

**Department of Health  
Consultation**

Options for the Future of Payment by Results:  
2008/09 to 2010/11

**Consultation Response Proforma**

Published: 15 March 2007

Closing: 22 June 2007  
Your comments must reach us by that date

- 1.1 As part of our reply to this consultation, we will provide an update on expressions of interest in the proposal to establish PbR Development Sites and confirm our plans.
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## Options for the Future of Payment by Results: 2008/09 to 2010/11 Consultation Response Proforma

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Respondent Details (Please provide the details of a single point of co-ordination for your response)

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If you are replying on behalf of a group of respondents or a number of organisations, please complete the following information:

Organisations represented within this response	<b>Doctors specialising in rehabilitation medicine across the UK</b>
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Note: We would also welcome any anonymous responses.

**Date of response:**

**22.6.07**

**Confidentiality:**

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information that you have provided to be confidential. If we receive a request for disclosure of the information we will take full account of your request, but we cannot give an assurance that confidentiality can be maintained. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in the majority of circumstances, this will mean that your personal data will not be disclosed to third parties.

## Chapter 2 – Strengthening the building blocks of PbR

### Qu. 2.1 – page 29

#### Classifications

Do you agree with the strategy outlined for the development of classifications to support PbR?

Strongly agree       Agree       Neither agree/Disagree       Strongly disagree       nor disagree

The BSRM notes that the HRGs v4 were signed off with the caveats that they were not yet fit for purpose and that further work was required a) to provide HRGs for the areas of rehabilitation not covered, b) to develop systems that account for different levels of complexity and c) to develop HRGs and currencies for complex specialised rehabilitation. We believe it is important that these developments are followed through and not forgotten.

We note the proposal to explore the use of existing systems such as those currently operating in Australia. Broadly, and there are many good aspects of the Australian system, particularly

- a) the recognition that DRGs fit poorly in rehabilitation and that function-related groupings provide a better reflect of differential costs of rehabilitation
- b) the use of per diem or blended payment models.

The BSRM supports the current proposals by the Rehabilitation EWG to explore both Australian models to see what can be learned from them, but at the same time we warn that rehabilitation services and practice are very different in the UK from Australia and neither the AROC or the VicRehab model can be imported wholesale

The BSRM has expressed its commitment to working alongside the Rehabilitation EWG to develop casemix classifications and costing models that are appropriate for rehabilitation services, both in hospital and the community

### Qu. 2.2 – page 29

#### Frequency of classification updates

What is a reasonable frequency for implementing updates to the classification from 2008/09 onwards; a) annual; or b) biennial?

Rehabilitation presents particular challenges for the development of casemix classification. It is unlikely that we will have all the answers by 2008/9 and so we anticipate that updates would need to be undertaken annually at least.

However, we note that recommendations by the Rehabilitation EWG made in 2005 have still not been incorporated in the most recent updates (see above), so stress that it is important that the updates are not only undertaken but reflect the advice given

**Qu. 2.3 – page 32**

**Currencies**

What steps should we take to ensure successful implementation of HRG4 in 2009/10?

A lot of work is required in the field of rehabilitation to develop the tools to support an appropriately sensitive case-mix classification, and to determine commissioning currencies that are suited to long term care in the community, which forms much of rehabilitation practice.

The BSRM supports proposals from the Rehabilitation EWG to undertake this development work, including the recent application for funding through the NIHR programme grant.

We note however that this is an extremely complex area, and one which systems in other countries have also failed to tackle successfully. Without proper funding and support, it will be extremely difficult to undertake the level of detailed work that is required. We therefore urge PbR to consider how this can be supported if that application is not successful.

We believe that developing the model for long term conditions as proposed by the EWG in Rehabilitation will have application in other similar fields – eg palliative care. In rehabilitation there are committed clinicians willing to take this forward with the backing of the specialist society (the BSRM) and we encourage PbR to take advantage of our offer to help develop the system and find solutions to the problems which we know are also being raised in other quarters.

**Qu. 2.4 – page 34**

**Costing**

Do you agree with our approach to implementing patient level costing?

                         
Strongly agree      Agree      Neither agree/Disagree      Strongly disagree      nor disagree

We agree that patient-level costing is a much better approach than crude average reference costs. However, given the diversity of rehabilitation services a wide sampling frame is required to ensure that the full range of services is represented. Costing must also be undertaken in relation to a measure of ‘rehabilitation need’ which goes further than just a measure of physical disability, such as the FIM or the Barthel Index.

