

## Setting a tariff for community paediatrics

C Ni Bhrolchain

## What is a tariff?



- Tariff = price paid for health care episode
  - Is considered an average that covers costs + a little surplus to keep services viable

## How does a tariff affect income?

- Income = tariff x activity
- Income requires:
  - Accurate activity in correct categories
  - Tariff that reflects the cost of good care
- Getting either wrong means you get wrong income and could mean redundancies/bankruptcy

• *This is serious stuff!*



## Steps in setting a tariff (with thanks to Peter Donnelly)

- Classification system to count what the service is doing (currency)
  - Clinically acceptable
  - Simple (not many categories)
- What it costs (tariff)
  - Top down (reference costs)
  - Bottom up (patient level costing or PLICS)



## Finding a currency



- Identify all the types of work we do
  - Categories used for reference costs
  - Pilot project to test collection
- Still needed:
  - Cluster activity into small number of categories
  - Decide if using individual contacts or pathways or mixture

## Next...

- Can clusters be grouped to reflect similar costs?
  - Use reference costs?
  - Use clinical judgement?
  - Must then cost contacts/pathways at patient level to check any assumptions are correct

## Setting the tariff

- Using previous information
  - Set 'shadow' tariff
  - Test 'shadow' tariff for a few years
- DH sets live tariff
- This all takes (quite a lot of) time

## Building blocks



- Classification system/programmes of care
- How much of each activity do we do?
- Can we cluster them into groups?
- Can we estimate how much the activities cost?
- Can we cluster them into groups costing about the same?
- Did we get our estimates right?

## What have others done?



- Cystic Fibrosis
  - Structure based on 1992 publication
  - Cluster groups already tested
  - Modified to increase complexity
  - Currencies developed and tested
  - Shadow tariff now being tested
- **NB Specialty already had a tried and tested structure and cost base**

Band 1: Patients receive mainly out-patient care from the multidisciplinary team

Band 2: Patients receive the above plus intravenous antibiotics, and may be occasionally admitted

Band 3: As above, but patients have more frequent in-patient visits

Band 4: Patients have severe disease and come into hospital 3 or 4 times a year for antibiotics. They may have diabetes and more resistant organisms. They may have gastrostomies and be under consideration for transplantation

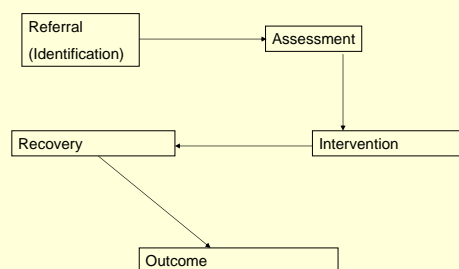
Band 5: Patients are severely ill and stay in hospital for long periods awaiting transplantation or receiving palliative care. As with Band 4 above, it is recognised that some patients at this stage of their illness prefer to be treated/managed at home with the support of the CF multi-disciplinary team. Patients may be receiving nocturnal ventilation and feeding gastrostomies. Patient's life expectancy is usually no more than a year to 18 months.

## Mental health



- Learning disability closer to our level
  - Beginning to define care pathways/clusters
  - Care clusters modified by level of need
  - If structure/classification can be agreed would then proceed to patient level costing

## Pathways of care LDs (applies to all programmes)





Classification system:  
programmes of care in  
community paediatrics already in  
place for reference cost  
collection

### TFC 291 = neurodisability

- General community paediatric clinics
- Specialist clinics
- MDT/CDC assessments disability
- Not
  - Statutory work (see next slide)
  - MDT meetings w/o parents present (not currently allowed under rules)

### Reference Cost collections TFC 290/CP60 = statutory work

- CP60FS and NFS      **Safeguarding**
- CP60FSS and NFSS      **Social services**  
(LAC/adoption)
- CPFSE and NFSE      **LEA statutory**  
(Medical advice)
- CPFCPH and NCPH      **Child public health**
- CPFO and NFO      **Other**

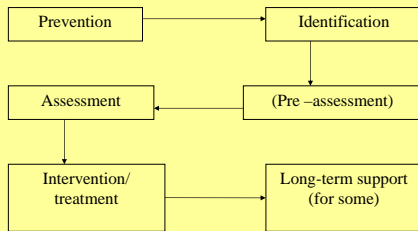
### General paediatrics TFC 420 (already paid by PBR)

- General paediatrics
- Continence?
- Physical CHS referrals?

