

IMPRESS

**Response to The Health Committee, the Select Committee of the House of Commons
New Inquiry – Commissioning 9 July 2009; closing date 17 September 2009**

1. Executive Summary

This is the response from the two leading clinical societies representing clinicians who care for people with respiratory symptoms and lung disease. It describes the importance of clarifying the roles of networks, leadership, audit, education and training in improving care and how these relate to commissioning. It highlights some of the problems and tensions of the procurement process and the crucial role of good coding as a first step towards payment by results.

2. Introduction

This response is from IMPRESS, a joint British Thoracic Society (BTS) and General Practice Airways Group (GPIAG) initiative (www.impressresp.com). This aims to provide the clinical leadership to drive high quality patient-centred care across the traditional boundaries of secondary and primary care to integrate and improve the services for people with respiratory disease. Therefore this response draws on the experience of commissioners (PCT and practice-based commissioning and social care), and clinicians in primary and secondary care with a particular interest in people with prevalent long term conditions such as asthma and chronic obstructive pulmonary disease (COPD).

3. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

3.1 Networks

Firstly, we want to make the point that IMPRESS believes system-wide approaches are necessary to achieve improvements and strongly recommends the formation of networks. These cross the purchaser/provider split recognising that expertise and knowledge needs to be shared. These networks would be along the line of managed clinical networks in Scotland, that agree on local needs and aim to raise standards through local discussion and agreement about the evidence and about the best way to implement it given local need. However, networks can be seen to be anti-competitive, and there are challenges about how to fairly involve all providers (including the private sector for example). There are also challenges about intellectual property: is it acceptable for the commissioners to seek expert advice from local providers for free, and then to use it to write a specification for services that it may award to a private sector provider? It would be good to have clarification about the roles of networks and markets. See <http://www.impressresp.com/Networks.aspx> for our main messages about networks.

3.2 Procurement

We think that there is a lot to learn about using competitive approaches and to ensure they work effectively. We attach a paper Commissioning a community COPD service: Lessons for the NHS based on a case study in Somerset PCT also found at

<http://www.impressresp.com/Portals/0/IMPRESS/CommissioningCOPDservicefv.pdf>

We have drawn out the main lessons here:

<http://www.impressresp.com/Commissioning/Procurement/Dosanddontsofprocurement.aspx>

Since then, we have kept a watching brief on other tenders for COPD care. There have been eleven so far. A recent tender, in West Herts, was allocated to a community trust. In terms of

dos and don'ts, we would reinforce a few points:

The competitive dialogue phase is important as it enables a detailed analysis of costs and services, and, if the commissioner has clearly specified the outcomes it wants, enables providers to make suggestions about other services that might be appropriate.

Adjudication of bids is extremely difficult. Most local experts may be conflicted because they may also be bidders in competition. It is difficult for an external expert to find the time, or the inclination to judge their peers. Yet there is a crucial responsibility to confirm whether the services proposed are safe, effective and within clinical guidelines. There needs to be guidance and a national coordinated approach to finding expert clinical adjudicators.

3.3 Alternatives: leadership, audit, education and training

There are alternatives to competitive procurement to raise standards: strong clinical leadership, audit, and education and training. We strongly encourage commissioners to invest in these. IMPRESS promotes the options of an Integrated Care consultant <http://www.impressresp.com/Portals/0/IMPRESS/ConsultantPhysinRespCare.pdf> and also a practitioner with a special interest.

4. Coding and tariff

Payment by Results (or activity) requires a financial language which can be understood and trusted by both providers and commissioners. This is one of the major challenges that need to be achieved before the current model of an NHS marketplace can evolve with confidence.

Correct coding is critical as the first step and the PbR data assurance framework 07/08 (www.audit-commission.gov.uk), 'provides the first comprehensive national picture of the quality of the data which underpin not only financial, but also clinical and commissioning information'. An average HRG error of 9.4% (range 0.3 – 52%) translated in to a gross financial error of £3.5 million in that sample. They noted that the net financial impact was close to zero in most cases (making gaming a less likely issue) but the wide range of error will result in financial risk in some individual units. The main areas that needed to be addressed were poor documentation, clinician involvement in coding and training and development of the clinical coding profession.

In an attempt to better define clinical activity and casemix severity there have been a number of new procedure codes and HRG revisions developed over the last 2 years. These additions don't always 'ripple out' efficiently to the front line clinicians, coders and finance departments and as a result when reference costs are being generated some of the newer HRGs are very poorly populated due to a lack of relevant clinical data entry. Reference costs may then be based on such small numbers as to be very unreliable. This is particularly true in the case of < 1 day interventions and experience so far has demonstrated that there may be very wide variations in the reference costs for some HRGs. The concerns raised by such findings and the perceived risk of financial destabilisation has led to a tendency to restrict many HRGs to non-mandatory and rely on local provider/commissioner negotiations. Such negotiations have not proved to be straightforward, presumably as a result of the many competing financial pressures within the different organisations. It is possible that providers may not have the same commitment to coding for the newer HRGs when there is no firm mandate for reimbursement. This in turn results in a further year of poor representation of these interventions in coding terms and once again results in a lack of sufficient data for the HRG to be approved as a mandatory reimbursable activity. The same cycle has the potential to continue on an annual basis and bearing in mind the built in lag before reference costs are

translated in to published tariffs this can mean that a new HRG with important relevance both in resources, epidemiology and clinical pathways may not play a full part in financial flows for many years.

The development of Patient Level Information and Costing Systems (PLICS) which is now being piloted for some interventions 'represents a change in the costing methodology in the NHS from a predominantly "top down" allocation approach, based on averages and apportionments, to a more direct and sophisticated approach based on the actual interactions and events related to individual patients and the associated costs.' A guide can be found at:

http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100049.pdf

This will offer the opportunity for healthcare professionals, in liaison with coders, finance and their specialist societies to generate bottom up costs for individual interventions which may reduce the wide variation in reference costs which are currently being generated and have the potential to destabilise health economies.

Although the DH mission statement is a move towards care closer to home and patient choice, it is still not possible to record and reimburse for specialist activity out in the community which will potentially act as a disincentive for such initiatives. We have been arguing the case for a new discharge code for Hospital at Home so that national data and benchmarking can be derived for this form of standardised pathway which studies have shown to be safe and highly appreciated by patients. However, the cost (using current HRG) is around £500 which is a considerable underestimate bearing in mind that the patient may be reviewed at home on a daily basis for a week. This provides a further disincentive for a healthcare package which fulfils all the DH's criteria for quality care.

It is perhaps understandable that when the drivers for NHS financial reform are based on a market place format there is a natural tendency to tread carefully in order to avoid serious financial instability but the concepts of PbR have moved rather more rapidly forward when compared with the sophistication and uptake of the coding building blocks upon which the financial language is based.

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Also at NHS networks <http://www.networks.nhs.uk/networks/page/942>