We support the work of the Rehabilitation EWG in developing alternative measures of rehabilitation complexity, but note that, as the EWG has indicated, there is still work to be done to adapt these to all the different settings in which they would be used

**Qu. 2.5 – page 35**

**Timeliness of data flows**

How realistic is it to deliver the proposed improvement in timeliness of data flows from 2008/09 and what issues need to be considered?

Because of the current absence of suitable rehabilitation codes, and because of slowness on the part of CfH to implement the recommendations of the Rehabilitation EWG on codes and coding advice, rehabilitation is well behind many other areas of practice in having the data collection systems in place for activity analysis.

We agree with the principal of setting challenging targets for activity data reporting, but since we do not yet have any of the tools in place for capturing rehabilitation data, the timescale is unrealistic.

**[Chapter 3 – Developing the national tariff](#)**

**Qu. 3.1 – page 37**

**Calculating the tariff using data from a sample of providers**

What particular issues do we need to consider in accrediting providers' data quality and in determining a 'representative' sample?

As noted above, rehabilitation services are diverse in terms of the patients treated and types and levels of services offered. A wide sampling frame will be required to ensure that all service types are represented – including those in the independent sector. Costing data will have to be set within the context of rehabilitation needs and outcomes.

**Qu. 3.2 – page 40**

**Prices that reflect quality and effectiveness**

Does the approach outlined provide the right incentives for change that delivers quality care and value for money?

Simply basing tariffs on average reference costs will not be adequate, as noted in the Rehabilitation EWG documentation. Currently, although complex specialised services are excluded from the HRG definitions, the coding systems do not provide any means to identify these services. Their inclusion in the reference costing will artificially elevate the cost of rehabilitation, and potentially mean that PCTs are forced to pay more than they currently do for basic level services. This will put financial pressure on PCTs without improving services for patients, and will increase the opportunities for some less scrupulous independent providers to cream-skin the less complex patients for quicker profits.

The BSRM supports the EWG's proposals for setting banded tariffs that properly support the additional costs of caring for more complex patients and notes in particular that simple measures of physical dependency (such as the FIM and Barthel Index) do not adequately reflect case complexity - particularly in areas such as brain injury rehabilitation where cognitive and behavioural problems are also key indicators of caseload complexity.

In rehabilitation there is good research evidence to demonstrate that reducing length of stay does not equate to cost-efficiency. Wherever fixed episode tariffs have been introduced around the world these have led to reduced length of stay, but with poorer outcomes. This means that patients are discharged at a lower level of functional independence, placing increased care and cost burden on their families and on the social services.

We do not agree that "average costs will reduce year on year". The way that services are likely to reduce their costs is by refusing to take on patients with more complex needs, thereby increasing the burden on other parts of the service.

We support the recommendation to collect data routinely that measures outcome in terms of cost-effectiveness, as recommended by the rehabilitation EWG, but emphasise the need for PbR to understand properly the balance between rehabilitation inputs and outcomes that constitutes real cost-efficiency.

### **Qu. 3.3 – page 43**

#### **PbR should support commissioning of care pathways**

Are there examples of where the tariff acts as a barrier to commissioning care pathways and, if so, what changes to the tariff structure would help overcome these problems (e.g. bundling or unbundling)?

Further work needs to be done on commissioning of long-term inputs for people with long term conditions, both in hospital and community settings.

The BSRM is keen to work alongside the rehabilitation EWG to develop this and notes that there is critical preparatory work to be done on the further development and adaptation of tools to identify rehabilitation needs and complexity in this context.

### **Qu. 3.4 – page 44**

#### **Unbundling the tariff**

Given the approach outlined, what, if any, are the barriers remaining for unbundling tariffs?

We agree that rehabilitation is a suitable area for unbundling. We do not agree that it should necessarily be commissioned 'only from primary care' – many rehabilitation services, especially those of high-cost low volume cases' fall under the specialised commissioning strategy.

Again there is a lot of work to be done on casemix and suitable commissioning currencies. At the present time the coding systems and advice are simply inadequate to identify the different levels of service.

**Qu. 3.5 – page 47**

**Applying the tariff to the same service in different settings**

Extending the use of HRGs to outpatient and community settings would require coding of activity in the same way as for admitted patient care where a procedure is undertaken. Is this a feasible proposition?

It is feasible and indeed important to extend HRGs to community settings where much of rehabilitation practice occurs, but once again appropriate casemix and currencies for long term care will need to be developed. Rehabilitation has much in common with palliative care in this respect and we welcome the opportunity to work with colleagues in other specialties to take this important aspect of the work forward. Once again robust coding systems and adequate granularity are required.

**Qu. 3.6 – page 50**

**Specialised services**

What is the best way to refine the approach to funding specialised services in 2008/09 under HRG3.5, and in the future under HRG4, in a way that funds services not institutions?