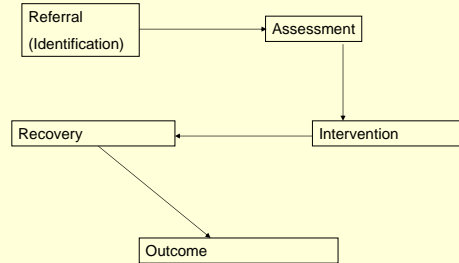
### Paediatric audiological medicine TFC 254

- Already recognised
  - includes neonatal screening programme

## Pathways of care (applies to all programmes)



## Pathways of care LDs (applies to all programmes)



British Association Of Community  
Child Health  
BACCH / PBR project  
Prof Mitch Blair  
Chair of Working Group

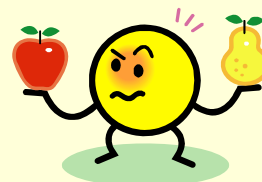
## PBR project pilot sites

- Blackpool
- Bolton
- Canterbury
- Derby
- East Kent
- East Sussex
- Greenwich
- Harrow
- MidSussex
- Medway
- South Birmingham
- Wirral

## Task 1 Common description of work (agreed domains)

- Communication Disorders
- Paediatric Neurodisability, e.g. Downs, cerebral palsy, muscular dystrophy
- Audiology
- Long Term Conditions, e.g. epilepsy, diabetes, cystic fibrosis
- Paediatric Mental Health
- Paediatric Palliative Care
- Childhood Continence
- Safeguarding Children – physical, mental and sexual abuse
- Looked After Children (LAC)
- General Paediatric Outpatients
- Court Attendance and Tribunals
- Child Death Reviews
- Lead Role – Designated Doctor for: Child Protection, LAC, Special Education Needs, Child Death Reviews
- Other Non Statutory Roles – Named Doctor for Child Protection, Immunisation, Child Public Health

## Task 2 Can we cluster them into groups?





## Building blocks



- Classification system/programmes of care
- **Yes**
- Can we count them?
- **Most people can do a bit but not consistent**
- Can we cluster them into groups?
- **Probably but need to reach consensus with profession**

## Building blocks



- Can we estimate how much the activities cost?
- **Not really**
- Can we cluster them into groups costing about the same?
- **No!**
- Did we get our estimates right?
- **No idea!!**

## Next tasks

- Reach consensus on currencies
  - Pathways or individual appts?
  - Cluster/needs groups
- Establish bottom up and top down costs for assessments and interventions
  - Better reference costs for pilot sites
  - PLICS project

## Lessons



- Busy people are busy
- Sustainability in face of credit crunch/massive NHS change
- Project management support required
- PBR team member support vital
- Further work required to cost pathways / patient level costings

## Otherwise...oops!



What you can do when you are challenged about PBR costs

Fawzia Rahman  
PBR Workshop BACCH ASM  
Leeds September 2009

## Hands up please 1

1. Did your Trust make a PBR return for 08/09 for community paed??
2. Do you know the name of the finance person who prepared it?
3. Was a senior community paed consulted?
- 4i. Did the clinician agree the activity figures?
- 4ii. Did the clinician agree the staffing numbers?
- 4iii. Was the clinician shown the other costs included (overheads, premises etc)

## Hands up please 2

5. Do you know what your final reference cost figure is in £?
6. Do you know which quartile this falls in?

## What you can do

1. Know your figure in £
2. Know your quartile
3. Know how it was worked out

Lower costs are not necessarily good  
Higher costs are not necessarily bad

## Basic maths

- Ref costs = service costs/ activity
- Have you got ALL the **activity**?
- Are the **staff lists** used correct?
- For **each** PBR category!







## Overheads and statutory work

- What % is contributed by overheads?
- What % is taken up by statutory activity?
- (are statutory roles properly resourced?)

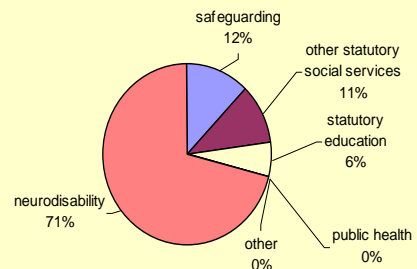
## In Derby

- Upper quartile
- Statutory roles properly resourced
- Statutory activity uses up 29% of costs for less than 10% of activity numbers
- Cost for neurodisability may not be that high! (compare with CAMHS costs)
- Overheads contribute 30% (?quartile position)

## Relative costs in £££

- Neurodisability @100 £ 
  - Statutory education @175 £ 
  - Other statutory social services @150 £ 
  - Safeguarding medicals @300 £ 
  - NAI @200 £ 
  - CSA @350 £ 
- (24/ 7 cons on call)

## contribution of statutory activity to costs



## Making sense of costs comparisons

- Are we counting the same things in the same way?
- Overheads must be separated out
- Data re staffing and activity must be accurate
- Statutory activity needs proper resourcing and reporting

## Implications for HRG type groupings

- Lowish- neurodisability wholesale (CP and epilepsy may need banding like CF)
- Medium: statutory education and other social services (cica, children in need)
- High: Safeguarding
- Work needs to be done!

## Conclusion

- Good information is needed to defend your services
- Clinical involvement is essential
- Join the BACCH PBR project !