



ADPH London

Meeting of: ADPH London

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Report title: An Analysis of a London-wide Introduction of an Integrated Sexual Health Tariff

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1. Purpose

- 1.1. This paper summarises the analysis of the integrated sexual health tariff produced at the request of the London DsPH by Pathway Analytics and sets out the key issues that may arise were a decision taken to move towards the introduction of this payment model for clinical sexual health services, in both community (CaSH) and secondary care (GUM) settings, across London.

2. Recommendations

- 2.1. DsPH are asked to:
- Consider the findings
 - Decide whether there is a robust case for change made
 - Indicate their willingness to progress towards implementation
 - Indicate which implementation options they favour

3. Background

- 3.1. Currently Reproductive Sexual Health (RSH) services across London (often branded as CaSH services) are primarily paid for as 'block contracts' – with fixed values being set for projected activity levels, and adjusted according to recent/ previous year trends with some allowances for projected activity changes and/ or service innovations. GUM services, on the other hand, are paid for based on actual attendance numbers using a two-price system – First Attendance and Follow-Up – known as 'PbR'.
- 3.2. The detailed picture is not as clear as one payment system for Provider 'A' and another for Provider 'B'. The introduction of integrated sexual health services, which are still relatively new in London, plus the greater freedoms now available since transition and the end to mandated national tariffs means that payment systems are inconsistent and can be unsatisfactory, varying from block contracts through to PbR and combinations of both.
- 3.3. The integrated sexual health tariff (ISHT) proposes a range of prices with each reflecting the 'actual cost' to the provider of delivering specific pathways of care. These pathways and associated costs were developed and agreed by a broad group of stakeholders, including leading SH commissioners, clinicians, FSRH, BASHH and DH representatives to represent good clinical practice - a fair price for actual work undertaken.

- 3.4. In early 2014 the Directors of Public Health in London requested that work be carried-out to consider what the current picture might be, regarding cost and benefits at Borough level, should the ISHT be introduced.
- 3.5. The scope of this programme (Appendix A) was to (i) refresh the cost and benefit analysis already undertaken for predecessor NHS PCT commissioners, based on LSOA/ LA resident population numbers as opposed to GP registered list numbers; (ii) to collect latest data from providers and commissioners so as to produce a 'real-time' analysis for DsPH; and (iii) to develop a set of 'scenarios' regarding potential impact of unintended consequences of the introduction of such a pricing model across the services concerned.

4. Conclusion

- 4.1. The information gathered from commissioners and providers identified spending plans/ expectations in 2014-15 under the current payment systems ('As Is Spend') of £138.7m across London. This takes into account both 'block' and 'PbR' payment arrangements, and reflects only those RSH and GUM services delivered by London providers for London residents that would be covered by the ISHT.
- 4.2. Analysis shows that had the same pathways of care, as reported by providers, been paid for using the proposed ISHT, then London would have saved circa £16.7m or 12% of spending across the associated services.
- 4.3. Concerns raised regarding potential 'unexpected outcomes' from introducing the integrated sexual health tariff centred around the possibility of material changes in activity levels and/ or case-mix where providers may perceive new 'incentives' particularly around LARC, complex contraception, and complex STI care.
- 4.4. Analysis presented shows the potential impact under ISHT of increases in different categories of RSH & STI activity; intervals of between 10% to 100% were used in this analysis. Increases in SRH-related activity delivered by London GUM providers would have a maximum impact of £5m under ISHT. A correlating increase in STI-related activity delivered by London SRH providers would have a maximum impact of £0.6m. If both these scenarios occurred to maximum effect (additional £5.6m ISHT charge), then overall ISHT cost savings would be £11.1m or 8% of current expenditure. Other scenarios have been tested under ISHT: 100% increases in LARC provision (additional £7m); Complex SRH (additional £1m); STI tests performed with microscopy (additional £2m); and HepB Tests (additional £7m). Historic activity profiles for London providers suggests that concurrent increases of 100% across all SH categories is highly unlikely.
- 4.5. In addition, analysis has been carried-out to consider the impact of only introducing the tariff across London's largest providers, by episodes of care and spend. This has looked at the top 10 and the top 15 providers with potential savings of £13.3m and £14.7m respectively.
- 4.6. And finally, consideration has also been given to the introduction of the ISHT across only Level 3 GUM services and not community based CaSH provision. Unfortunately gathering data, as submitted, in such a fashion has proven difficult when considering the number of Acute Trust providers that deliver CaSH services.
- 4.7. In considering the potential for introducing this pricing model, DsPH and LAs should be aware of the range of risk to the provider landscape. It is clear that, on the whole, Providers suffer a

financial loss from the implementation of tariffs – which is estimated to be an overall net Provider loss of £17.7m (this figure includes an estimate of the change in income received from Out of London Commissioners).

