Change to NHS payment mechanisms: accurately coded data will be needed to deliver them

Lord Darzi's report on the state of the NHS was concerned about productivity and suggested the re-introduction of payment for activity could improve it. While commentary on the Budget and the coming 10 Year Health Plan has focused on the need for policy and financial incentives to be aligned.

Adrian Jones, director - Maxwell Stanley at Clanwilliam UK, says potential changes are just another reason for acute trusts to focus on the accuracy of their coded data.

Lord Darzi's Independent Investigation of the National Health Service in England generated plenty of headlines ahead of the Budget and the launch of a consultation on next year's 10 Year Health Plan.

The eminent surgeon and former Labour health minister concluded that the NHS "is in serious trouble"; although he also argued the service has "strong vital signs" and can recover with the right "repair." One area for "repair" that should have received more attention than it has is the payment mechanisms the NHS uses.

Lord Darzi points out that "over the past decade there has been a significant shift away from activity-based mechanisms," such as Payment by Results, in favour of block contracting. His report suggests this may have hit productivity.

"With block contracts, providers are funded for their efforts rather than their outputs," he writes. "It is perhaps not a coincidence that the drop in clinical productivity metrics for the urgent and emergency pathway is nearly double that for outpatients and elective surgery, since it remains on block contracts" (while non-elective care hasn't).

Aligning policy and financial flows and incentives

Lord Darzi is not the only NHS leader interested in financial flows and incentives. Responses to the October Budget and the launch of a consultation on the 10 Year Health Plan that is expected in January also focused on the need to align reforms with financial flows and incentives.

While health and social care secretary Wes Streeting seems to be aware of the issues. In post-Budget comments, he told the BBC: "We have got to improve productivity – and ask some hard questions about where money goes in the system."

And in an earlier article for the Health Service Journal, he mused that: "Some would like a return to more activity-based 'payment by results' tariff, and the idea of extending this to preventative care interventions has been floated."

Accurate coded data

Before we consider what changes the policy makers tasked with responding to the investigation might consider, it's worth noting that any payment mechanism requires good data. In healthcare, that means accurately coded data.

Prior to COVID-19, acute trust drivers for accurate clinical coding were to ensure their activity, income, and performance indicators - such as mortality rates - were correctly reported. In particular, these relied on the accurate recording and coding of patients' chronic conditions and comorbidities.

During the pandemic, when more money went into the service and more of it was distributed through block contracts, there was less focus on the link between coding and income. However, this

has become important once again with the reintroduction of activity-based payments to incentivise hospitals to reduce waiting lists.

What many trusts have found is that the depth and accuracy of their coding has declined. Indeed, some are finding their data suggests the complexity case mix of their patients is less now than they were before Covid-19 - which is very unlikely to be the case.

Reasons for concern over the depth and accuracy of coding

The accuracy and depth of coding may have declined for a number of reasons. During the pandemic, clinical coders shifted to working from home and many have never returned to the office – if they still have an office and their trust has not repurposed it as clinical space.

Working from home isn't a problem in itself, but clinical coders may not have access to all the systems they would have on site. Instead of working from a full set of notes, for example, they may be working from a discharge summary – and there are well-known issues with the timeliness and completeness of discharge summaries across the NHS.

There has also been a change in electronic patient record systems. The Frontline Digitisation programme is moving trusts from paper and first-generation systems to full EPRs. This should deliver benefits to clinical care and flow, but it can take trust teams time to adjust and find the data they need.

It's important that trusts pinpoint and address these issues, so they can make sure they have the accurately coded data they need to hold effective negotiations with commissioners for work that is still covered by block contracts or to secure the income to which they are entitled under the reintroduction of payment for activity.

Incentives and drivers for change

There is also that bigger picture on re-introducing direct incentives to deliver more work and support reform. Although, in the short term, changes are likely to be limited. The reintroduction of activity-based payments for emergency and unplanned work would be a significant change that would need careful planning.

It's more likely that policy makers will look at the introduction of new incentives, perhaps rewarding trusts for carrying out specific checks, tests or procedures, on something like the model of the quality and outcomes framework in GP surgeries.

There could also be more experimentation with payment for pathways. This is already being used to a limited degree. For example, there is a maternity pathway for which trusts are paid for antenatal care, the delivery, and post-partum care.

This could be extended to other areas, although it's complex because it requires alignment across the NHS, from primary to secondary and sometimes tertiary or specialist services. From a data perspective, that's challenging, because it requires accurately coded data at each point, with the ability to link activity across different services.

Paying for integrated, preventative care?

The really big, long-term idea could be for local healthcare economies to receive a capitated budget to deliver wellness and health services for their entire population. This was one direction that sustainability and transformation partnerships could have taken when they were introduced a decade ago.

In principle, it would provide incentives for integrated care systems to shift the focus of their attention away from performance managing trusts and towards joining up services and focusing on prevention, to avoid expensive hospital trips and interventions whenever possible.

However, it would be difficult to set up. As things stand, there are real questions about whether the system has the necessary data to profile populations and target interventions appropriately. When these questions come up, there tends to be a lot of focus on how IT systems can be integrated to generate the data required.

There's less focus on making sure that the data in those IT systems is of good quality. Yet accurate coding would be key to such a fundamental shift in the way that healthcare is organised and paid for, and it would require investment.

Accurately coded data matters today, for productivity, and the future
Meanwhile, trusts need accurately coded data for all sorts of reasons. Accurately coded data allows them to monitor quality and mortality. It allows them to hold more effective negotiations with their commissioners.

It also allows them to claim the income to which they are entitled under activity-based payments, incentive schemes, or integrated pathways. Judging by the Darzi review and other, recent, policy discussions, more areas of activity are likely to be covered by these in the future, so accurately coded data will become even more important.

If some of the big picture shifts on incentives and financial flows are enacted, it will be essential for everybody in the system to know who is being treated and for what. Accurate coding will be key to getting that right.

Maxwell Stanley's part
Maxwell Stanley is the leading clinical coding specialist in the NHS. Our solution undertakes a targeted and automated identification of individual admissions with potential coding errors and missed comorbidities that impact on performance metrics and income.

If the NHS does indeed return to a more activity-based payment model, Maxwell Stanley can help trusts to assess the accuracy of their coded data, ensure it's correct and give them confidence in that data going forward, ensuring accurate income for the complexity of activity undertaken.