**Comments:**

Complex specialised rehabilitation services fall outwith the current HRGs. We agree with the recommendations of the Rehabilitation EWG that these should be identified separately and designated in the basis of clear criteria (of which the most important are carrying a complex caseload and delivering highly specialist rehabilitation of suitable intensity and quality).

The Warner report has also recommended designation of specialised services according to clear criteria and the National Definition Set for Specialised Services (of which Brain injury and complex rehabilitation is no 7) are currently being revised to clarify these criteria

A sensible approach is that used in Australia where rehabilitation units that are able to deliver appropriate quality care for patients with more complex needs are ‘designated’ as specialist rehabilitation services. Only these can claim the higher level reimbursement that goes with managing a complex caseload. Designation requires both that the services is ‘accredited’ as able to provide high quality specialised services, but also that it is ‘designated’ as a service that the commissioners wish to purchase those services from

The BSRM has already developed standards for high quality services and would be interested to work alongside specialised commissioners to assist in the development of criteria, inspection and accreditation to identify services that may be considered as suitable

for designation as ‘complex specialised services’ so that a network of suitable services could be commissioned across the UK.

A useful model is the Pan London neurorehabilitation services specialised commissioning consortium where the nine designated specialised brain injury rehabilitation services for London have been collaboratively commissioned by a consortium of 27 PCTs.

## **Chapter 4 – Future of tariff setting**

### **Qu. 4.1 – page 56**

#### **Governance**

Do our new arrangements for tariff setting provide the transparency that stakeholders want in a way that is consistent with the Secretary of State’s responsibilities to operate within a fixed cash limit?

Sad to say, we do not believe that the current arrangements for tariff setting provide transparency, as it is not yet clear what these are! As noted above Connecting for Health has currently declined to accept the recommendations offered by the EWG and the Information Centre with regard to OPCS codes and coding advice. The result is widespread confusion amongst Trusts with regard to how they should code rehabilitation episodes.

We further understand that revision of the OPCS4.5 codes has been postponed, to that the requested changes to deal with the confusion will not now come into force until at least later this year. This effectively means that data gathered to support reference costs for last year (2006/7) and this year (2007/8) will still effectively be useless.

### **Qu. 4.2 – page 57**

#### **Multi-year price signalling**

Will the proposed arrangements for multi year price signalling (2008/09 – 2010/11) support better service planning, and what additional information would help improve this?

Yes – the most accurate information possible to inform planning of future costs and uplifts would be helpful

## **Chapter 5 – Extending the scope of payment by results**

### **Qu. 5.1 – page 59**

#### **Three generic models of PbR**

Do the three proposed models of PbR offer a sound basis for expanding the scope of PbR in the future?

Strongly agree       Agree       Neither agree/Disagree       Strongly disagree       nor disagree

We believe that rehabilitation will cross all three models, and we think the added flexibility of this system is very helpful. As noted above, rehabilitation services are notably diverse and local knowledge of the particular service characteristics will often be helpful in determining the cost according to particular attributes of the service and its facilities.

**Qu. 5.2 – page 62**

**Criteria for applying PbR to different services**

How could the proposed criteria for applying the three models of PbR to different services be improved?

As services provide for more complex and specialised caseloads, so the national tariff become less applicable and more local understanding is needed to commission and price the high-cost low-volume services.

The key issue is what currencies will be used for national currencies. Along side the EWG's proposed model for assessment complexity, we recommend consideration of both the per-diem model (VicRehab) and the blended payment model (AROC) to see which, if any, has greater applicability within the UK health system.

**Qu. 5.3 – page 62**

**Priorities for developing national currencies**

Based on the proposed criteria, what are the priorities for developing national currencies?

Development of suitable currencies is extremely important as we are currently haemorrhaging services, and will continue to do so until the appropriate currencies can be properly established. However, as noted above there is still a lot of preparatory work to be done to develop the tools for describing and costing rehabilitation interventions. Starting from such a low base, there is clearly a long way to go before national currencies could be introduced and so realistically the time frame is unlikely to be before 2010/11. Nevertheless this does not diminish the urgency of proceeding with the preparatory work

**Qu. 5.4 – page 67**

**Needs-based funding**

Which areas of healthcare could most benefit from a needs-based funding approach?

Rehabilitation, rehabilitation, rehabilitation....Oh! and possibly rehabilitation!  
However choosing the right tools to define need is critical, and once again the BSRM agrees with the EWG for Rehabilitation approach to explore tools which capture needs other than simple physical dependency.

