commissioners as part of the SLA process.		£321	+ £X