- 4.8. The presentation of the analysis (Appendix B) was worked through with sexual health commissioners from across London (at least 29 Boroughs were represented) at the Network meeting on Friday 8th May. Whilst few errors were identified or queries raised with regards to the data and the calculations at play, there were a number of concerns voiced regarding the potential barriers to and impact of implementation, and on the ability (of both commissioners and providers) to be 'business ready' ahead of any transitional date to this payment method. Despite these reservations, London Providers have been routinely making automated ISHT calculations and distributing these to Commissioners since 2011.
- 4.9. DsPH and LAs will want to consider an appropriate 'road-map' to introduction, with a number of possibilities available. Issues that need to be taken into consideration include:
- i. **System benefits beyond the financial savings identified.** The reporting model that will be used to drive the integrated tariff payments is much more granular than we currently receive and will allow us to see not only the various pathways of care being provided, but also the packages of care delivered to each individual attendee. The software as developed to date would allow for a move to e-based data and finance/invoice validation. Data is recorded, submitted, and validated online alongside the raising of any queries and, if necessary, disputes.
 - ii. **Commissioner & Provider Readiness.** With a new, potentially entirely e-based, payment system as noted above will come introductory and maintenance demands for the users at both ends. A smooth transition and then competent and confident day-to-day use will require some dedicated learning time prior to introduction. Much of this has already been running for the last 4 years.
 - iii. **Potential Changes in Provider Behaviour.** The analysis is based on data submitted by providers, which of itself is taken from their GUMCAD and SHRAD returns – a mandated information return expected of providers at a national level. Confidence is high on the robustness of the data. Nevertheless, a move to a 'fee for service' model, where for each area of care delivered the provider receives a fee, cumulative if a number of care pathways are delivered to any single patient, may for obvious reasons lead to changes in provider behaviour.

Analysis shows that the average number of care packages/ pathways delivered to each London resident attending a London provider is 1.9 – i.e. most people's needs are met with the delivery of less than two care packages/ pathways at an average overall cost of £122. The ISHT is structured in such a way (using a marginal cost model) that multiple tariffs triggered during a single patient visit do not duplicate payments for common elements of care. However, the data shows evidence that very small numbers of patients are being delivered upwards of five pathways of care in a single attendance. Stemming from Point i. above, it will be vital that commissioners understand their providers current activity patterns and case mix, so that relevant challenge can be raised where necessary in the future. Pathway Analytics are implementing benchmarking to allow commissioners to readily identify anomalous provider activity that is at odds to the

background norms. DsPH may also wish to consider options for capping / managing claims from providers relating to 'exceptional cases'.

- iv. **Service Specifications.** These will need to be reviewed to ensure they describe the full expectations of commissioners when providers deliver the pathways of care aligned to the tariffs. For example, at present GUM attendances are divided into 'First' and 'Follow-Up', and commissioners set-out the expectations of providers regarding the 'service offer'. Not all commissioners have explicit requirements on providers to include prevention as a core part of delivery as activity is simply divided as type of attendance, rather than care / service elements delivered. This would change with introduction of the tariff, which describes packages of care offered. Without an explicit requirement on providers to include prevention throughout each care pathway they deliver then this could be exploited.
- v. **Management of a Phased/ Staggered Introduction.** We may have to, or indeed wish to, introduce an ISHT system in a gradual fashion. This could be staged (i) at Borough level due to commissioner requirements, such as where contracts as written will not allow for the introduction of the tariff in a time-frame wished for by other LAs; or (ii) by service area, were a decision to be taken that a disproportionate risk existed to a 'type' of service / organisation (e.g. a stand-alone CaSH provider); or (iii) in the case of identifying that a single, yet significant, provider may be at risk from immediate introduction. Data systems to support a multi-faceted phased introduction of this type will be under test by Q3 2015 and in place by Q1 2016.
- vi. **Comms.** If the ISHT were introduced, and providers financially impacted because of it, there will be 'noise' and there may well be 'exits' by some providers. LAs will need to prepare for this. It is also important the LAs understand this is simply the replacement of a payment system. Introduction of the ISHT does not in any way result in 'less work to do' for public health departments/ local SH commissioners.
- vii. **Areas Not Yet Included.** A number of services commissioned across London have never been proposed for inclusion in the ISHT. DsPH may wish to consider work to explore the potential appropriateness of expansion of the tariff to such areas, and the possible impacts. Services such as community and e-based programmes (chlamydia screening and the expansion of home sampling/ testing); GP and Pharmacy Provision; and education and prevention projects and interventions are not included in the modelling to date.

List of appendices:

Appendix A - SH Tariff Programme Proposal V1.02 May 14.pdf

Appendix B – ISHT London FIA 150521 Released.pdf