## **General**

### **Qu. G.1**

Of the issues discussed in this document, which are the three most important and should therefore be prioritised?

1. Take the advice of the Rehabilitation EWG with respect to coding and coding advice. In particular to provide a means by which to flag up, identify and separate activity that should be coded under complex specialised rehabilitation
2. The further development and definition of tools to capture rehabilitation needs, complexity and inputs across the range of rehabilitation services and settings
3. Exploration of alternative currencies such as per diem rates for blended payment models, as used in the Australian systems.

However, it must be recognised that rehabilitation comes from a very low level of reporting currently due to the lack of appropriate codes hitherto. These developments will require support and proper research and the BSRM looks forward to the opportunity to contribute providing the funding application is successful. The BSRM is a small society and does not itself have funds to undertake this sort of work

### **Qu.G.2**

Do you have any ideas for developing PbR that you would wish to pilot? If so, please express your interest here to allow us to pass on to the relevant SHA or to the FT Network as appropriate.

Yes, the BSRM has already expressed an interest in supporting the programme of research put forward by Professor Turner-Stokes towards the further refinement of tools and costing models. We believe that this approach has application in other areas, especially within the long term conditions grouping and we look forward to working with colleagues in other specialties such as palliative care and mental health to explore how these may be taken forward

### **Qu.G.3**

If you have any additional comments on any aspect of the consultation document, please list here.

This form has not provided a very easy medium in which to provide coherent feedback. We apologise if we have been overly repetitive at times, but suspect that different sections of the form may be analysed separately so we felt that it was better to repeat ourselves than to risk having our view missed. We hope nevertheless that our comments are clear and that they will be taken on board

### **Annex B**

#### **Qu. B.1**

If you have any comments on the extension of PbR to the services outlined in Annex B, please list them below, specifying which services your comments relate to.

We welcome the inclusion of rehabilitation under long term conditions for version 5 and onwards. However we note that since the rehabilitation HRGs in version 4 are far from perfect it is important not to lose momentum on the maintenance and continued work to try to make HRGs fit for purpose within the current version.

### **Economic, social or environmental impacts**

#### **Qu. I.1**

Would any of our proposals lead to economic, social or environmental impacts on you or your organisation?

Yes, if rehabilitation services are destabilised as a result of failure to get the tariff right or a loss of momentum whilst the IC team's attention is diverted elsewhere. It is essential that we gain the respect of local purchasers and engage rehabilitation teams on the ground in generating the data required.

## **Equality Impact Assessment**

### **Qu.E.1**

#### **Equality Impact Assessment**

Please outline any ways in which the PbR policy described in this document may impinge on human rights.

The introduction of a 'one-price fits all' approach will discriminate against people with more complex needs and potentially deprive them of the services they need, if providers feel unable to afford to take on the more costly cases

### **Qu.E.2**

#### **Equality Impact Assessment**

Please outline any way in which the PbR policy described in this document may discriminate or cause inequality relating to groups covered by equality legislation: race, disability, gender, age, sexual orientation and religion and belief.

As above it is the more disabled patients who are most likely to be excluded

### **Qu.E.3**

#### **Equality Impact Assessment**

Please outline any way in which the PbR policy described in this document may protect human rights and promote equality (within race, disability, gender, age, sexual orientation and religion and belief) and prevent inequality.

The EWG in Rehabilitation's proposal for banding tariffs and reimbursing equitably in relation to service need is an appropriate and fair way to deal with the problem. We are not certain if these are yet embedded in PbR policy, but we recommend that they should be.

## Code of Practice on Consultation

All written, public consultations must follow the Cabinet Office Code of Practice on Consultation. The full text of the code of practice is on the Cabinet Office website at: [www.cabinetoffice.gov.uk/regulation/consultation/code.asp](http://www.cabinetoffice.gov.uk/regulation/consultation/code.asp).

The code contains the following six criteria to be followed when undertaking consultations:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your Department's effectiveness at consultation, including through the use of a designated Consultation Co-ordinator.
6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The Code also invites respondents to "comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process". For DH consultation, comments or complaints (but not your response to this consultation) should be directed to:

Consultations Coordinator  
Department of Health  
Skipton House  
80 London Road  
London SE1 6LH  
Email: [Mb-dh-consultations-coordinator@dh.gsi.gov.uk](mailto:Mb-dh-consultations-coordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address.**

### **WHERE TO SEND YOUR RESPONSE TO THE CONSULTATION**

Completed questionnaires, responses and comments should be sent by 22 June 2007 either by email to:

[futureofpbr@dh.gsi.gov.uk](mailto:futureofpbr@dh.gsi.gov.uk)

or by post to: Payment by Results, Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE.