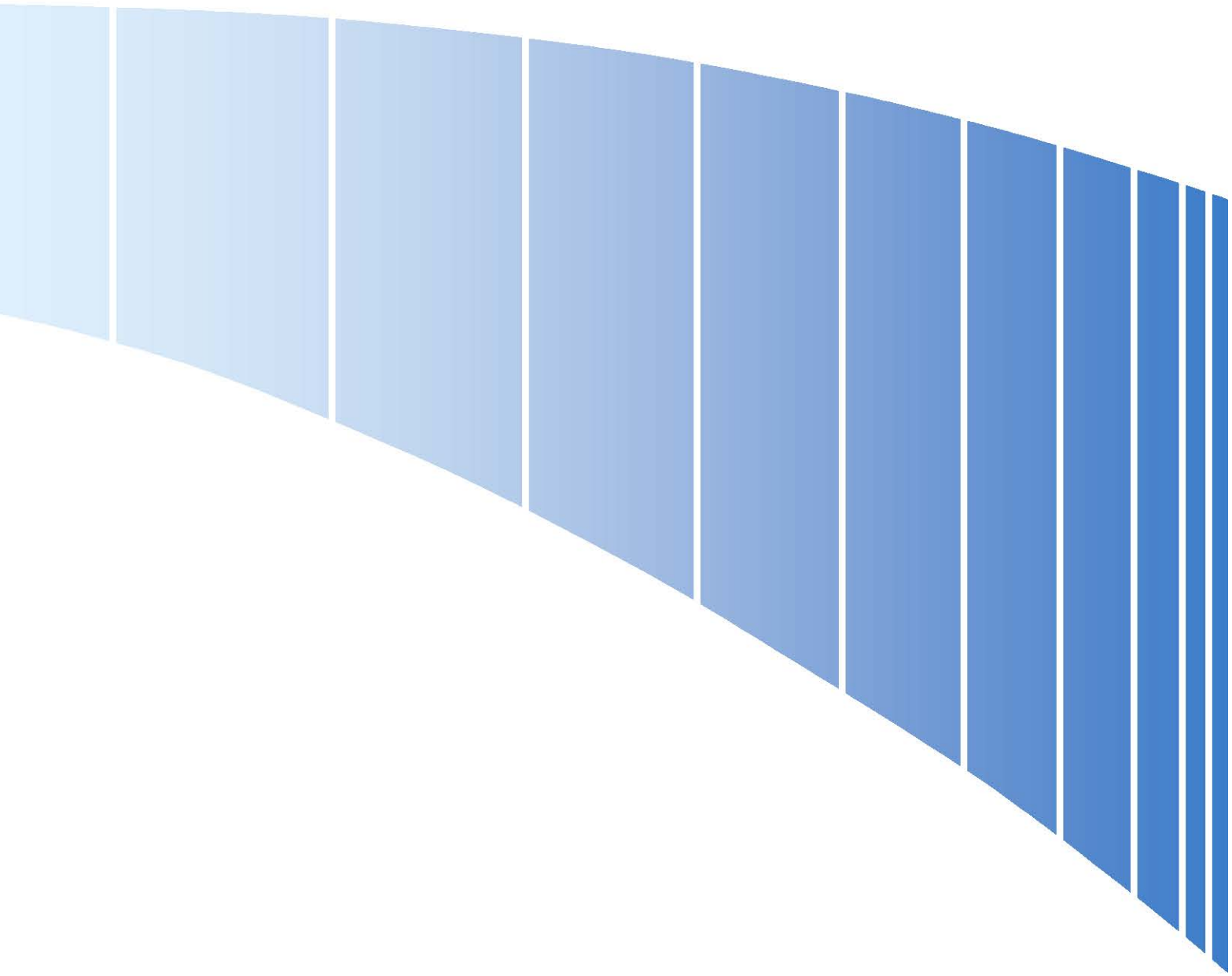
Payment by Results Guidance for 2012-13



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List of abbreviations

A&E	Accident and emergency
AEC	Ambulatory emergency care
BADS	British Association of Day Surgery
BNF	British National Formulary
BPT	Best practice tariff
CAMHS	Child and adolescent mental health services
CC	Complications and comorbidities
CCMDS	Critical care minimum data set
CDS	Commissioning data set
CNST	Clinical negligence scheme for trusts
COPD	Chronic obstructive pulmonary disease
CPA	Care Programme Approach
CPPP	Care Pathways and Packages Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised tomography
DOA	Dead on arrival
DSCN	Data set change notice
DVT	Deep vein thrombosis
ECG	Electrocardiogram
ERP	Enhanced Recovery Programme
ERP	Expert Reference Panel
ESA	Erythropoiesis Stimulating Agents
ESD	Early supported discharge
EVAR	Endovascular aortic repair
FCE	Finished consultant episode
GP	General practitioner
GUM	Genito-urinary medicine
HES	Hospital episode statistics
HoNOS	Health of the Nation Outcome Scales
HRG	Healthcare resource group
HTCS	Healthcare travel cost scheme
IAPT	Improving access to psychological therapies
ICD	International classification of diseases
ISB	Information Standards Board
ISTC	Independent sector treatment centre
LHB	Local health board
MFF	Market forces factor
MHCT	Mental health clustering tool
MHMDS	Mental health minimum data set
MIU	Minor injury unit
MRI	Magnetic resonance imaging
MSC	Main speciality codes
NAO	National Audit Office
NCA	Non contract activity
NCHOD	National Centre for Health Outcomes Development

NHFD	National hip fracture database
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NJR	National Joint Registry
NPSA	National Patient Safety Agency
NRD	National Renal Dataset
NSF	National service framework
NTAC	NHS Technology Adoption Centre
OPCS	Office for population censuses and surveys
PIAG	Patient Information Advisory Group
PbR	Payment by Results
PCT	Primary care trust
PETCT	Positron emission tomography computed tomography
PROMs	Patient reported outcome measures
PTS	Patient transport services
QALY	Quality adjusted life year
SCG	Specialist commissioning group
SHA	Strategic health authority
SPECT	Single photon emission computed tomography
SSC	Specialised service code
SSNDS	Specialised service national definition set
SUS	Secondary uses service
SUS PbR	Secondary uses service, Payment by Results mart
TA	Technology Appraisal
TARN	Trauma Audit and Research Network
TFC	Treatment function code
TIA	Transient ischaemic attack
TIPS	Transjugular intrahepatic portosystemic shunt
UAE	Uterine artery embolisation
UFE	Uterine fibroid embolisation
UKMi	United Kingdom Medicines information
UKRR	UK Renal Registry

Section 1: Introduction

Purpose

1. This guidance provides information to support the operation of Payment by Results (PbR) in 2012-13. It should be used alongside the following[1]:

   (a) *2012-13 tariff information spreadsheet*, which includes:
   - i. 2012-13 national mandatory tariffs – for admitted patient care, outpatient procedures and attendances, accident and emergency (A&E), direct access tariffs, and best practice tariffs
   - ii. 2012-13 non-mandatory tariffs – for specified services
   - iii. specialised service top-ups – percentages, eligible providers, ICD-10 and OPCS-4 trigger codes
   - iv. best practice tariffs (BPTs) – BPT flags, ICD-10 and OPCS-4 trigger codes
   - v. PbR exclusions – showing services, procedures, admitted patient care Healthcare Resource Groups (HRGs), outpatient attendance Treatment Function Codes (TFCs), drugs and devices excluded from the scope of PbR
   - vi. 2012-13 market forces factor (MFF) payment index and underlying index values
   - vii. unbundled HRGs – indicating whether they have a separate tariff, have had their costs rebundled, or are excluded from PbR
   - viii. post discharge tariffs

   (b) *Code of Conduct for PbR 2012-13* – establishes the principles that should govern organisational behaviour under PbR and sets expectations as to how the system should operate

   (c) *Step-by-step guide: calculating the 2012-13 national tariff* - where this guidance raises questions about the calculation of the tariff we recommend readers consult the step-by-step guide

   (d) *PbR and the market forces factor in 2012-13* – comprehensive guidance on the application of the MFF in PbR

   (e) *PbR Q&A for 2012-13* – questions and answers to complement the issues covered in this guidance

   (f) *Guidance for the implementation of SUS PbR from April 2012*[2].

2. Newcomers to PbR might like to begin with *A simple guide to Payment by Results*[3].

[1] http://www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/payment-by-results/ The document at (e) will be available in due course.
[2] Available at www.connectingforhealth.nhs.uk/systemsandservices/sus/supports/pbr/pbr-guidance/index_html in due course.
[3] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128862

Main changes in 2012-13

3. The main changes to note are covered in this section. There are important changes to note relating to the expansion in the number of service areas covered by best practice tariffs and the introduction of mandatory currencies for contracting adult mental health services. In addition, there have been changes in the underpinning healthcare resource group (HRG) structure, further information on which can be found on the NHS Information Centre's website.[4]

4. PbR arrangements for 2012-13 build on the changes made in 2011-12 and continue to be guided by four key principles:

   (a) incentivising quality and better outcomes for patients
   (b) embedding efficiency and value for money within the tariff
   (c) promoting integration and patient responsiveness
   (d) expanding the scope of PbR.

Incentivising quality and better outcomes for patients

5. We are further expanding the best practice tariff programme (Section 8), for example by **introducing same day emergency care best practice tariffs for a number of emergency clinical scenarios**. The aim is to promote management of these scenarios on a same day basis in an ambulatory emergency care manner. We are introducing best practice tariffs to incentivise procedures to be undertaken in an **outpatient setting** for female sterilisation, diagnostic hysteroscopy and diagnostic cystoscopy. We are also introducing a new best practice tariff for **major trauma care** (paragraph 341) designed to reward providers who meet quality criteria on a per-patient basis.

6. We are rolling forward existing best practice tariffs, but with revisions to:

   (a) **fragility hip fracture** (paragraph 366) and **stroke** (paragraph 377) – increasing the payment differential between best practice and non-best practice approaches. The best practice criteria for fragility hip fracture will also be expanded to include cognitive impairment testing for dementia
   (b) **paediatric diabetes** (paragraph 357) – will have a mandatory tariff to incentivise best practice outpatient care
   (c) **interventional radiology** (paragraph 295) – will be extended to peripheral artery disease, TIPS for portal hypertension, thoracic EVAR, percutaneous excision of benign breast lesions and diabetic foot disease. The aim is to increase the visibility of and provide fair reimbursement for less invasive techniques
   (d) **day case setting** (paragraph 283) – will be extended to include tonsillectomy and septoplasty to incentivise procedures being undertaken on a day case basis where appropriate

[4] http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads

(e) **home haemodialysis** (paragraph 328) **and assisted automated peritoneal dialysis** (paragraph 333) – building on the adult renal dialysis tariff introduced in 2011-12, the aim of this new best practice tariff is to promote greater choice for patients of home therapies for dialysis.

7. We are rolling forward the existing approach for the best practice tariffs for cataracts, TIAs (transient ischaemic attack - mini strokes) and hip and knee replacements, and will complete the transition to a mandatory tariff for adult renal dialysis.

Embedding efficiency and value for money within the tariff

8. We are maintaining the approach introduced in 2011-12 for reimbursing hospital stays, whereby a minimum trim point of five days is set so that relatively short stays do not attract a long stay payment (paragraph 97).

9. We are incentivising the provision of care in less acute settings where clinically appropriate by:

(a) continuing to set prices for a small number of HRGs which are the same across all settings, or across day case and outpatient procedures (paragraph 68)
(b) further increasing the number of mandatory outpatient procedure HRG tariffs (paragraph 182).

Promoting integration and patient responsiveness

10. We will begin the introduction of **post discharge tariffs**, (Section 4) initially for cardiac and pulmonary rehabilitation, and rehabilitation following hip and knee replacement. These tariffs will be mandatory where acute and community services are integrated in one trust. The use of post discharge tariffs may be extended to all trusts in 2013-14.

11. We will continue the policy of non-payment for some **emergency readmissions**, with the savings being invested in better post discharge care for patients, but for 2012-13 we are revising and simplifying our approach to give a firmer clinical basis for the application of this policy. Further details can be found at paragraph 121.

Expanding the scope of PbR

12. In 2012-13 we will mandate the use of currencies for contracting for **adult mental health services** (Section 11).

13. We will phase in the introduction of a **year-of-care tariff for cystic fibrosis** (paragraph 473) by transitioning from non-mandatory to mandatory prices, with a view to introducing a national mandated tariff in 2013-14. The transition to a mandatory tariff for **adult renal dialysis** will be completed (paragraph 308).

14. We are introducing mandatory tariffs for a number of directly-accessed tests (Section 6):
    (a) Direct access diagnostic imaging
    (b) Direct access respiratory tests for simple airflow studies and simple bronchodilator studies
    (c) Direct access flexible sigmoidoscopy

15. We are introducing mandatory currencies for contracting for **chemotherapy delivery** (paragraph 611), **external beam radiotherapy** (632) and **ambulance services** (paragraph 587). We are also introducing a non-mandatory currency for **HIV outpatient services** (paragraph 650).

Other changes

16. We will make available outside of this guidance information on a **maternity pathway system** for payment (paragraph 664) which will be introduced in shadow form in 2012-13, with the intention of mandating its use in 2013-14.

17. We would like to direct providers in particular to the section of the guidance which relates to **chemotherapy and radiotherapy** (paragraphs 611 and 632), so they are aware of the changes being made. This includes mandating the use of currencies for chemotherapy delivery and external beam radiotherapy. Also introduced for the first time in 2012-13 are mandatory zero prices for HRGs SB97Z (same day chemotherapy admission / attendance) and SC97Z (same day external beam radiotherapy admission / attendance). This will require some providers to make changes to current payment arrangements to ensure that they are correctly reimbursed.

18. There are some changes to the permitted tariff flexibilities (Section 13), including the flexibility for commissioners to vary tariff price where a provider is not doing the full range of services within a HRG category.

Scope of the national mandatory tariff

19. The national mandatory tariff plus an adjustment for MFF is payable by commissioners for day cases, ordinary elective and non-elective admitted patient care, attendances and some procedures in outpatients, and A&E services. It is payable to NHS trusts, NHS foundation trusts and independent sector providers.

20. The national mandatory tariff does not apply to procedures undertaken in wave one and phase two independent sector treatment centres (ISTCs). ISTCs are paid for services according to the terms and conditions of their contracts. Future contracts to provide services from ISTCs will be paid at tariff.

21. We introduced HRG4 as the currency underpinning the admitted patient care tariff in 2009-10. Not all services covered by HRG4 have a national tariff, for a number of reasons, including the quality of available costing and activity data. The 2012-13 tariff is based on 2009-10 NHS reference costs[5]. The costs of services that are currently outside the scope of reference costs[6] are, by default, not included within the tariff. Some activity remains outside the scope of the mandatory tariff and is subject to local price negotiation.

Tariff adjustment

22. Table 1 sets out the efficiency requirement and tariff adjustment for 2012-13. The national efficiency requirement is -4% and pay and price inflation is assessed at +2.2%. This gives an adjustment of -1.8% which should be the starting point for discussions on price for non-tariff services.

Table 1: Tariff adjustment

	%
Pay and price inflation	+2.2%
Total national efficiency requirement *	-4.0%
Net price adjustment	-1.8%

* of which 0.3% efficiency is embedded in tariff prices

23. As 0.3% efficiency is embedded in tariff prices through some of the best practice tariffs, tariff prices have been adjusted by -1.5%. In addition, prices have been adjusted with regard to the Clinical Negligence Scheme for Trusts (CNST)[7]. We have recognised this additional cost pressure of 0.3% (£63 million) through targeted adjustments to tariff prices (paragraph 26). As set out in the Operating Framework for the NHS in England 2012-13, the costs associated with the clinical audit subscriptions have been recognised in an adjustment to relevant tariffs (paragraph 28).

24. Where the pricing of best practice tariffs links to operational efficiency, we have recognised this when setting the overall national efficiency requirement. Where the pricing of best practice tariffs reduces income to providers who do not adopt best practice, this is not recognised as part of the national efficiency requirement, as the expectation is that providers will change the way they deliver services, where necessary, so that patients are receiving the best possible standard of care.

[5] www.dh.gov.uk/nhscosting
[6] Listed in section 16 (services excluded from reference costs) of 2009-10 reference costs guidance (March 2009) at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112590
[7] www.nhsla.com/Claims/Schemes/CNST/

25. We have not made any allowances in the tariff adjustment for CQUIN. The increase from 1.5% to 2.5% in the amount providers can earn, as set out in the NHS Operating Framework, is to be met from PCT allocations.

Clinical negligence scheme for trusts

26. Rather than include the cost pressure arising from NHS contributions to the CNST in the overall tariff adjustment, we have made £63 million of targeted adjustments to tariff prices, taking into consideration:

    (a) services where the size of the contribution and the proposed increase is significant
    (b) services which form clearly defined groups of activity within the tariff rather than activities which are spread across a wide range of service areas (eg anaesthetics).

27. We targeted CNST costs on tariff prices by identifying the relevant HRG chapters or sub-chapters and apportioning the costs across the HRGs in proportion to overall costs. Table 2 shows the adjusted HRG chapters for each of the specialty areas reflected in the CNST.

Table 2: Apportioning CNST costs to HRGs

HRG chapter or sub-chapter	Specialty	% increase in tariff prices
AA	Nervous System Procedures and Disorders	0.45%
AB	Pain Management	0.30%
BZ	Eyes and Periorbita Procedures and Disorders	0.26%
CZ	Mouth Head Neck and Ears Procedures and Disorders	0.12%
DZ	Thoracic Procedures and Disorders	0.04%
EA	Cardiac Procedures	0.14%
EB	Cardiac Disorders	0.07%
FZ	Digestive System Procedures and Disorders	0.16%
GA	Hepatobiliary and Pancreatic System Surgery	0.17%
GB	Hepatobiliary and Pancreatic System Endoscopies and Radiological Procedures	0.11%
GC	Hepatobiliary and Pancreatic System Disorders	0.16%
HA	Orthopaedic Trauma Procedures	0.56%
HB	Orthopaedic Non-Trauma Procedures	0.50%
HC	Spinal Surgery and Disorders	0.87%
HD	Musculoskeletal Disorders	0.14%
HR	Orthopaedic Reconstruction Procedures	0.45%
JA	Breast Procedures and Disorders	0.12%
JC	Skin Surgery	0.19%
JD	Skin Disorders	0.09%
KA	Endocrine System Disorders	0.14%
KB	Diabetic Medicine	0.03%
KC	Metabolic Disorders	0.04%

HRG chapter or sub-chapter	Specialty	% increase in tariff prices
LA	Renal Procedures and Disorders	0.08%
LB	Urological and Male Reproductive System Procedures and Disorders	0.10%
MA	Female Reproductive System Procedures	0.00%
MB	Female Reproductive System Disorders	0.03%
NZ	Obstetric Medicine	0.20%
PA	Paediatric Medicine	0.39%
PB	Neonatal Disorders	0.00%
QZ	Vascular Procedures and Disorders	0.21%
RC	Interventional Radiology	0.00%
SA	Haematological Procedures and Disorders	0.04%
VA	Multiple Trauma	0.47%
WA	Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare contacts	0.12%
A&E (excl Minor)		1.61%

Clinical audits

28. The Operating Framework for the NHS in England 2012-13 set out that the current contract states that providers will participate in the national clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) relevant to the services they provide. Work is underway to transfer the cost of established national clinical audits within NCAPOP to providers of relevant and tariffed services from 2012-13. The intention is for providers to subscribe to the audit programme, with the aim of providing stability in funding for audit and to provide financial headroom in the central programme budget to support the development and commissioning of new audits. The clinical audit subscription has been recognised in an adjustment to the relevant tariffs for the services associated with the subscription.

29. Relevant tariffs have been adjusted by a total of £2.7m to specific HRGs. The audits covered by the tariff adjustment are: bowel cancer; head & neck cancer; lung cancer; oesophageal cancer; angioplasty; myocardial infarction; heart failure and carotid interventions. The audit covering neonatal intensive care is also included in the subscription plans. However, this service is currently outside the scope of PbR and the additional costs associated with subscriptions will need to be reflected in local prices.

30. We continued to take account of NICE technology appraisals published since April 2008. We also made a number of pricing adjustments following sense check to tariffs which did not seem to be reimbursing activity appropriately. These are described in *Step-by-step guide: calculating the 2012-13 national tariff*.

Queries and feedback

31. It is neither desirable nor possible for this guidance to provide advice for every situation that arises locally, and in these circumstances, we ask commissioners and providers to exercise judgement in interpreting the guidance and come to a local agreement. Commissioners will wish to specify in contracts, and within PbR rules, what they will and will not pay for. For their part, providers will wish to ensure that the way they cost and charge for activity is consistent.

32. With the above in mind, queries about PbR that remain unanswered after referring to this guidance should be directed as follows:

    (a) Commissioners and NHS trusts should contact their SHA PbR leads[8]
    (b) NHS foundation trusts, SHAs and other organisations should contact the PbR team via pbrcomms@dh.gsi.gov.uk.

33. Other queries should be directed as follows:

    (a) HRG4 and grouper software to enquiries@ic.nhs.uk
    (b) clinical coding and the NHS Data Model and Dictionary to datastandards@nhs.net
    (c) SUS PbR to bt.sus.helpdesk@bt.com.

34. We would also welcome feedback on any aspect of this guidance, but in particular:

    (a) improving the operation of PbR
    (b) use of flexibilities, particularly innovation payments
    (c) expanding the best practice tariff programme
    (d) developing new currencies and tariffs.

35. Please contact us at pbrcomms@dh.gsi.gov.uk.

[8] www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_4000363

Section 2: Classification, currency and grouping

Currency

36. A currency is the unit of healthcare for which a payment is made and can take a variety of forms. HRGs are the currency for admitted patient care, A&E, some procedures performed in outpatients and (in combination with TFCs) outpatient attendances. We introduced the latest version, HRG4, as the payment currency for the tariff in 2009-10.

37. HRG4 design remains under constant review for changes in clinical practice and the 2012-13 Local Payment Grouper includes new HRGs that improve differentiation of care (for example for endoscopic approaches) as well as removal of HRGs (for example due to low volumes of activity). As the 2012-13 tariff is based on the 2009-10 reference costs, the basis for these HRG design changes is the changes made between the 2008-09 and 2009-10 reference cost groupers[9].

38. More information about HRGs is available on the NHS Information Centre (IC) website.[10] The HRG4 grouper roots documentation is particularly helpful in understanding changes to the HRG4 design.

Classification

39. Clinical classification systems describe information from the patient records using standardised definitions and nomenclature. PbR relies on two standard classifications to process clinical data on acute care:

    (a) International Classification of Diseases tenth revision (ICD-10) for diagnoses[11]
    (b) Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions[12]. The latest upgrade for OPCS-4, OPCS-4.6, was implemented in April 2011.

40. The fourth edition of the ICD-10 diagnosis classification will be implemented from April 2012. Further information is available on the NHS Connecting for Health website.[13] The NHS IC is planning to publish a summary of ICD-10 changes and the impact on the local payment grouper however it is not expected that this change will impact materially on any one provider.

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[9] Information available at http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment
[10] www.ic.nhs.uk/casemix
[11] As signalled in *Equity and Excellence: Liberating the NHS*, we expect to introduce the latest version of ICD-10 in 2012-13.
[12] www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4
[13] http:/www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/icd-10/icd_updates

41. The Terminology Reference-data Update Distribution (TRUD) service[14] supplies a number of data sets to support consistent coding of activity, including:

    (a) The chemotherapy regimens list, including adult and paediatric regimens, with mappings to OPCS-4 codes
    (b) The National Interim Clinical Imaging Procedure (NICIP) code set of clinical imaging procedures
    (c) The high cost drugs list and maps to OPCS-4 codes.

42. The renal dialysis HRGs use data items available from the national renal dataset (NRD)[15] and further details are at paragraph 311.

Grouping

43. Grouping is the process by which diagnosis codes (in admitted patient care only) and procedure codes (in admitted patient care and outpatients), treatment codes (A&E only) and investigation codes (A&E only) on patient records map to an HRG using software produced by the NHS Information Centre[16]. The relevant Grouper is the HRG4 2012-13 Local Payment Grouper. The NHS Information Centre also publish comprehensive documentation alongside the Grouper, including a Code to Group workbook that enables users of the Grouper to see how HRGs are derived and to understand the logic used.

44. In general, providers use the Grouper to plan, benchmark and send the results to commissioners as part of their request for payment. Commissioners use the Grouper to assess and validate claims for payment from providers, using the SUS PbR data available to them.

45. The Grouper groups data to HRGs, but does not apply exclusions or tariff adjustments. This needs to be done by users or a third party. Secondary Uses Service Payment by Results (SUS PbR) however groups the data and applies exclusions and tariff adjustments. SUS PbR houses the HRG4 grouping logic and, given the same input as the Grouper, produces the same results.

46. This guidance assumes that where users are locally grouping data, that they are making use of the 2012-13 Local Payment Grouper. Where users are using different grouping methods or software then this guidance may need to be adapted locally to fit. This guidance is consistent with the 2012-13 SUS PbR algorithm.

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[14] http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home
[15] http://www.ic.nhs.uk/services/datasets/dataset-list/renal Local reporting arrangements will be required for these data items in 2012-13; further details are at paragraph 316.
[16] www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment

Data stages

47. Grouping is one of several broad stages in the application of PbR rules to patient data. Table 3 shows each stage.

Table 3: Applying PbR rules to patient data

Stage	Description
PbR pre-processing stage	Excluding episodes and adjusting lengths of stay prior to grouping
Grouping	Running the data through the Grouper software
PbR post-grouping stage	Excluding spells after they have been grouped
PbR adjustments stage	Applying tariff adjustments to data

48. These stages apply to the tariff types shown in Table 4 with their corresponding Commissioning Data Set (CDS).

Table 4: Tariff type and CDS

Tariff type	CDS
Admitted patient care	CDS V6 Type 120 Admitted Patient Care - Finished Birth Episode CDS CDS V6 Type 130 Admitted Patient Care - Finished General Episode CDS CDS V6 Type 140 Admitted Patient Care – Finished Delivery Episode CDS CDS V6 Type 160 Admitted Patient Care – Other Delivery Event CDS
Outpatient procedures	CDS V6 Type 020 Outpatient CDS
Outpatient attendances	CDS V6 Type 020 Outpatient CDS
A&E	CDS V6 Type 010 Accident & Emergency CDS

PbR pre-processing stage

49. PbR pre-processing describes the preliminary processing of episode level data before it is fed through the Grouper.

50. Prior to applying exclusions, it is important to note that the full dataset is required to flag potential emergency readmissions. This is because under the rules governing payment of emergency readmissions (paragraph 121) an initial admission preceding an emergency readmission is not necessarily in the scope of PbR.

51. Certain episodes are excluded because they are outside the scope of PbR, eg private patients in NHS hospitals. The majority of pre-processing exclusions are identified at TFC level. Under HRG4, HRG exclusions are applied at the post-processing spell level stage and not the pre-processing episode level stage. The *tariff information spreadsheet* includes a full list of exclusions. Only those marked as pre-processing at episode level should be excluded at this stage.

52. Some pre-processing exclusions do not have specific codes listed (e.g. community services). We recommend that where there are no specific codes, commissioners and providers agree these exclusions using previous definitions as a starting point and negotiate payment locally. These episodes can still be excluded from SUS PbR prior to processing by the use of the '=' exclusion. Guidance is available from the NHS Information Centre website.[17]

53. At pre-processing it is important that episode lengths of stay are adjusted to take into account lengths of stay for services outside of PbR, ie rehabilitation, critical care and specialist palliative care. The minimum length of stay for an episode is 0. Once the data has been grouped, these adjusted episode lengths of stay will feed into the spell length of stay.

54. The Grouper has input fields for lengths of stay for rehabilitation and specialist palliative care as well as critical care. SUS PbR will not apply length of stay adjustments for rehabilitation or specialist palliative care as the fields do not currently flow into SUS. We are working with the NHS Information Centre to correct this for the next CDS release.

55. Therefore, for the purposes of PbR, a spell's length of stay is the sum of the episode length of stays within it, less any pre-processing exclusions and length of stay adjustments.

56. Once the relevant excluded episodes have been removed and any relevant adjustments have been made for length of stays, the data is ready to be grouped.

57. SUS PbR performs the pre-processing stage, which it then applies to data submitted by providers in CDS records.

Grouping stage

58. Users should refer to the manuals on the NHS Information Centre website[18].

PbR post-grouping stage

59. After grouping, post-grouping exclusions should be applied to the data. These include outpatient attendance TFC and HRG exclusions, besides exclusions from the rules governing payment for emergency readmissions. HRG exclusions are only applied post-processing and at the spell level under HRG4.

[17] http://www.ic.nhs.uk/services/secondary-uses-service-sus
[18] www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment

PbR adjustments stage

60. The final stage is the application of any relevant PbR tariff adjustments (paragraph 65 lists these for admitted patient care). The MFF (paragraph 708) is applied to the tariff after any adjustments.

61. It should be noted that the final tariff should be rounded to the nearest whole pound. This is consistent with SUS PbR processing.

Section 3: Admitted patient care

Structure

62. For admitted patient care, the currency for payment is HRG4. There are different tariffs depending upon the patient's admission type and an HRG may not necessarily have a tariff for each admission type. The tariff is based on spells, this is the period from admission to discharge or death, which comprise one or more finished consultant episodes (FCEs). The spell starts when a consultant, nurse or midwife assumes responsibility for care following the decision to admit the patient.

63. The admitted patient care tariffs include the costs of diagnostic imaging carried out in admitted patient care.

64. The relevant tariff to apply is determined by date of discharge, regardless of date of admission.

65. A number of adjustments to the admitted patient tariffs may apply. These are:

    (a) marginal rate emergency tariff
    (b) short stay emergency adjustment
    (c) long stay payment
    (d) specialised service top-up payment
    (e) adjustments for meeting best practice (Section 8).

66. The flow diagrams in Annex A illustrate the application of these adjustments.

Elective care

67. To promote the move to day case settings where appropriate, the majority of HRGs remain set on the average of day case and ordinary elective costs, weighted according to the proportion of activity in each.

68. Having a tariff for procedure-driven HRGs in an outpatient setting can also help to encourage a move to this more cost efficient setting, where clinically appropriate. There are a number of outpatient procedures with mandatory HRG tariffs (Section 5). For a small number of HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. We have only done this where there is significant outpatient activity, cost differences are already relatively low, and clinicians agree this is appropriate.

69. A spell should be defined as the period of admission to discharge or death for the same patient at the same provider. Where a patient has multiple distinct admissions on the same day (eg admission in the morning, discharged, re-admitted in the afternoon for a second

admission and then discharged) then each of these admissions should be counted separately and may attract a separate tariff as part of a pathway agreed with commissioners

70. The published tariffs are not an indication of the appropriate setting for activity, which is a matter for commissioners and providers to document as part of pathway specifications agreed with providers.

Marginal rate emergency tariff

Purpose

71. A marginal rate of 30% of the relevant published tariff will continue to apply for increases in the value of emergency admissions above a baseline of the actual value of the full 12 months of activity in the financial year 2008-09 priced at the 2012-13 tariff. The marginal rate provides an added incentive for closer working between providers and commissioners, to support the shift of care out of hospital settings and keep the number of emergency admissions to a minimum.

72. We have received feedback on the operation of the marginal rate and appreciate that there is an unintended consequence where a provider may have an overall value of emergency admissions for 2011-12 which is below the 2008-09 baseline, but continues to have funds deducted because of fluctuations in small volume contracts. Although we do not have an obvious evidence base to help manage this, we are seeking to address this through a change to the operation of the policy in 2012-13. Contracts worth 5% or less of the 2008-09 baseline should not attract the marginal rate, where the overall value of emergency admissions is below the 2008-09 baseline. We will keep this under review during the year.

Application

73. The marginal rate applies to increases, but not decreases, in the value of emergency activity. Where the actual value of emergency activity in 2012-13 remains below or at the baseline, commissioners will continue to pay providers at the full rate of tariff for that activity. The point at which the actual value of emergency activity exceeds the baseline value will trigger the introduction of the 30% marginal rate. For example, if the baseline is £1 million, and the actual value of activity in 2012-13 is £0.9 million, then the payment is also £0.9 million and not £0.97 million (being 30% of the difference between actual and baseline). But if the actual value of activity in 2012-13 is £1.1 million, then the payment is £1.03 million (being 30% of the difference between actual and baseline).

74. The marginal rate should be applied to the tariff after any other national adjustments for short stay emergency spells, long stay payments or specialised service top-ups.

75. The marginal rate applies at an annual level but commissioners will need to monitor on a cumulative monthly or quarterly basis in line with contractual arrangements. The *tariff information spreadsheet* provides examples to illustrate the principles for calculating the difference between the values of actual and baseline activity and making in-year adjustments. Our simplified examples assume an even profile; in reality, emergency activity will probably be monitored using a suitable seasonal profile.

Defining emergency

76. Emergency spells are defined by admission method codes 21-25 and 28[19] for the purposes of the marginal rate.

77. While the marginal rate does apply to emergency transfers (included in admission code 28), we recognise that these might have more complex care pathways which are more difficult to demand manage. Therefore, we have allowed for flexibility in how these are treated in the baseline (paragraph 87(c)).

78. Because it is determined solely by admission method code, the marginal rate applies to babies born at home as intended and then subsequently admitted because of clinical need (included in admission method code 28) but not other births (admission codes 82 or 83), and it applies to admission method codes 21-25 and 28 regardless of TFC.

79. The marginal rate does not apply to:

    (a) activity outside the scope of PbR
    (b) non-contract activity
    (c) activity covered by the best practice tariffs, with the exception of the new best practice tariff which promotes same day emergency care
    (d) A&E attendances
    (e) outpatient appointments
    (f) contracts with commissioners in the devolved administrations.

80. In 2012-13, there are new best practice tariffs designed to encourage management of a range of emergency clinical scenarios on a same day basis in an ambulatory emergency care manner. The marginal rate policy will apply to this activity as it is expected that the marginal rate will act as an effective mechanism for limiting any inappropriate increases in emergency admissions arising from the introduction of the BPT.

Setting the baseline

81. The baseline above which the marginal rate takes effect is determined on the basis of contractual relationships between commissioners and

19 http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1

providers. Where there is one provider and several PCTs in the contract, then we would expect arrangements to be agreed locally in line with contractual payment flows (see paragraph 72). There will need to be explicit agreement of the baseline for each contractual relationship, which should be included within the 2012-13 contract and concluded as part of the 2012-13 contract negotiations.

82. Where a provider reduces the value of its emergency activity against the baseline value in aggregate, the marginal rate will still apply for those contracts where the value of its emergency activity is above the baseline. Table 5 illustrates this.

Table 5: Setting the baseline

Provider A (figures in £m)					
	Baseline	Actual	Change	Reduction based on 30% marginal rate	Contract payment
	A	B	C = B - A	D = C (if > 0) * 0.7	E = B - D
PCT A	2	3	1	0.7	2.3
PCT B	3	1	-2	0	1
Sum of contracts[20]	5	4	-1	0.7	3.3

83. The 2012-13 baseline will be the actual value of the full 12 months of activity in the financial year 2008-09 priced at the 2012-13 tariff. To calculate the baseline, commissioners will need to group and price 2008-09 activity (on HRGv3.5) to HRG4, and price it using the features of the 2012-13 national tariff structure. This includes the rules for not paying for emergency readmissions within 30 days of discharge. The value of emergency readmissions subject to non-payment should be removed from the baseline. The *tariff information spreadsheet* includes a worked example. Because the baseline is priced using features of the 2012-13 national tariff, 2008-09 features do not apply. As the worked example in the *tariff information spreadsheet* makes clear, the baseline operates on the bottom line value and not at individual HRG or any other disaggregated level.

84. The marginal rate does not apply to activity covered by best practice tariffs for acute stroke, fragility hip fracture and major trauma. Although the most effective way to do this is to fully adjust the baseline and actual outturn values to reflect the relevant activity, commissioners and providers may use one of the following approaches where both parties agree:

    (a) making no adjustment (where there are very low levels of activity)
    (b) making an estimate of the proportion of growth accounted for by the value of best practice tariff activity
    (c) removing the value of best practice activity from the actual outturn figures.

[20] Note that the contract payments are £3.3 million even though the aggregate value of activity is £4 million against a baseline of £5 million.

85. Where a service opened during 2008-09 then the activity data needs to be annualised, or a later year's activity used. Where a new service is opened or an existing service is significantly reconfigured, then the baseline should be set using 2012-13 plan, annualised part year activity data from 2011-12, or 2010-11 full year activity, depending on when the service is opened or reconfigured.

86. Where a service has transferred between providers since 2008-09, or is to be transferred in 2012-13, the baseline will be derived from the previous provider's 2008-09 activity. This principle also applies to a planned transfer of emergency capacity or activity between providers.

87. The only other circumstances in which an amendment to the value of the baseline may be made are where:

    (a) a PCT is able to demonstrate that emergency activity has sustainably reduced
    (b) there has been a significant service redesign which would make the 2008-09 outturn unrepresentative of future patterns of activity (for example, more emergency admissions to one provider as a result of an A&E department at a second provider moving location)
    (c) there is evidence of or planned changes to service patterns, for example an increase in emergency transfers of patients to tertiary centres or the establishment of major trauma centres. Commissioners should be monitoring patterns of tertiary referrals to ensure they are appropriate
    (d) agreed changes in counting and coding have occurred since 2008-09.

SHA risk pool

88. In recognition that commissioners have a joint responsibility with providers in managing health system risk, SHAs should manage the 70% savings accruing from the triggering of this business rule to create a pool for system risk management and transformation. It is for SHAs to determine how they collect and utilise these savings but we would expect some of them to be invested in emergency admission avoidance. For example, in order to maximise the benefit to be gained from the transformation fund in 2011-12, North East SHA invited business case proposals from its acute provider trusts before the start of the year. The anticipated transformation fund was then immediately re-distributed from PCTs to the providers in order to pump prime a range of schemes specifically designed to reduce the incidence of and/or the consequences arising from emergency readmissions.

89. Where a PCT has a contract with a provider in another SHA, then the PCT's SHA and not the provider's SHA removes the savings.

Short stay emergency adjustment

90. The short stay emergency adjustment is a mechanism for ensuring appropriate reimbursement for lengths of stay of less than two days where the average HRG length of stay is longer. It is illustrated in Annex A Figure 1d.

91. The short stay emergency prices are published in the *tariff information spreadsheet,* based on the percentages in Table 6 (which remain unchanged in 2012-13), and do not need to be locally calculated. The level of reduction depends on the national average length of stay of the HRG. For example, the payment is 70% of tariff for an HRG with an average length of stay of 2 days.

Table 6: Short stay emergency adjustment percentages

Band	HRG with national average length of stay	% of full tariff
1	0-1 days	100%
2	2 days	70%
3	3-4 days	45%
4	5 or more days	25%

92. In 2012-13, we are introducing a new best practice tariff to promote same day emergency care (see paragraph 243)

93. The short stay emergency adjustment applies when all of the following criteria are met:

(a) the HRG is not within the scope of a best practice tariff
(b) the patient's length of stay is either zero or one bed day
(c) the patient is not for a child, defined as aged under 19 years on the date of admission
(d) the admission method code is 21-25 or 28
(e) the average length of non-elective stay for the HRG is two or more days
(f) the HRG is not defined by length of stay
(g) the assignment of the HRG has the potential to be based on a diagnosis code, rather than on a procedure code alone, irrespective of whether a diagnosis or procedure is actually dominant in the HRG derivation.

94. If all of these criteria are met, then the short stay emergency tariff and not the non-elective tariff applies, regardless of whether the patient is admitted under a medical or a surgical specialty. Any adjustments to the tariff, such as specialised service top-ups, are applied to the reduced tariff. The *tariff information spreadsheet* shows for which HRGs the reduced short stay emergency tariff is applicable.

Long stay payments

95. A long stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a trim point specific to the HRG. It is illustrated in Annex A Figure 1e.

96. The HRG costs reported in the published 2009-10 reference costs do not include the cost of stays beyond a defined trim point (these are reported separately in reference costs as excess bed days). The trim point is defined in the same way as for reference costs, but is spell-based and there are separate elective and non-elective trim points. The payment will operate after a patient's length of stay exceeds the trim point, when a daily rate will apply.

97. In 2012-13 we are continuing with the approach adopted in 2011-12, whereby there is a trim point floor of five days[21] and standardised long stay payments by HRG chapter.

98. If a patient is medically ready for discharge and delayed discharge payments[22] have been imposed on local authorities under the provisions of the Community Care (Delayed Discharges etc) Act 2003, then commissioners should not be liable for any further long stay payment. SUS PbR will apply an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the CDS, by removing the number of days between that and actual discharge from any long stay payment. This is the only circumstance in which long stay payments may be adjusted. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that appropriate charging to local authorities is taking place.

Specialised service top-up payments

99. Specialised service top-up payments are designed to recognise the additional costs of specialised activity compared to non-specialised activity within the same HRG. Annex A Figure 1f illustrates their application.

100. Top-up policy in 2012-13 has been informed by analysis of the additional costs of specialised care completed on behalf of the Department by the Centre for Health Economics (CHE) at the University of York.[23] CHE have repeated their analysis for 2012-13, concluding that the results used for 2011-12 were robust. When published the report will be available on the Department's website.

[21] For simplicity, we have shown a trim point floor of at least five days for all HRGs in the tariff spreadsheet, regardless of whether the HRG includes length of stay logic of less than five days.
[22] http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Delayeddischarges/index.htm
[23] http://www.york.ac.uk/che/news/che-research-paper-61/

101. In light of this, there are no changes to top-up policy in 2012-13 other than a revised top-up applied to specialised children's services in line with a phased transition to a level more comparable to that recommended by the CHE analyses.

102. The specialised children's top-up no longer applies to cochlear implant OPCS codes D241 (implantation of intracochlear prosthesis) and D242 (implantation of extracochlear prosthesis). These codes have been removed from the trigger lists in the grouper software.

103. Where the provider is eligible for any of the specialised services top-ups, this will be payable in addition to the major trauma best practice tariff (paragraph 341).

104. Top-ups are a percentage of the relevant HRG tariff and are shown in Table 7 together with the relevant specialised service code (SSC) flag and provider eligibility.

Table 7: Specialised service top-ups

	Top-up	SSC flag	Eligible provider list?
Children	50%	23	Yes
Neurosciences	28%	8	Yes
Orthopaedic	24%	34	No
Spinal surgery	32%	6	Yes

105. To determine which spells are applicable for specialised service top-ups, the Grouper uses lists of ICD-10 and OPCS-4 codes in the *tariff information spreadsheet* that are based on the third edition of the Specialised Services National Definition Set (SSNDS) published in 2009[24]. The Grouper then applies one of the SSC flags in Table 7 to the patient record. OPCS-4 codes can be in any position in the patient record, but ICD-10 codes must be in the primary position. As in 2011-12, all HRGs are eligible for top-ups.

106. Not all organisations are eligible. Eligibility lists are included in the *tariff information spreadsheet* and were agreed by a panel of SCGs, NHS Specialised Services and other NHS organisations in November 2010. Because the Grouper does not apply tariff adjustments, it does not incorporate organisation eligibility and therefore manual intervention is required to ensure that only those top-ups that an organisation is eligible for are applied to any data.

107. A spell may be eligible for more than one top-up, and the Grouper is able to output multiple SSCs (eg 8 and 34) for one spell, but only the highest is applied.

108. The specialised services top-up is applied after a short stay emergency adjustment, long stay payment or best practice tariff. However, please

[24] http://www.specialisedservices.nhs.uk/info/specialised-services-national-definitions

note the additional payments for the acute stroke and fragility hip fracture are not eligible for the specialised services top-ups.

109. Although there is no specialised services top-up for cardiac services, we are continuing the flexibility which enables commissioners to support specific services where the tariff may not provide sufficient reimbursement (paragraph 695).

Births

110. We are introducing a maternity pathway system for payment, in shadow form, covering antenatal care, the birth spell and post natal care. This is explained in more detail at paragraph 664.

111. There are a number of changes in the obstetrics chapter to revise the birth HRGs.

112. The Normal and Assisted Birth HRGs have been expanded to differentiate the resource implications of epidurals, induction and post-partum surgical intervention.

113. The caesarean section birth HRGs have been split to differentiate the resource implications between planned lower uterine caesarean sections, emergency or upper uterine caesarean sections, and caesarean sections with eclampsia, pre-eclampsia or placenta praevia. The planned lower and emergency or upper uterine caesarean section HRGs have been split to differentiate between with or without complications and co-morbidities.

114. Home births continue to be collected in the admitted patient care other delivery event CDS and reimbursed at the same rate as a normal delivery without complications, as illustrated in Annex A Figure 1g.

Non-delivery maternity admissions

115. HRG4 expanded the number of HRGs for non-delivery maternity activity from the previous one (N12) to seven (NZ04 to NZ10). This was intended to allow differentiation of the types of admission and lead to more accurate costing.

116. These HRGs continue to be subject to what appears to be inconsistent recording and poor costing. Although we have again adjusted prices by shifting some costs from the non-delivery HRGs to the delivery HRGs, we have not attempted to address this issue further because of the introduction (albeit in shadow form in 2012-13) of a pathway tariff for maternity which supports women's choices[25] (paragraph 664).

[25] The current HRGs and CDSs will continue to be needed for choice and referrals to tertiary providers.

117. In the meantime, many commissioners are working with their providers to understand the variation in recording practice, and to facilitate this we published a *simple guide to maternity services and Payment by Results* (July 2010)[26]. We strongly recommend that providers review their current recording and delivery practice to ensure that activity is correctly recorded, both clinically and administratively, and correctly costed. We also encourage commissioners to work with providers to benchmark this activity to understand what clinical activity takes place during these contacts. Where the published tariff is clearly over-reimbursing actual local costs as a result of changes made to local recording practices (rather than just inefficient service) commissioners should consider the use of a flexibility (paragraph 696), with review, to manage the situation.

Zero price

118. Table 8 shows HRGs that have a mandatory tariff of zero pounds (£0). There should be no payment for this activity.

Table 8: Zero price HRGs

HRG code	HRG description	Justification
LA08E	Chronic kidney disease with length of stay 1 day or less associated with renal dialysis	Empty core HRG for renal dialysis for chronic kidney disease
PB03Z	Healthy baby	Costs are included with the mother's care
SB97Z	Same day chemotherapy admission/attendance	Empty core HRG for chemotherapy
SC97Z	Same day external beam radiotherapy admission/attendance	Empty core HRG for external beam radiotherapy
UZ01Z	Data invalid for grouping	Organisations should not be funded for invalid data

No tariff price

119. Where insufficient costing or activity data was submitted to support the calculation of a tariff for an HRG we have not included that HRG in the national tariff, for example AA01Z intracranial procedures for trauma with major diagnosis. However, these HRGs can still be used as contract currencies with locally agreed prices.

120. No tariff information (£-) has been supplied in the *tariff information spreadsheet* where a tariff is not applicable for that combination of HRG and admission method.

Emergency readmissions

121. In 2011-12 the policy of non-payment for emergency readmissions applied to all readmissions following an elective admission and to a locally agreed proportion of readmissions following a non-elective admission. Both types were subject to a number of exemptions and the

[26] http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_118001

local threshold following a non-elective admission was to be set to deliver a reduction of 25% where clinically possible.

122. After engaging with NHS colleagues and reviewing the impact of the policy in Quarter 1, we understand that the application of the policy has proved very difficult to operate locally from the perspective of both commissioners and providers. Nationally this has resulted in an unacceptable level of variation on how the policy has been implemented. There are also concerns about the management of the savings generated by the policy with a significant amount either not being reinvested or not being reinvested in an agreed, transparent way. We have therefore worked with a number of pilot sites to assess the feasibility of replacing the 2011-12 guidance with simpler rules for 2012-13.

Key changes for 2012-13:

- No distinction between readmission following elective and non-elective initial admission (unless otherwise agreed)
- Clinical reviews to determine level of non-payment for readmission
- Deduction following readmission to a second provider subject to national rules

Piloting a new approach

123. The aim of the pilot work was to see if the readmissions policy could be put on a firmer clinical evidence base by asking providers and commissioners to come together to carry out an in-depth review of the drivers of readmissions, including those which are not within the immediate control of the acute provider, and to establish the level of readmissions at the trust, above which there should be no further payment.

124. Five pilot sites carried out reviews of admissions which had taken place in a single week, working to an agreed methodology which included the composition of the review team and a standard reporting proforma. For each patient, joint acute and primary care teams were asked to reach a decision as to whether the admission was avoidable through the actions of either the providing trust, the primary care team, community health services or social services. The aim was not just to identify poor quality care in hospitals but to uncover any actions by any appropriate agency which could have prevented readmission.

125. The results from the pilot sites showed that it was possible, at short notice and relatively low cost, to establish a review team and complete a review which, whilst not statistically significant, gave all parties a better understanding of why readmissions were happening and allowed them to agree the proportion of all the eligible readmissions which were avoidable.

126. The threshold for non-payment needs to include those admissions which are preventable through actions in the community so that a fund is established to tackle those issues and prevent patients being admitted to hospital unnecessarily. Examples of these types of action, arising from the pilots, are:

- provision of intravenous antibiotics at home service
- prevention of dehydration in nursing home
- provision of psychological support in primary/community settings
- domiciliary medication review
- faster (within 24 hours) response time for referrals to district nursing/community matrons

127. With regard to agreeing a split between those admissions which were unavoidable and those which were not, and therefore setting a threshold for non-payment, the results were as follows:

Table 9: Emergency readmissions pilot – avoidable and unavoidable admissions

	Site 1	Site 2	Site 3	Site 4	Site 5*
Avoidable admissions	19%	38%	33%	17%	3%
Unavoidable admissions	75%	59%	62%	80%	97%
Data entry errors/unknown	6%	3%	5%	3%	-

* Result is for admissions solely preventable by the trust

128. The average finding across the four trusts which looked at all avoidable admissions was not dissimilar to the proportion of admissions which the Q1 review showed had been planned as not paid for: 27% for the pilot sites and 25% (across both readmissions following elective and non-elective admission) for planned non-payment in 2011-12.

Revised guidance for 2012-13

129. Building on the work of the pilot sites, and suggestions from commissioners, we are refining the operation of the emergency readmissions policy so that from 1 April 2012 it will be based on a clinical review of readmissions. Providers should not be reimbursed for the proportion of readmissions judged to have been avoidable by any agency following such a review and, if agreed, separate proportions can

be set for readmissions following elective admission and readmissions following non-elective admission.

130. Providers and commissioners should undertake a clinical review of readmissions over a set period using a standard reporting format and methodology. The aim of the clinical review is to gather information about the issues affecting post discharge care and to set a threshold for all avoidable readmissions, including those preventable by actions outside the acute provider, above which providers will not be reimbursed.

131. If it is not possible to complete the review in time to influence contracts, a planning assumption can be made which will be superseded once the outcome of the review is known. Reviews must be completed by the end of the first quarter. If local agreement already exists to base reimbursement on the results of clinical reviews, and those reviews are not restricted to the actions of the acute trust, then those arrangements can, by agreement, continue in 2012-13.

The review

132. The review should be undertaken between the provider and its coordinating commissioner, initiated and funded by the commissioners. The findings should be used to inform all contracts between the provider and those commissioners within the group. For some larger, tertiary providers additional reviews may be necessary – one to establish a threshold for patients covered by the coordinating commissioning arrangements and one to establish a threshold for patients travelling to the provider from other areas. The coordinating commissioner can act as commissioner for both reviews with remote commissioners being required to accept the results.

133. The review team must be clinically led by a person not employed by the provider, for example a general practitioner or public health physician. Relevant clinical staff from the provider trust must be included as must representatives from the commissioning body, local primary care providers and, if at all possible, social services. The pilot programme suggested that the inclusion of a pharmacist in the team was highly desirable and, in some areas, the ambulance service may also be involved. Appropriate consideration should also be given to information governance with regard to the confidentiality of patient medical records.

134. The team should review the readmissions taking place within an agreed period. Our pilot reviews looked at readmissions taking place over one calendar week but a longer review period or a series of rolling reviews, giving greater confidence in the results, is encouraged and should be agreed locally. The review should be retrospective so that notes are easily available. In order to make best use of clinical time it is helpful to have administrative staff complete the basic parts of the proforma – date of birth etc – before the review and to flag where to look in the case

notes for the relevant admissions. The review team should also be supplied with a synopsis of HES data for all readmissions taking place within the last available 12 month period. This will enable them to place the focussed, in-depth review within the wider context.

135. For each readmission the team should complete a proforma based on the standard model attached at Annex I. This can be adapted if there is a desire locally to use the review to obtain further insight into readmissions. For each patient a decision should be reached as to whether the admission was avoidable through the actions of either the provider, the primary care team, community health services or social services, or a contracted body to any of these organisations. The aim is not just to identify poor quality care in hospitals, but to look at actions which could have prevented the readmission by any appropriate agency. The analysis should also look at whether there are particular local problems, and promote discussion on how services could be improved, who needs to take action, and what investment should be made. To this end, it may be worthwhile leaving in the sample any patients whose costs would be excluded from the policy (see paragraph 141) so that any gaps in service or other issues affecting their post discharge care can be identified. These cases would need to be disregarded when setting the threshold.

136. In cases of any dispute as to whether an admission was avoidable or not, the SHA Medical Director should be asked to adjudicate.

Reinvesting non payment money for emergency readmissions

137. Providers should not be reimbursed for readmissions above the agreed threshold. Commissioners must reinvest money from the non-payment for emergency readmissions into post discharge reablement services which support rehabilitation, reablement and the prevention of readmission, and particularly into those areas suggested by the clinical reviews. To ensure transparency within the system, commissioners need to discuss with providers where this money will be reinvested. Commissioners will be required to provide data on savings through the Financial Information Management System (FIMS) return and should ensure that they can provide a full audit trail of how the money is being used to prevent readmissions from occurring. We will be asking SHAs to monitor the use of the savings to ensure that the money is being reinvested in relevant areas and that all parties have been involved in decisions.

138. Commissioners must:

- be able to account for the money they have saved
- be able to demonstrate that they have transparently reinvested at least the same amount in a range of services
- be able to show that they have consulted with relevant stakeholders in how that money was reinvested.

Operating the policy

139. The emergency readmissions policy has applied to all readmitted patients discharged since 1 April 2011, regardless of where the initial admission occurred. From 1 April 2012, the definition of an emergency readmission in this context is any readmission:

    (a) where the time period between discharge from the initial admission and the readmission is equal to or less than 30 days
    (b) which has an emergency admission method code[27] of 21-25 or 28
    (c) which has a national tariff
    (d) irrespective of whether the initial admission has a national tariff
    (e) irrespective of whether it is to the same provider
    (f) irrespective of whether it is non-contract activity (paragraph 719)
    (g) irrespective of whether the initial admission or readmission occurs in the NHS or independent sector.

140. Where multiple admissions precede a readmission, the admission immediately preceding the readmission should be considered the initial admission. The amount that will not be paid is the total price associated with the continuous inpatient readmission spell,[28] including any associated unbundled costs, e.g. critical care or high cost drugs. PCTs will create a post-discharge fund from the savings (paragraph 147).

141. There are a number of exclusions from this policy, which will apply to emergency readmissions following both elective and non-elective admissions:

    (a) any readmission which does not have a national tariff
    (b) maternity and childbirth - where the initial admission or readmission is in HRG subchapter NZ (obstetric medicine)
    (c) cancer, chemotherapy and radiotherapy - where the initial admission or readmission includes a spell first mentioned or primary diagnosis of cancer (ICD-10 codes C00-C97 and D37-D48) or an unbundled HRG in subchapter SB (chemotherapy) or SC (radiotherapy). We intend to revisit and limit this exclusion in future years.
    (d) young children – where the patient is under 4 at the time of readmission
    (e) patients who are readmitted having self-discharged against clinical advice – included in discharge method code 2 in the initial admission

[27] As defined in the NHS Data Model and Dictionary at http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1

[28] The definition of a continuous inpatient readmission spell in this context is a continuous period of care from admission to discharge, regardless of any emergency or other transfers which may take place.

(f) emergency transfers of an admitted patient from another provider, where the admission at the transferring provider was an initial admission and not itself a readmission[29]
(g) cross border activity – where the initial admission or readmission is in the devolved administrations (paragraphs 723 to 741).
(h) patients receiving renal dialysis
(i) patients readmitted subsequent to a transplant.

142. Commissioners should continue to reimburse providers for readmitted patients when any of these exclusions apply.

143. Where a patient is readmitted to a different provider from the one where the initial admission occurred, the second provider must be reimbursed, but the commissioner will deduct an amount from the first provider when reconciling activity for payment as soon as practical, even if this is outside the monthly reporting timetable in paragraph 717**.**

144. For these cross-provider readmissions the amount to be deducted should be the same as is being applied to readmissions at the first provider following the clinical review, regardless of whether either admission was subject to the marginal rate, plus the second provider's MFF. Emergency transfers of an admitted patient from another provider which form part of a continuous inpatient readmission spell will be also deducted from the first provider at the agreed rate for the first provider following clinical review (plus the second provider's MFF).

145. In a change from last year, SUS PbR will, from April 2012, contain a report on readmissions that will be available to both commissioners and providers. This report will include both cross-commissioner and cross-provider data. *Guidance for the implementation of SUS PbR form April 2012* will contain advice on how SUS PbR will support the readmission rule.

Reablement and post discharge support

146. PCTs are required to develop local plans in conjunction with providers, GPs and local authorities to develop seamless care for patients on discharge from hospital and to prevent readmission to hospital, and to use these plans as a basis for co-ordinating activity on post discharge support. In 2011-12, PCTs received £150 million in their recurrent allocations, rising to £300 million from 2012-13, to develop local reablement services in the context of post discharge support[30].

147. The rules on non-payment for emergency readmissions have created

[29] Emergency transfers of an admitted patient from another provider are included in admission method code 28, which also includes other means of emergency admission. Organisations may wish to adopt additional rules to flag emergency transfers.

[30] http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_123460

additional savings for PCTs to reinvest in reablement and post discharge services. Commissioners must invest savings from this policy in better patient care and must agree that investment with local health and social care partners and publish the results.

148. SHAs will monitor the progress of PCTs in identifying and using these savings. PCTs need to be more specific and transparent about where they are reinvesting the reablement and post discharge support funds and need to engage stakeholders when doing this.

149. In 2012-13 we will continue to encourage the use of locally agreed year of care tariffs for named patients with complex long-term conditions who are frequently readmitted to hospital, with a view to developing more pathway and year of care tariffs in the future.

150. For 2012-13 we have worked with local partners and clinical leads to develop post discharge tariffs for specific care pathways. More detailed guidance on these tariffs can be found in Section 4.

Section 4: Post discharge tariffs

Introduction

151. To take forward the Secretary of State's vision of a shift of responsibility for patient care following discharge from hospital from commissioners to acute providers, we have developed, with the help of NHS colleagues, post discharge tariffs for four specific rehabilitation pathways, learning from best practice examples already operating in the NHS and social care.

152. From 1 April 2012, we will expand the acute tariff to include new tariffs covering post discharge care in four areas:

- Cardiac rehabilitation
- Pulmonary rehabilitation
- Hip replacement
- Knee replacement.

153. The tariffs, which are set out in the *tariff information spreadsheet*, are based on clinical advice and, where available, existing DH commissioning packs. They are sufficient to fund an entire pathway and not just the first 30 days after discharge.

Implementation of post discharge tariffs

154. The post discharge tariffs will be introduced in a progressive way and in 2012-13 will be mandatory for the care of patients for whom the trust provides relevant, integrated acute and community services. For all other trusts and patients the tariffs will be non-mandatory in 2012-13 with the expectation of becoming mandatory in 2013-14.

155. Degrees of service integration vary and commissioners and providers will need to establish which health communities receive both their acute and community services from a single trust.

156. Where services are not integrated we are encouraging the use of these tariffs as part of local negotiations on the joint commissioning of post discharge pathways of care as it is likely that they will be rolled out to all trusts in the future.

157. The tariff payments should be paid on completion of a full rehabilitation pathway. More details on this are included in the sections for each tariff. We anticipate that these tariff payments will be funded from a number of sources including:

(a) savings from non-payment for avoidable emergency readmissions
(b) the funds available to commissioners to develop local reablement services (see paragraph 146)

(c) savings from the application of the marginal rate emergency tariff
(d) other funding streams and any discontinued current equivalent activity funding, for example activity paid for in a block contract.

158. In 2012-13, commissioners will not pay for avoidable emergency readmissions. Providers who are subject to these mandatory post discharge tariffs are not exempt from the emergency readmissions policy for patients who receive post discharge care.

159. The post discharge activity and tariff will not be identified by the Grouper or by SUS PbR, so local agreement between commissioners and provider trusts will be required on the number of patients expected to complete rehabilitation packages, followed by a reconciliation to the actual numbers completed at the year end.

Cardiac rehabilitation post discharge tariff

160. Post discharge care for patients referred to cardiac rehabilitation courses will be the responsibility of the integrated provider trust from which the patient is discharged. Any post discharge activity outside a defined cardiac rehabilitation pathway for these patients during the period of rehabilitation will remain the funding responsibility of the patient's commissioner and is not covered by this tariff.

161. The tariff is based on the pathway of care outlined in the Department's Cardiac Rehabilitation Commissioning Pack.[31] Commissioners should pay at the mandatory tariff rate even where the provider offers a different care pathway as the provider is bearing the potential risk of the patient being readmitted and it is for them to assess what type of rehabilitation is provided and how it is provided.

162. Based on clinical guidance, the post discharge tariff will only apply to a subset of those patients identified in the Commissioning Pack as potentially benefitting from cardiac rehabilitation, where the evidence for the impact of cardiac rehabilitation is strongest. This is those patients discharged having had an acute spell of care for acute myocardial infarction, heart failure or percutaneous coronary intervention and patients undergoing coronary artery bypass grafting (CABG).

163. Therefore, the post discharge tariff is payable for patients discharged from acute care within the defined list of spell primary diagnoses and spell dominant procedures below, who subsequently complete a course of cardiac rehabilitation.

> **Acute Myocardial Infarction:** A spell primary diagnosis of: I210, I211, I212, I213, I214, I219, I220, I221, I228 or I229

[31] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_117504

Percutaneous Coronary Intervention: A spell dominant procedure of: K491, K492, K493, K494, K498, K499, K501, K502, K503, K504, K508, K509, K751, K752, K753, K754, K758 or K759
Coronary Artery Bypass Graft: A spell dominant procedure of: K401, K402, K403, K404, K408, K409, K411, K412, K413, K414, K418, K419, K421, K422, K423, K424, K428, K429, K431, K432, K433, K434, K438, K439, K441, K442, K448, K449, K451, K452, K453, K454, K455, K456, K458, K459, K461, K462, K463, K464, K465, K468 or K469
Heart Failure: A spell primary diagnosis of: I500, I501, I509

Pulmonary rehabilitation post discharge tariff

164. Post discharge care for patients referred to pulmonary rehabilitation courses will be the responsibility of the integrated provider trust from which the patient is discharged. Any post discharge activity outside a defined pulmonary rehabilitation pathway for these patients during the period of rehabilitation will remain the funding responsibility of the patient's commissioner and is not covered by this tariff.

165. The tariff is based on the pathway of care outlined in the Department's Chronic Obstructive Pulmonary Disease (COPD) Commissioning Pack which is expected to be published in March 2012. Commissioners should pay at the mandatory tariff rate even where the provider offers a different care pathway as the provider is bearing the potential risk of the patient being readmitted and it is for them to assess what type of rehabilitation is provided and how it is provided.

166. The post discharge tariff will apply to patients discharged having had an acute episode of care for COPD. The mandatory tariff payments should therefore only be paid for patients discharged from acute care with an HRG for the spell of care of DZ21A to DZ 21K, who subsequently complete a course of pulmonary rehabilitation. The DH Commissioning Pack provides detailed guidance on the evidence base for those discharged from a period of care for COPD who will benefit from pulmonary rehabilitation.

Hip replacement

167. Post discharge rehabilitation care for some patients following defined primary non-trauma total hip replacement procedures will be the responsibility of the integrated provider trust from which the patient is discharged. Any post discharge activity not directly related to rehabilitation from their surgery for these patients during the period of rehabilitation will remain the funding responsibility of the patient's PCT and is not covered by this tariff.

168. The defined clinical pathway for post discharge activity for primary non-trauma total hip replacements provided by clinical leads suggested a pathway of:

- 7 nurse/physiotherapist appointments
- 1 occupational therapy appointment
- 2 consultant-led clinic visits

169. The tariff given therefore represents the funding for this pathway of rehabilitation and will act as a maximum level of post discharge rehabilitation tariff. Local agreement will need to be reached on the level of transfer from commissioners when integrated provider trusts take responsibility for post-discharge rehabilitation for patients who, after clinical evaluation, require less intensive pathways of rehabilitation. The post discharge tariff will fund the pathway for the first three months after discharge and does not cover long term follow-up treatment.

170. Mandatory tariff payments should only be paid for patients discharged from acute care with an episode of care with a spell dominant procedure of W371, W381, W391, W931, W941 or W951.

171. The post discharge tariffs for hip and knee replacement cover the defined clinical pathway only for post discharge activity. Commissioners looking to develop a whole pathway approach for these patients may wish to take account of the primary total hip and knee replacement BPT (paragraph 389), which encourages a shorter length of stay.

Knee replacement

172. Post discharge rehabilitation care for some patients following defined primary non-trauma total knee replacement procedures will be the responsibility of the integrated provider trust from which the patient is discharged. Any post discharge activity not directly related to rehabilitation from their surgery for these patients during the period of rehabilitation will remain the funding responsibility of the patient's PCT and is not covered by this tariff.

173. The defined clinical pathway for post discharge activity for primary non-trauma total knee replacements provided by clinical leads suggested:

    - 10 nurse/physiotherapist appointments
    - 1 occupational therapy appointment
    - 2 consultant-led clinic visits

174. The tariff given therefore represents the funding for this pathway of rehabilitation and will act as a maximum level of post discharge rehabilitation tariff. Local agreement will need to be reached on the level of transfer from commissioners when integrated provider trusts take responsibility for post-discharge rehabilitation for patients who, after clinical evaluation, require less intensive pathways of rehabilitation. The post discharge tariff will fund the pathway for the first three months after discharge and does not cover long term follow-up treatment.

175. The mandatory tariff payment should therefore only be paid for patients discharged from acute care with an episode of care with a spell dominant procedure coding of W401, W411, W421 & O181.

176. The post discharge tariffs for hip and knee replacement cover the defined clinical pathway only for post discharge activity. Commissioners looking to develop a whole pathway approach for these patients may wish to take account of the primary total hip and knee replacement BPT (paragraph 389), which encourages a shorter length of stay.

Section 5: Outpatient care

Structure

177. The outpatient attendances tariffs are based on treatment function code (TFC) [32]. We also have 79 tariffs for procedure-driven HRGs in outpatients. We have rebundled the costs and activity for remaining procedure-driven HRGs not on this list into the relevant outpatient attendance TFCs, as described in *Step-by-step guide: calculating the 2012-13 national tariff*[33]*.* These will be reimbursed using the relevant outpatient attendance tariff, unless commissioners and providers wish to employ the flexibility at paragraph 678.

178. Commissioners and providers should have regard for the provisions in the *Code of Conduct for PbR in 2012-13* around standard notice periods and transition arrangements where the introduction of mandatory tariffs for outpatient procedures and attendances results in increased reporting of activity.

179. Where patient data groups to a non-admitted attendance HRG (HRG4 sub-chapter WF), SUS PbR determines whether the TFC has a mandatory tariff and applies the appropriate outpatient attendance tariff. If the TFC does not have a mandatory tariff, the price is for local negotiation between commissioners and providers. This is illustrated in Annex A Figure 2a.

180. Where patient data groups to a procedure-driven HRG (ie not from HRG4 sub-chapter WF), SUS PbR determines whether the HRG has a mandatory procedure tariff and applies it. Where it does not, SUS PbR determines whether the relevant mandatory outpatient attendance tariff (HRG4 sub-chapter WF), based on TFC, is applicable. This is illustrated in Annex A Figure 2b.

181. In 2011-12, we introduced a distinction between HRGs that are excluded across all settings, and HRGs that are excluded for admitted patient care but where the activity may still generate an outpatient attendance tariff. For example, the HRG for lung volume studies (DZ45Z) is excluded from admitted patient care and does not have an outpatient procedure tariff, but the activity may generate an outpatient attendance TFC tariff.

Procedures in outpatients

182. In 2012-13 we have increased the number of mandatory tariffs for procedure-driven HRGs only to reflect changes in HRG design. For example, where an HRG had an outpatient tariff in 2011-12, but the

[32] TFCs are defined in the NHS Data Model and Dictionary as codes for "a division of clinical work based on main specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including consultants."
[33] Published as part of the final PbR package for 2012-13.

activity in that HRG will be split into two new HRGs in 2012-13, we have a tariff for both of those HRGs for 2012-13 unless we have been advised that this is inappropriate. We do not expect every procedure that maps to these HRGs can be appropriately carried out in an outpatient setting.

183. The tariff for procedure-driven HRGs is paid instead of the outpatient TFC attendance tariff, regardless of whether or not the activity is consultant led or if the TFC is excluded for outpatient attendances, except where the service as a whole is excluded. If more than one of these procedures is undertaken in a single outpatient attendance, the HRG will be based on the same logic as used in admitted patient care (ie based on the procedure that is ranked highest in the grouping hierarchy), and only one HRG will be chargeable.

184. Commissioners and providers should agree appropriate categorisation of outpatient attendance and day case activity. The NHS Data Model and Dictionary is a source of information on this issue[34]. Providers should ensure that the way that they charge for activity is consistent with the way that they cost activity in reference costs, and consistent with any conditions for payment that commissioners include within contracts. The Audit Commission are reviewing definitional issues in conjunction with the Department, NHS Connecting for Health and the NHS Information Centre.

185. In 2012-13 we are introducing best practice tariffs for diagnostic cystoscopy, diagnostic hysteroscopy and hysteroscopic sterilisation performed in an outpatient setting (paragraph 268).

Outpatient attendances

Eligibility

186. The mandatory outpatient attendance tariff remains applicable only to pre-booked, consultant led attendances. The pre-booked requirement is not limited to Choose and Book[35], and may include local systems accepting patients based on GP letters or phone calls. Genito-urinary medicine (GUM) services, and other sexual health services providing confidential open access, are an exception to the pre-booked requirement. The tariff applies to these services, whether walk-in or appointment based, and provided by acute trusts or PCTs. Prices for other outpatient attendances that are not pre-booked or consultant-led should be agreed locally – this should not be a barrier to the provision of such services which may be entirely appropriate to the patients in question.

[34] http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/cds/admitpat/day case

[35] Choose and Book is the national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

187. Where an attendance with a consultant from a different main specialty during a patient's admission replaces an attendance which would have taken place regardless of the admission, then provided it meets the relevant conditions (ie it is pre-booked and consultant-led) it can attract a tariff.

188. The attendance does not have to take place in trust premises, so consultant led outreach clinics held in a GP practice or a children's centre could be eligible to receive the tariff. For these clinics, it will be important to make sure the data flows into SUS PbR. Home visits are not eligible and should be subject to local pricing. The advice we have received is that home visits should be part of the work to develop currencies and tariffs for community services.

189. As with admitted patient care, not all activity taking place in outpatient clinic settings, even when supported by separate data flows, will attract a separate payment under the national tariff. Data may be required to support other policy initiatives and, where there is doubt about funding, providers should refer to the methodology used to compile their reference cost returns to establish where the funding for a service is expected to be found.

190. Where a patient has multiple distinct outpatient attendances (and/or procedures) on the same day (eg attendance in the morning, second separate attendance in the afternoon) then each of these attendances should be counted separately and may attract a separate tariff as part of a pathway agreed with commissioners.

Consultant led and non-consultant led

191. The NHS Data Model and Dictionary definition of a consultant led service is a "service where a consultant retains overall clinical responsibility for the service, care professional team or treatment. The consultant will not necessarily be physically present for each consultant led activity but the consultant takes clinical responsibility for each patient's care."[36] A consultant led service does not apply to nurse consultants or physiotherapist consultants.

192. There is no national tariff for non-consultant led clinics. The NHS Data Model and Dictionary states that "all non-consultant led activity is identified in the admitted patient care CDS and HES by a pseudo main speciality code of 560 for midwives, 950 for nurses and 960 for allied health professionals." We encourage health economies to consider setting local prices for this activity.

193. The exception to this approach is for maternity services in an outpatient setting. We have set the same mandatory price for consultant and

[36] http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_led_service_de.asp?shownav=1

midwife led activity[37], reflecting that the majority of pregnant women receive the same care from a midwife, whether or not a consultant is responsible. This tariff applies to both TFCs 501 (obstetrics) and 560 (midwife episode). Providers should code consultant led activity to 501 and midwife led care to 560.

First and follow-up attendances

194. There are separate tariffs for first and follow-up attendances. A first attendance is the first or only attendance in respect of one referral. Follow-up attendances are those that follow first attendances as part of a series in respect of the one referral. The series ends when the consultant does not give the patient a further appointment, or the patient has not attended for six months with no forthcoming appointment. If after discharge the condition deteriorates, a new referral occurs and the patient returns to the clinic run by the same consultant, this is classified as a first attendance.

195. The end of a financial year does not necessarily signify the end of a particular outpatient series. If two outpatient attendances for the same course of treatment are in two different financial years but are less than six months apart, or where the patient attends having been given a further appointment at their last attendance, the follow-up tariff applies.

196. To disincentivise follow-ups where these are not necessary, we have added 10% of the costs of follow-up attendances to first attendances when setting tariffs (with the exceptions of infectious diseases and nephrology, where correct clinical management demands a follow-up regime).

197. Some clinics are organised so that a patient may be seen by a different consultant team (within the same specialty and for the same course of treatment) on subsequent follow-up visits. Where this is the case, commissioners and providers may wish to discuss an adjustment to funding to recognise that a proportion of appointments being recognised in the data flow as first attendances are, as far as the patient is concerned, follow-up visits.

198. There has been some concern about levels of consultant-to-consultant referrals, and when it is appropriate for these to be reimbursed as a first rather than follow-up attendance. Given the variety of circumstances in which these may occur, it is not currently feasible to mandate a national approach to counting and reimbursement. The Audit Commission have found that consultant-to-consultant referrals are not the main driver of increases in outpatient activity. They found that the share of referrals for new outpatient attendances has remained more or less the same over the three years to 2009-10 (in 2009-10, 57% from GP referral, 8% from

[37] which may include community midwife clinics provided that the principles in paragraphs 10.1.6 and 10.1.7 of the *Code of Conduct* apply.

consultant referral, 17% from A&E referral and 18% from other sources)[38].

199. We are again publishing a non-mandatory price for non face-to-face outpatient activity (paragraph 503), which commissioners and providers may wish to use to facilitate changes to outpatient pathways.

Multi-professional and multi-disciplinary

200. There are separate tariffs for multi-professional and single-professional outpatient attendances. The multi-professional tariff is payable for two types of activity, distinguished by the following OPCS-4 codes:

    (a) X622 - assessment by multi-professional team NEC - for multi-professional consultations
    (b) X623 - assessment by multi-disciplinary team NEC – for multi-disciplinary consultations.

201. Multi-professional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. The TFC of the consultant clinically responsible for the patient should be applied to a multi professional clinic where two consultants are present. Where there is joint responsibility then this should be discussed and agreed between commissioner and provider.

202. Multi-disciplinary attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time when two or more of the care professionals are consultants from different national main specialties.

203. These definitions apply when a patient benefits in terms of care and convenience from accessing the expertise of two or more healthcare professionals at the same time. The clinical input of multi-professional or multi-disciplinary attendances must be evidenced in the relevant clinical notes or other relevant documentation.

204. They do not apply if one professional is supporting another, clinically or otherwise, e.g. in the taking of notes, acting as a chaperone, training, professional update purposes, operating equipment and passing instruments. They also do not apply where a patient sees single professionals sequentially as part of the same clinic. Such sequential appointments count as two separate attendances, should be reported as

[38] *More for less 2009-10 Are efficiency and productivity improving in the NHS?* (December 2010), available at http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20101216moreforless200910.pdf

such in line with existing NHS Data Model and Dictionary guidance on joint consultant clinics[39].

205. The multi-disciplinary attendance definition does not apply to multi-disciplinary meetings, where care professionals meet in the absence of the patient. Multi-disciplinary meetings should not be reported as multi-disciplinary attendances.

206. We provide below some examples of multi-professional and multi-disciplinary consultations, but the list is not exhaustive, and commissioners and providers should exercise common sense and document in contracts when determining where multi-professional or multi-disciplinary applies.

207. Some examples of multi-professional attendances are where:

    (a) a patient sees both an obstetric consultant due to concerns about risk factors associated with a previous miscarriage and a midwife to discuss the birth plan
    (b) an orthopaedic nurse specialist assesses a patient and a physiotherapist provides physiotherapy during the same appointment.

208. Some examples of multi-disciplinary attendances are where:

    (a) a breast surgeon and an oncologist discuss with the patient options for surgery and treatment of breast cancer
    (b) a respiratory consultant, a rheumatology consultant and nurse specialist discuss with the patient treatment for a complex multi-systemic condition, e.g. systemic lupus erythematosus
    (c) a patient sees a paediatrician to discuss their disease and a clinical geneticist to discuss familial risk factors.

209. Some examples of where the multi-professional or multi-disciplinary definitions do not apply are:

    (a) a consultant and a sonographer, when the sonographer is operating equipment for the consultant to view the results
    (b) a consultant maxillo-facial consultant and a dental nurse passing examination instruments to the consultant
    (c) a consultant and a nurse specialist, when the nurse specialist is taking a record of the consultation
    (d) a consultant and a junior doctor, when the junior doctor is present for training purposes
    (e) a consultant ophthalmologist and a nurse, where the nurse administers eye drops or gives the sight exam as part of the consultation.

[39] http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/cds/outpatact/sharedcare

Rebundling of diagnostic imaging

210. We have continued to rebundle diagnostic imaging into the outpatient attendance tariffs, except where the diagnostic imaging is accessed directly, eg via referral from a GP. The *Step-by-step guide: calculating the 2012-13 national tariff* describes the methodology.

211. Rebundling should not be a barrier to the provision of this service in alternative settings. We have published separate mandatory prices for direct access diagnostic imaging (paragraph 219), and a flexibility for more complex diagnostic imaging (paragraph 681).

Pre-operative assessments

212. There is not currently a definition of what constitutes a pre-operative assessment, and therefore a national approach to counting and reimbursement is not currently appropriate or feasible. Payment for pre-operative assessments continues to be a matter for local agreement in 2012-13.

213. Where a pre-operative assessment takes place following admission, the costs are reflected in the admitted patient care HRG. Where the assessment takes place prior to admission, and constitutes a pre-booked consultant-led outpatient attendance, it will generally be reported as a follow-up outpatient attendance and attract the relevant tariff. The best practice tariff for cataracts includes the pre-operative assessment. In addition, some commissioners have contracts in place preventing separate payments for pre-operative assessments occurring on the same day as an admission.

Zero price

214. Outpatient attendance TFCs that have a mandatory tariff of zero pounds (£0) are shown in Table 10. No payment should be agreed or made for this activity.

Table 10: Zero price outpatient TFCs

TFC code	Description	Justification
812	Diagnostic imaging	To ensure that direct access diagnostic imaging unbundling can generate a core outpatient TFC attendance tariff, but without generating an additional tariff

Section 6: Direct Access

Introduction

215. For 2012-13 we are introducing a number of mandatory tariffs for activity accessed directly, eg commissioned directly from primary care. Some of this activity has previously had non-mandatory tariffs, eg diagnostic imaging and airflow tests, but we are also introducing direct access tariffs for flexible sigmoidoscopy.

216. SUS PbR and the Grouper do not identify services which have been accessed directly. We are working with the NHS Information Centre to correct this for the next CDS release. We suggest that commissioners and providers use local data flows to identify services accessed directly.

217. Diagnostic imaging and echocardiograms will create unbundled HRGs. For non-direct access, we have rebundled the costs of this activity. The unbundled HRG should not attract any additional payment for non-direct access activity.

218. Where direct access activity is processed through the Grouper both a core HRG and the unbundled HRG will be created. When the activity is direct access, the core HRG should not attract any payment and the unbundled HRG should attract a payment.

Direct access diagnostic imaging

219. We have previously published non-mandatory prices for direct access diagnostic imaging. From 2012-13 these prices will be mandatory, except where a contract for 2012-13 has already been negotiated and agreed.

220. The costs of reporting are included in the published prices, but are also shown separately so that they can be used if an organisation provides a report, but does not carry out the scan.

221. These prices can also be used by commissioners to:

    (a) reduce the attendance tariff for patients who have had directly accessed diagnostic imaging and subsequently have a related outpatient attendance, where the direct access imaging removes the need for a further diagnostic resulting from the outpatient attendance.
    (b) support the commitment in *Equity and Excellence: Liberating the NHS*[40] to introduce choice for diagnostic testing.

[40] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

222. Commissioners should ensure that providers are appropriately reimbursed for their total direct access and outpatient diagnostic imaging costs.

223. Direct access plain film x-rays do not have mandatory or non-mandatory prices and will need to be priced locally.

Direct access simple echocardiograms

224. As with other imaging, we have rebundled the costs of this activity, except for direct access where we are publishing a mandatory price.

Airflow studies

225. For 2012-13 we are introducing mandatory tariffs for direct access simple airflow studies (HRG DZ44Z) and simple bronchodilator studies (HRG DZ35Z). The mandatory tariffs for 2012-13 are at the same level as the previous non-mandatory tariffs for this activity.

Flexible sigmoidoscopies

226. For 2012-13 we are introducing mandatory tariffs for direct access diagnostic flexible sigmoidoscopy 19 years and over, with and without biopsy (HRGs FZ54Z and FZ55Z).

227. The tariffs are to support the cancer strategy, as set out in *Improving Outcomes: A Strategy for Cancer*, published on 12 January 2011[41].

228. The tariffs for these two HRGs have been set to the same across all settings (direct access, outpatients and admitted patient care) to recognise that the activity carried out for flexible sigmoidoscopies does not differ between settings. Commissioners should ensure that when this service is offered for direct access it includes appropriate consultation with the patient.

[41] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Section 7: Urgent care

Accident and emergency services

229. There are five A&E tariffs for services delivered in A&E and minor injury units (MIUs), spread over 11 HRG classifications based on investigation and treatment. It is illustrated in Annex A Figure 3.

230. Non-24 hour A&E units and MIUs remain eligible for the band 5 tariff only regardless of which HRG is triggered from the data.

231. Patients who are dead on arrival (DOA) should always attract the band 3 tariff. These do not have an HRG, however SUS PbR will include a SUS-specific HRG for DOA.

232. Where a patient is admitted following an A&E attendance, both the relevant A&E and non-elective tariffs are payable.

Major trauma

233. Information on the new major trauma best practice tariff can be found at paragraph 341.

Section 8: Best practice tariffs

Introduction

234. A best practice tariff (BPT) is a national tariff that has been structured and priced to incentivise and adequately reimburse care that is high quality and cost effective. A specific approach has been developed for each BPT, tailored to the clinical characteristics of best practice and the availability and quality of data.

235. The service areas of the BPTs have all been selected using the following criteria:

    (a) high impact (ie high volumes, significant variation in practice, or significant impact on outcomes);
    (b) a strong evidence base on what constitutes best practice; and
    (c) clinical consensus on the characteristics of best practice.

General guidance

236. This guidance covers all new and existing BPTs introduced since 2010-11. For each BPT, operational level guidance is provided first with a separate sub-section on policy related information.

237. The *tariff information spreadsheet* lists the BPT prices, HRGs and associated technical detail.

238. Unless otherwise stated in the guidance below, each of the best practice tariffs are mandatory and therefore share the same status as the rest of the national tariff, including the opportunity to use the same flexibilities described in Section 13 where the principles of application apply.

239. Where the BPT applies at the sub-HRG level, with the use of a BPT flag, there will be a conventional tariff applicable to the HRG. The conventional tariff however is to reimburse the costs of the activity unrelated to the BPT within the same HRG. The BPT is the mandatory tariff for the activity identified by the flag and is therefore not optional. An explanation of why BPT flags are used is provided in the BPT flag sheet in the *tariff information spreadsheet*.

240. The new BPTs for 2012-13 apply to patients discharged from 1 April 2012 with the exception of paediatric diabetes which applies to all relevant patients as described in the associated section below.

Summary of BPT package

241. The BPT package in 2012-13 comprises a number of new BPTs as well as those introduced since 2010-11. The table below summarises the

package in 2012-13 and how existing BPTs have been revised, where relevant.

Table 11: Summary of BPT package

BPT	2010-11	2011-12	2012-13
Acute Stroke	Introduced	Increased price differential	Further increase in price differential
Cataracts	Introduced and maintained		
Fragility hip fracture	Introduced	Increased price differential	Further increase in price differential and expansion of best practice characteristics
Day case procedures	Gall bladder removal	12 further procedures added	2 further procedures added; breast surgery procedures amended and revision to some day case rates
Adult Renal Dialysis		Vascular access for haemodialysis	Home therapies incentivised
Paediatric Diabetes		Activity based structure (non-mandatory)	Year of outpatient care structure (mandatory)
Transient ischaemic attack		Introduced and maintained	
Primary total hip and knee replacements		Introduced and maintained	
Interventional radiology		2 procedures introduced	5 further procedures added
Procedures in Outpatients			3 procedures introduced
Same day emergency care			12 clinical scenarios introduced
Major trauma care			Introduced

242. Where a BPT is based on reference costs, the price has been updated to reflect the 2009-10 reference costs.

New areas for 2012-13

Same day emergency care

Operational guidance

243. We are introducing best practice tariffs (illustrated in Annex A Figures 4a to 4j) for a number of emergency clinical scenarios. The aim is to promote management of these scenarios on a same day basis in an ambulatory emergency care manner. The clinical scenarios are:

(a) cellulitis
(b) pulmonary embolism
(c) asthma
(d) acute headache
(e) chest pain

(f) lower respiratory tract infections without chronic obstructive pulmonary disease
(g) appendicular fractures not requiring immediate fixation
(h) renal/ureteric stones
(i) falls including syncope and collapse
(j) epileptic seizure[42]
(k) deliberate self harm
(l) deep vein thrombosis (DVT)

244. The BPT for each clinical scenario is made up of a pair of prices: one applied to emergency admissions with a zero day length of stay, the other to emergency admissions with a stay of 1 or more days.

Tariff	**Length of stay**
Same day emergency care	Zero day
Non-elective	>=1 day

245. The Short Stay Emergency Adjustment does not apply to the associated HRGs. Long stay payments are applicable.

246. The implementation of the BPT will differ by scenario. For around two thirds of the scenarios, the BPT will apply to the HRG. For the remaining scenarios, the BPT will apply at the sub-HRG level with the use of a BPT flag to capture the relevant activity within the associated HRGs. The BPT flags are generated by the Grouper[43] and SUS PbR, where the spell meets the following criteria:

(a) patient aged 19 or over
(b) emergency, or transfer admission method (admission method codes 21-25, 28 and 81)
(c) a primary diagnosis from the list in the *tariff information spreadsheet*

247. The *tariff information spreadsheet* details the prices, whether they apply at HRG or BPT flag level and the relevant ICD-10 codes.

248. SUS PbR will automate payment by:

(a) generating the relevant flag, where required
(b) applying relevant prices either to the BPT flag within relevant HRGs or at the HRG as appropriate

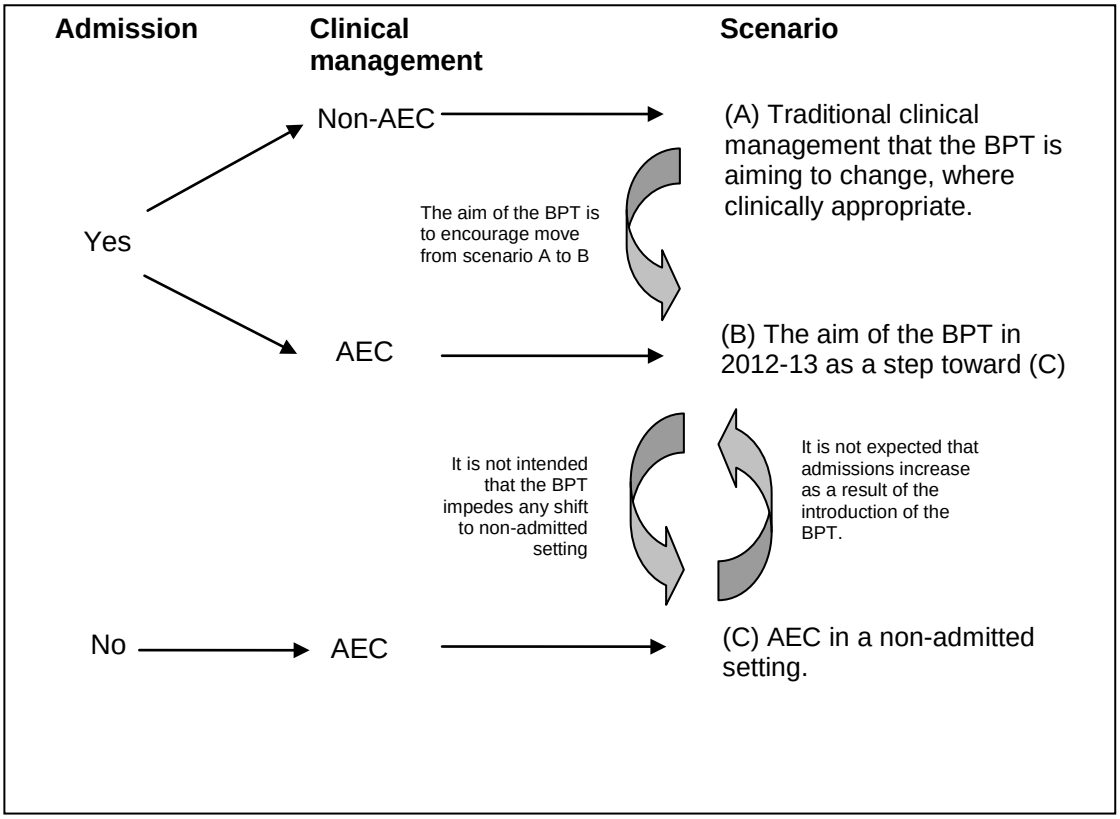
249. Some providers have already implemented best practice in ambulatory emergency care. The BPT is designed for providers that are not so well

[42] Includes first seizure and seizure in known epileptic
[43] Note that as the Local Payment Grouper generates the flag irrespective of the HRG there may be BPT flags generated in HRGs for which the BPT does not apply. Annex A details how to handle multiple BPT flags in a spell.

advanced. It will be important to make sure that those delivering best practice are not disadvantaged by the BPT. In line with the principle of local flexibilities set out in Section 13, organisations may agree local arrangements that either encourage development of pathways outside of the admitted setting or ensure adequate reimbursement for acute providers that have already established such pathways.

250. Figure 1 illustrates the way in which the BPT needs to be flexible to recognise where good practice is already in place. It sets out a stylised model of managing patients suitable for ambulatory emergency care (AEC).

Figure 1: Model of managing patients suitable for ambulatory emergency care



251. In relation to scenario B, with the focus on the admitted setting, it is not intended that the BPT discourages the development of AEC pathways (move from scenario B to C). For example where scheduled care in an urgent or routine outpatient setting is most appropriate. It is important that the national tariff does not constrain local innovation and service redesign.

252. In relation to scenario C, if the acute provider avoids admitting patients suitable for AEC then it needs to receive adequate reimbursement for those patients who do need to be admitted. It is suggested that these patients attract reimbursement equivalent to the higher price of the BPT (same day admissions) rather than the lower price of the BPT (overnight stays). Recognising that these are stylised scenarios and that reality is

likely to be more complex, commissioners and providers will need to be reasonable in agreeing to what extent the flexibility is applied.

253. If local arrangements are in place to reimburse AEC pathways then these may remain, subject to agreement with commissioners.

254. It is not expected that the rate of emergency admissions will increase as a result of the introduction of the BPT for the clinical scenarios. It would be expected that either the rate remains constant with the proportion of zero stays increasing, or the rate reduces as providers implement additional same day emergency care pathways appropriate to a non-admitted setting. As the 30% marginal rate will apply to the BPTs then providers should only admit patients where clinically appropriate.

255. Commissioners will want to monitor and reassure themselves that the admission rates are not increasing. To support this, it is suggested that organisations undertake a baseline exercise, at a population level, that accounts for any established pathways that currently avoid admissions.

Policy guidance

256. The Royal College of Physicians' Acute Medicine Task Force and the College of Emergency Medicine have agreed a working definition of Ambulatory Care[44]:

> "Ambulatory care is clinical care which may include diagnosis, observation, treatment and rehabilitation, that is not provided within the traditional hospital bed base or within traditional out-patient services, and that can be provided across the primary/secondary care interface."

257. With effective ambulatory emergency care in place, only patients who actually require admission to an acute hospital bed will be admitted and the length of stay will be commensurate with their acute care needs.

258. As a first step towards realising the potential of ambulatory emergency care, the aim of the same day emergency care BPT initially is to promote ambulatory care management of patients who are currently admitted and stay overnight. The expected outcome is therefore a shift in the proportion of admitted patients from stays of one or two nights to same day discharges. In the future, once datasets in the non admitted setting become rich enough to capture the activity of ambulatory emergency care, there is the potential for nationally mandated tariffs to be developed to encourage further shifts from the admitted setting.

259. Ambulatory emergency care is different to ambulatory care sensitive conditions. It may involve the same condition but represents different

[44] Acute Medical Care: The right person, in the right setting – first time (2007) Report of the Acute Medicine Task Force. Page xxi, Glossary http://bookshop.rcplondon.ac.uk/contents/pub235-b42eb97d-209b-4ecd-9127-ef95cc21c819.pdf

points in the patient's journey. Preventative healthcare or long-term management of the condition reduces the risk of an acute episode occurring but if one does occur then the acute management of the condition does not necessarily require admission to an acute hospital bed or an overnight stay.

260. The 12 scenarios have been selected from the NHS Institute's Directory of AEC in Adults[45]. The Directory is intended to be a list of potential clinical scenarios, 49 in total, which can be managed using ambulatory emergency care. It presents ranges of potential delivery of ambulatory care, expressed as percentages of current non-zero length of stay admissions for each condition. The Directory highlights the top 25 conditions ranked by volume of admissions with a length of stay of at least one day adjusted against potential for ambulatory care. The 12 scenarios either are in the top 25, or are related to them.

261. The tariff price and structure is similar to the BPTs for increasing elective day case rates. It means that the prices are designed to encourage management of emergency scenarios on a same day basis by adoption of ambulatory care whilst ensuring that overall best practice does not cost commissioners more. This has been achieved by:

- Introducing separate prices, with the price for same day emergency care set relatively higher than that for longer stays;
- decreasing the absolute level of both tariffs to reflect the lower cost of providing greater number of emergency admissions on a same day basis.

262. With this approach, same day admissions are over-reimbursed and longer stays are under-reimbursed. Providers have a clear incentive to manage patients suitable for AEC on a same day basis. Although longer stays will be under-reimbursed, as long as providers perform broadly in line with the target rates then, overall, providers will be adequately funded.

263. It is recognised that the time of attendance at hospital may in the first instance dictate whether an overnight stay is required. For simplicity, and to encourage the development of consistent responses to patient need regardless of time of day we have set the threshold length of stay to be zero days and expect that as time of access of patients should be similar across providers that this should not disproportionately affect the income of providers.

264. The BPTs for 2012-13 are based on the 75th percentile same day rate[46] by provider for each clinical scenario. It is believed that these rates represent a sufficiently stretching, but achievable rate for most providers.

[45] http://www.institute.nhs.uk/quality_and_value/high_volume_care/ambulatory_emergency_care_.html

[46] Calculated as: (zero day emergency admissions) / (total emergency admissions)

It also means that there is margin within the tariff prices to accommodate local circumstances where providers have started to implement AEC pathways in the non-admitted setting. In general the 75th percentile rate is significantly lower than the lower bound rate cited in the NHS Institute's Directory for each scenario. In subsequent years, we will look to increase the target rates towards the ambitions set out in the Institute's Directory.

265. The table below shows for each clinical scenario the 75th percentile same day rate and the current national average same day rate based on data from 2009-10 Hospital Episode Statistics.

Table 12: Same day emergency care rates

Clinical scenario	**75th percentile rate**	**Current national average rate**
Deep vein thrombosis (DVT)	74%	56%
Cellulitis	33%	24%
Pulmonary embolism	13%	10%
Asthma	30%	23%
Acute headache	41%	35%
Chest pain	46%	41%
Lower respiratory tract infections without chronic obstructive pulmonary disease	45%	37%
Appendicular fractures not requiring immediate fixation	38%	28%
Renal/ureteric stones	43%	32%
Falls including syncope and collapse	41%	27%
Epileptic seizure[47]	32%	27%
Deliberate self harm	55%	48%

266. It is not expected that all patients will be suitable for management on a same day basis and that is the reason why the rates are below 100%.

267. In line with the NHS Institute's Directory, HRGs that have a split for major complications and co-morbidities are excluded from the scope of the BPT. For some scenarios, the HRGs with intermediate complications or co-morbidities are also excluded following clinical advice.

Incentivising procedures in outpatients

Operational guidance

268. We are setting BPTs for three procedures to be performed in an outpatient setting, as follows:

    (a) Diagnostic cystoscopy
    (b) Diagnostic hysteroscopy
    (c) Hysteroscopic sterilisation

[47] Includes: first seizure and seizure in known epileptic

269. With diagnostic cystoscopy and diagnostic hysteroscopy, the aim is to shift activity into the outpatient setting. For hysteroscopic sterilisation the aim is to maintain the high outpatient rate and remove tariff as a barrier to greater use of hysteroscopic over laparoscopic sterilisation where clinically appropriate and chosen by patients.

270. For the diagnostic procedures, the BPT is made up of a pair of prices for each procedure: one applied to outpatient setting, the other to ordinary and day case elective admissions. For hysteroscopic sterilisation, the BPT is a single price that applies to the outpatient setting. Reimbursement for any day case or ordinary elective admissions will be the conventional tariff for MA10Z.

271. The BPT for all three procedures apply at the HRG level.

272. SUS PbR will automate payment by applying the relevant prices to the HRG.

273. The *tariff information spreadsheet* details the prices, relevant HRGs, and the relevant OPCS codes.

Policy guidance

274. Performing the procedures as an outpatient offers advantages to both the patient and the provider. Outpatient procedures provide the patient with a quicker recovery, as well as allowing the patient to recuperate at home. There are also wider benefits of performing an outpatient procedure, importantly that patients can get back to work and daily life sooner. Providers benefit from reduced operating theatre and anaesthetic time.

275. It is recognised that patient choice and need must be accounted for, and not all cases of these procedures will be suitable for the outpatient setting. The rate used for tariff calculation, the achievable rate and an estimate of the current rate are detailed in the table below.

Table 13: Achievable and estimated outpatient rates for diagnostic hysteroscopy and cystoscopy

Procedure	Rate for 2012-13 tariff calculation	Achievable outpatient rate[48]	Estimated[49] outpatient rate
Diagnostic hysteroscopy	60%[50]	80%	36%
Diagnostic cystoscopy	50%	50%	11%

276. To qualify for the outpatient BPT, the procedure must occur in an outpatient setting as defined by the NHS Data Dictionary. Organisations may find it helpful to note that clinically, for these particular outpatient procedures, it is expected that any procedures recorded as a day case would be performed in a theatre-based setting with the administration of a general anaesthetic, and any procedures recorded as an outpatient would be performed in a non theatre-based setting with local or no anaesthetic.

277. For these two diagnostic procedures, the tariff for the elective inpatient activity applies to both the day case and ordinary elective setting to offset any potential incentive to shift activity from the day case to the ordinary elective setting.

278. The tariff price and structure is similar to the BPTs for increasing elective day case rates. It means that the prices are designed to encourage a shift to the outpatient setting whilst ensuring that overall best practice does not cost commissioners more. This has been achieved by:

    - Introducing separate prices, with the price for the outpatient procedure set relatively higher than that for inpatient setting;
    - decreasing the absolute level of both tariffs to reflect the lower cost of providing greater proportion of procedures in an outpatient setting.

279. With this approach, outpatient procedures are over-reimbursed and procedures performed in inpatient setting are under-reimbursed. Providers therefore have a clear incentive to shift activity. Although inpatient procedures will be under-reimbursed, as long as providers perform broadly in line with the target rates then, overall, providers will be adequately funded.

[48] Based on expert clinical advice to supplement evidence for diagnostic hysteroscopy available at Gulumser C, Narvekar N, Pathak M, Palmer E, Parker S, Saridogan E. See-and-treat outpatient hysteroscopy: an analysis of 1109 examinations. Reprod Biomed Online. 2010 Mar;20(3):423-9), and 09/10 HES data highlighting a number of providers achieving high OP rates.

[49] Estimates based on 09/10 Reference cost activity data and HES 09/10 spell level data.

[50] Based on clinical opinion staged move starting with 60% moving to 80% in 2013-14 in order to allow providers transition time to providing outpatient hysteroscopy services

280. With regard to hysteroscopic sterilisation, there is agreement from a range of stakeholders that outpatient reference costs are unrepresentative of the true costs for this procedure. It is not clear why the reported costs do not accurately reflect the true cost but evidence suggests that the device related costs may not be fully apportioned to the HRG.

281. The BPT is designed to cover all of the costs associated with the procedure in order to fairly reimburse the activity. It applies only to hysteroscopic sterilisation in the outpatient setting. The conventional tariff applies to procedures carried out as ordinary or day case admissions.

282. The BPT is based on actual costs identified by an NHS provider and benchmarked against national average of reference costs less the device costs.

Incentivising day cases

Operational guidance

283. We are again expanding the list of procedures covered by the BPT model for incentivising higher day case rates, where clinically appropriate.

284. A day case is defined in the NHS Data Dictionary as[51]:

> A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission.

285. The procedures for which we have developed BPTs are listed in Table 14.

[51] http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1

Table 14: Procedures with day case BPTs

Procedure	Age
Breast surgery	
Excision of breast*	Adults
Excision of breast* with sentinel lymph node biopsy **or** axillary sample	Adults
Simple mastectomy +/- axillary surgery**	Adults
Sentinel lymph node biopsy, axillary sample, axillary clearance	Adults
Ear, nose and throat (ENT)	
Tonsillectomy	All ages
Septoplasty	Adults

*includes quadrantectomy, partial excision, any other excision
**where axillary surgery includes axillary clearance, axillary sample, or sentinel lymph node biopsy

286. The BPT is made up of a pair of prices for each procedure: one applied to day case admissions the other to ordinary elective admissions.

287. For all procedures the BPT prices apply at the sub-HRG level, with the use of a BPT flag to capture the relevant procedures within the HRGs.[52]

288. The *tariff information spreadsheet* details the prices, the BPT flags and the relevant OPCS codes.

289. SUS PbR will automate payment[53] by:
    (a) Generating the relevant flag
    (b) Applying relevant prices to the BPT flag within relevant HRGs.

Policy guidance

290. The British Association of Day Surgery (BADS) publishes a directory of procedures that are suitable for day case admissions or short stays along with rates that they believe are achievable in most cases[54]. The procedures selected for BPTs come from the third edition of this directory. They are high volume, and have day case rates that vary significantly between providers and are nationally below the BADS rates.

[52] Note that the BPTs for hernia repair, operations to manage female incontinence and prostate procedures apply at HRG level rather than sub-HRG level as in 2011-12.
[53] Note that as the Local Payment Grouper generates the flag irrespective of the HRG there may be BPT flags generated in HRGs for which the BPT does not apply. Annex A details how to handle multiple BPT flags in a spell
[54] The BADS Directory of Procedures (3rd edition) suggests day case rates which should be achievable in most cases, but also set certain caveats which mean that these rates may not be achievable. The BADS directory of procedures is available at: https://www.daysurgeryuk.net/bads/shop/shopdisplayproducts.asp?id=9&cat=BADS+Publications

291. Performing these procedures as a day case offers advantages to both the patient and provider. Many patients prefer to recuperate in their familiar home environment, while providers benefit from reduced pressure on admitted patient beds. BADS has no evidence to suggest that a shortened length of stay produces any greater risk in relation to potential post-operative complications or readmission rates.

292. The tariff price and structure is the same as adopted in previous years to increase elective day case rates. It means that the prices are designed to encourage a shift to the day case setting whilst ensuring that overall best practice does not cost commissioners more. This has been achieved by:

- Introducing separate prices, with the price for the day case setting set relatively higher than that for ordinary electives;
- decreasing the absolute level of both tariffs to reflect the lower cost of providing a greater proportion of procedures in the day case setting.

293. With this approach, day case procedures are over-reimbursed and ordinary elective procedures are under-reimbursed. Providers therefore have a clear incentive to shift activity. Although ordinary elective procedures will be under-reimbursed, as long as providers perform broadly in line with the target rates then, overall, providers will be adequately funded.

294. Tables 15 and 16 respectively list the new (or amended) procedures for 2012-13 and those introduced in previous years. The tables also contain a range of different rates: those used in tariff calculation; the rates from the BADS Directory of procedures and estimates of the current rates using 2009-10 HES. Where the tariff calculation rate differs to BADS, either the intention is to move to the BADS rate over time or following specific clinical advice we have used an alternative rate. The BADS and target rates are designed to incorporate patient choice and need.

Table 15: New or amended day case BPTs for 2012-13

Procedure	BADS rate	Tariff calculation rate	Current rates	Comment
Breast surgery				
Excision of breast - quadrantectomy - partial excision - any other excision	 15% 15% 95%	 75% (for all procedures)	 52% (average)	Differs from BADS rates based on advice from the NHS Improvement team working on *Delivering major breast surgery safely as a day case or one night stay*.[55]
Excision of breast with sentinel lymph node biopsy **or** axillary sample	n/a	75%	21%	
Simple mastectomy (with or without axillary surgery)	n/a	15%	2%	The target rate is to be reviewed each year, with a move to an 80% target rate over three years if deemed clinically appropriate.
Sentinel lymph node biopsy or axillary sample	n/a	80%	48%	
Axillary clearance	n/a	40%	7%	The target rate is to be reviewed each year, with a move to an 80% target rate over three years if deemed clinically appropriate
Ear, nose and throat				
Tonsillectomy - Children - Adults	 70% 80%	 70% 80%	 29% 32%	
Septoplasty	60%	60%	43%	

[55] http://www.improvement.nhs.uk/documents/DayCaseBreastSurgery.pdf

Table 16: Existing day case BPT areas

Procedure	BADS rate	Tariff calculation rate	Current rates	Comments
Gynaecology				
Operations to manage female incontinence	80%	45%	31%	Differs from BADS rate based on clinical advice and reduced from 2011-12 rate of 80% to 45% in 2012-13
Urology				
Endoscopic resection of prostate (TUR)	15%	15%	1%	
Resection of prostate by laser	90%	60%	16%	Phased increase to BADS rate over 3 years in 30 percentage point increments.
General surgery				
Cholecystectomy	60%	60%	28%	
Repair of umbilical hernia	85%	85%	66%	
Repair of inguinal hernia	95%	95%	61%	
Repair of recurrent inguinal hernia	70%	70%	49%	
Repair of femoral hernia	90%	90%	62%	
Orthopaedic surgery				
Arthroscopic subacromial decompression	80% (75%)	n/a	51%	The figures in parentheses in the BADS rate column are the 75th percentile day case rates from HES 2009-10. We are in consultation with BADS and British Orthopaedic Association to agree these as the target rates for tariff calculation for 2012-13.
Bunion operations with or without internal fixation and soft tissue correction	85% (72%)	n/a	53%	
Dupuytren's fasciectomy	95% (90%)	n/a	73%	

Interventional radiology (IR)

Operational guidance

295. We are expanding the list of interventional radiology procedures covered by the BPT programme to include a further five.

Table 17: Interventional radiology procedures in BPT programme

Condition	Procedure
New in 2012-13	
Peripheral artery disease (PAD)	Angioplasty and stenting of the superficial femoral artery (SFA) or iliac artery
Diabetic foot disease	Angioplasty and stenting
Thoracic aneurysm	Thoracic endovascular aortic repair (EVAR)
Portal hypertension	Transjugular intrahepatic portosystemic shunt (TIPS)
Benign breast lesions	Vacuum assisted percutaneous excision of benign breast lesions
Introduced in 2011-12	
Abdominal aortic aneurysms	Abdominal endovascular aortic repair (EVAR)
Uterine fibroids (benign tumours of the uterus)	Uterine Fibroid Embolisation (UFE)

296. All IR BPTs only apply to day case and ordinary elective admissions. Abdominal EVAR and UFE apply to all ages. The remaining BPTs apply to adults only.

297. For abdominal EVAR and UFE, the BPT applies at the HRG level. For the other five procedures, the BPT applies at the sub-HRG level with the use of a BPT flag to capture the relevant activity within the associated HRGs. The process is illustrated in Annex A Figure 4i.

298. The *tariff information spreadsheet* details the prices, whether they apply at HRG or BPT flag level and the relevant OPCS and ICD-10 codes. Annex B provides coding guidance for abdominal EVAR and UFE.

299. SUS PbR will automate payment[56] by:
    - generating the relevant flag, where required
    - applying relevant prices either to the BPT flag within relevant HRGs or at the HRG as appropriate.

300. Certain high cost devices such as stents and stent-grafts are excluded from the BPTs, the costs of which are payable separately. A full list of devices excluded from PbR can be found in the *tariff information spreadsheet*.

Policy guidance

301. Interventional radiology can offer gains in clinical outcome, productivity, patient experience and length of stay when compared with alternative traditional procedures. The National Imaging Board's publication: *Interventional radiology: Guidance for service delivery*[57], provides a

[56] Note that as the Local Payment Grouper generates the flag irrespective of the HRG there may be BPT flags generated in HRGs for which the BPT does not apply. Annex A details how to handle multiple BPT flags in a spell.

[57] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121904

useful summary of the clinical evidence base and describes a framework for IR to support providers and commissioners to plan appropriate provision of IR services for their patients. NICE Interventional Procedure Guidelines provide further evidence of the safety and efficacy for certain IR procedures.

302. The clinical evidence base for the IR procedures is summarised in Annex C.

303. IR will not be best practice in all circumstances, for all patients. For this reason the BPTs have been designed to offer a neutral financial incentive, meaning that the BPTs are set to adequately fund IR rather than over-reimburse it or under-reimburse the alternatives. The intention is that with greater visibility of the procedures within the payment system, either through creation of dedicated HRGs or BPT flags, that provision of IR services will improve.

304. In developing the 2012-13 BPTs, we have worked with a number of providers on a dedicated costing exercise to produce 'bottom up' costings for the procedures. These costings were used to inform the prices in conjunction with other sources of information. The BPTs mean that the IR procedures are reimbursed at a higher rate than they would have otherwise, though we recognise that they may not fully reimburse the costs. We plan to run a larger costing exercise and use PLICS data to inform and refine the BPTs in 2013-14.

305. Where the estimated costs of the IR activity justify a higher tariff than the other activity within an HRG we have set the conventional tariff below what it would have been in order to ensure that commissioners are not paying more overall.

306. The level of the BPTs for abdominal EVAR and UFE BPT is the same as in 2011-12. From 2013-14, we plan to use costs collected against the specific HRGs in the 2010-11 reference cost collection to inform tariff prices.

307. The National Imaging Board's publication, *Interventional Radiology: Guidance for service delivery* provides evidence for other IR procedures beyond those with BPTs, including:

    (a) percutaneous nephrostomy
    (b) fistuloplasty
    (c) embolisation for gastro-intestinal bleed
    (d) embolisation for trauma.

Adult renal dialysis

Operational guidance

308. The conventional and best practice tariffs for adult renal dialysis for patients with chronic kidney disease will be mandatory in 2012-13. The tariffs exclude all modalities of paediatric dialysis and dialysis for acute kidney injury or renal failure. Funding for dialysis for these patients is for local agreement.

309. For tariff purposes, organisations should distinguish between patients starting renal replacement therapy on chronic and acute dialysis on the basis of clinical judgement in the same way that they do for returns to the UK Renal Registry (UKRR).

310. The tariffs apply at HRG level. The HRGs and prices are contained in the *tariff information spreadsheet*.

311. The HRGs are generated by data items from the National Renal Dataset. Commissioners should include, as a minimum, the data items listed in Table 18 in information schedules of NHS contracts where these services are provided.

Table 18: National Renal Dataset fields Renal care

Renal Care [1] renal treatment modality, e.g. haemodialysis, peritoneal dialysis [6] renal treatment supervision code, e.g. home, hospital Person observation [75] blood test HBV surface antigen [77] blood test HCV antibody [79] blood test HIV Demographics [19] PCT organisation code Dialysis [182] type of dialysis access, e.g. fistula [23] dialysis times per week Organisations will also need to derive: • a unique patient identifier • patient age (in years derived from date of session – date of birth)

Dialysis away from base

312. The national tariff prices are applicable to dialysis away from base (DAFB) with two flexibilities available for local use:

(a) All patients who require haemodialysis away from base will be paid the arteriovenous fistula or graft tariff price. Any additional payments will need to be actioned locally as there is no method of reimbursing providers under the existing mechanism.

(b) Commissioners will have the flexibility to pay above the national tariff to providers who face significantly high proportions of patients who require dialysis away from base. The appropriate additional level of reimbursement and the proportion of dialysis away from base are for local negotiation between commissioners and providers. As a guide, we would expect that a significant proportion of dialysis away from base would be around 85-90%.

Drug exclusions

313. Due to the variation in funding and prescription practices across the country, the tariff for renal dialysis is not intended to fund the following drugs in 2012-13:

(a) ESAs: Darbopoetin alfa; Epoetin alfa, beta (including methoxy polyethylene glycol-epoetin beta), theta and zeta

(b) drugs for mineral bone disorders: Cinacalcet; Sevelamer; Lanthanum

314. Organisations should continue with current funding arrangements for these drugs when used in renal dialysis or outpatient attendances in nephrology (TFC 361). For all other uses, the relevant tariff prices are intended to reimburse the associated costs of the drugs.

315. Patients with iron deficiency anaemia of chronic kidney disease will require iron supplementation. For patients on haemodialysis, the tariff prices are intended to cover the costs of intravenous iron. For patients, either on peritoneal dialysis or otherwise, the costs will be reimbursed through the appropriate mandatory tariff, either in outpatients or admitted patient care, depending on the type of drug and method of administration (slow infusion or intravenous).

Reporting process

316. The reporting process for renal dialysis will differ from other tariff services. The data items defined in the NRD are not contained in the CDS and do not flow into SUS PbR. We therefore expect organisations to implement local reporting in 2012-13 while we continue to work towards a national solution. The Local Payment Grouper will support local processes in the generation of HRGs from the relevant data items extracted from local systems.

Core and unbundled HRGs

317. Dialysis sessions for chronic kidney disease are recorded in the NRD and we would not expect an associated admission or attendance in the admitted patient care or outpatient CDS where the patient attends only for a dialysis session. To reflect these changes the new HRGs are core rather than unbundled. Therefore, for patients with chronic kidney disease attending solely for a dialysis session there is no requirement to submit data on the admitted patient care or outpatient CDS for PbR payment. Where providers do report dialysis activity within the CDS, an HRG - LA08E Chronic kidney disease with length of stay 1 day or less associated with renal dialysis HRG - will be generated, with a tariff set to zero.

Acute kidney injury/renal failure

318. The introduction of adult renal dialysis into PbR is for patients with chronic kidney disease and not those with acute kidney injury. Principally this is because acute renal failure is excluded from the scope of the NRD for detailed data collection.

319. Previously, where recorded by OPCS codes, dialysis events associated with acute kidney injury would produce an unbundled dialysis HRG from sub-chapter LC. In 2012-13, the grouper will only produce HRGs from the sub-chapter LD and not LC. Organisations will need to put in place local arrangements for capturing and reporting this information for payment purposes. It would be possible for organisations to report such activity using the seven NRD items that generate the LD HRGs but as the tariff prices apply only to chronic kidney disease patients, payment for this activity would be for local agreement.

Policy guidance

320. The move to mandatory tariff prices completes the transition from mandatory currency and local prices in 2011-12.

Haemodialysis

321. The aim of the BPT for haemodialysis is to encourage the adoption of clinical best practice with respect to vascular access where there is clear clinical consensus, as set out in these guidelines and standards:

    (a) Renal Association guidelines (guidelines 1.1 and 1.2)
    (b) Vascular Society and Renal Association joint guidelines
    (c) NSF for renal services (standard 3) 47.

322. In line with guidance from the Renal Association, which recommends that 85% of all prevalent patients on haemodialysis should receive dialysis via a functioning arteriovenous fistula, we indicated in the 2011-12 guidance our intention to set the BPT to incentivise a movement to this rate over three years. In 2011-12, the rate was set at 75% and this will be increased to 80% in 2012-13 as part of the progression.

323. The ideal form of vascular access should be safe and efficient and provide effective therapy. A native arteriovenous fistula is widely regarded as the optimal form of vascular access for patients undergoing haemodialysis. The presence of a mature arteriovenous fistula at the time of first haemodialysis reduces patient stress and minimises the risk of morbidity associated with temporary vascular access placement as well as the risk of infection.

324. If an arteriovenous fistula cannot be fashioned then an acceptable alternative form of definitive access is an arteriovenous graft which involves an artery and vein being surgically joined together, using an artificial graft, usually polytetrafluoroethylene.

325. The advantages of a native arteriovenous fistula over other forms of access with infective and thrombotic complications are significant. In addition, dialysis via a fistula will also provide the option of higher blood flows during the procedure, resulting in more efficient dialysis.

326. Renal units will need to collaborate with surgical services to establish processes that facilitate timely referral for formation of vascular access.

327. Whilst not a condition of the BPT, contribution to national clinical audits should be considered a characteristic of best practice for providers of high quality renal dialysis care.

Home haemodialysis

328. We are introducing mandatory tariffs for home haemodialysis in 2012-13 in order that home haemodialysis is a real choice for patients.

329. The tariffs have been calculated based on feedback from NHS renal units as part of a recent NHS Kidneycare survey, NHS reference costs and information offered specifically by renal units

330. It is intended that the BPT price and structure offer incentives to both providers and commissioners to offer home haemodialysis to all patients who are suitable.

331. The tariff price for home haemodialysis will reflect a week of dialysis, irrespective of the number of dialysis sessions prescribed. Providers and commissioners should put in place sensible auditing arrangements to ensure that home haemodialysis is at least as effective as that provided in hospital.

332. It is expected that the tariff price will cover the direct costs of dialysis as well as the associated set up, removal and utility costs incurred by the provider (eg preparation of patients' homes, equipment and training).

Peritoneal Dialysis and assisted Automated Peritoneal Dialysis (aAPD)

333. The tariff prices for peritoneal dialysis have been updated to reflect the data returned by NHS providers in the 2009-10 reference costs collection exercise.

334. In addition to the tariffs for peritoneal disease, we have also introduced a mandatory tariff in 2012-13 for aAPD.

335. The tariff is a per diem rate and covers the costs of providing assistance to the patient, in addition to the associated dialysis costs.

336. The price has been set based on information obtained from a number of organisations and reflects a mix of service delivery models.

Dialysis away from base

337. A review of the current situation regarding dialysis away from base has been undertaken, including gathering evidence from some of the small organisations and NHS units providing this service.

338. This has highlighted that there appear to be some additional costs associated with providing dialysis away from base but that because the reference costs include these additional costs, the tariff should adequately fund, on average, providers dialysing a mix of regular and away from base patients. However, in recognition of the importance to patients of being able to dialyse away from base and that some providers will have a significantly disproportionate mix of patients we have introduced two local flexibilities for 2012-13 (described in paragraph 312).

339. These local flexibilities have been included to ensure that

    (a) the difference in haemodialysis tariff prices is not a factor in patients being offered holiday dialysis
    (b) those providers who have a high proportion of patients who require dialysis away from base can receive additional payments

340. We plan to undertake further work with the Kidney Alliance and other stakeholders to inform the 2013-14 tariff in relation to dialysis away from base.

Major Trauma

Operational guidance

341. We are introducing a BPT (illustrated in Annex A Figure 4j) for the care of trauma patients treated in Major Trauma Centres (MTCs). The aim is to encourage best practice treatment and management of trauma patients within a regional trauma network. The BPT is paid on activity at MTCs for the most seriously injured patients. Although funding is attached to individual patients, the aim of the tariff is to move funding

into MTCs. This is to reflect the enhanced specification required to deliver the specialised major trauma pathway to any patients who are triaged to the MTC as potential major trauma cases.

342. The BPT is not conditional upon the patient's HRG being in the VA chapter (multiple injuries). The BPT is made up of two levels of payment differentiated by the Injury Severity Score (ISS)[58] of the patient and conditional on achieving the criteria below. The BPTs for levels 1 and 2 are available in the *tariff information spreadsheet*. The BPT applies to adults and children.

343. Level 1 is payable for all patients with an ISS more than 8 providing that the following criteria are met:

    (a) the patient is treated in an MTC
    (b) Trauma Audit and Research Network (TARN) data is completed and submitted within 40 days of discharge
    (c) rehabilitation prescription is completed for each patient and recorded on TARN
    (d) any coroners' cases are flagged within TARN as being subject to delay to allow later payment.

344. Level 2 is payable for all patients with an ISS of 16 or more providing that the Level 1 criteria are met and either of the following two scenarios are met:

    (a) If the patient is admitted directly to the MTC or transferred as an emergency, the patient must be received by a trauma team led by a consultant in the MTC. The consultant can be from any specialty and must be present within 30 minutes of the patient's arrival in the MTC

    or:

    (b) If the patient is transferred as a non-emergency they must be admitted to the major trauma centre within 2 calendar days of referral from Trauma Unit (TU). If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution.

345. The BPT will not be applied by SUS PbR and organisations will need to use the TARN database to support the payment. The reporting process for payment is set out in Annex D. Reports will be available from TARN from April 2012 and MTCs and Specialist Commissioning Groups (SCGs) will be able to produce reports for patients.

346. Where contractual arrangements are already in place for 2012-13, SCGs may monitor the best practice tariff in shadow form. The criteria used to

[58] http://www.trauma.org/archive/scores/iss.html

support payment in this situation must be higher than those outlined in paragraphs 343 and 344 above.

347. The new trauma networks will give MTCs a small rise in emergency admissions. Any patients eligible for the major trauma BPT should be excluded from the 30% marginal rate emergency admissions threshold. This should be agreed by providers, local commissioners and SCGs. The establishment of MTCs represents a service redesign as set out in paragraphs 691 to 693.

348. Within the criteria to attract the BPT for major trauma is that every patient with an ISS of more than 8 has a rehabilitation prescription. The core components of the rehabilitation prescription will be recorded as part of the TARN minimum data set return.

Policy guidance

349. International evidence shows that regional trauma networks save resources by reductions in length of stay (LoS) due to prompt transfers and reduced Intensive Care Unit bed stays, shorter rehabilitation, fewer treatment complications and better quality care.

350. An independent review by ScHARR, University of Sheffield, February 2011, has confirmed the cost effectiveness of trauma networks with networks proving to be cost effective at the threshold of £20,000 per Quality Adjusted Life Year (QALY). This was achieved on reductions in death and disability alone and did not factor in the additional benefit from the reduction in LoS that is expected in the NHS in England.

351. The enhanced specifications include immediate consultant input, immediate access to imaging and surgery, combined multispecialty input and planning of complex rehabilitation.

352. The major trauma BPT uses the Injury Severity Score (ISS), an established medical score to assess trauma severity to calculate the two levels for the best practice tariff.

353. A patient cannot attract both additional payments for Level 1 and 2. For example a patient with a ISS score of 17 would get a maximum additional payment of the level 2 score, not both level 1 and level 2.

354. The major trauma BPT will attract any relevant specialised services top-up provided the spell and provider are eligible.

355. SHAs have agreed to consider any local issues in relation to set-up and infrastructure costs.

356. Commissioners will want to monitor emergency admissions in trauma units.

Paediatric diabetes

Operational guidance

357. We are introducing a mandatory BPT for paediatric diabetes. This will apply to all providers who provide services in accordance with the best practice specification set out below. The aim of the new tariff is to enable access to consistent high quality management of diabetes.

358. The new BPT is an annual payment that covers outpatient care as detailed in the criteria listed below, from the date of discharge from hospital after the initial diagnosis of diabetes is made, until the young person is transferred to adult services at the age of 19. It does not include any admitted patient care or the cost of any items excluded from PbR, including insulin pumps and insulin pump consumables. Insulin and blood glucose testing strips prescribed as an emergency by the Specialist Team will be covered by the tariff. Routine prescriptions for insulin, blood glucose testing and ketone monitoring are issued in primary care and so are not part of the tariff. More details for exclusions from PbR can be found at Section 9.

359. The best practice service specification is:

    (a) On diagnosis, a young person with the diagnosis of diabetes is to be discussed with a senior member of paediatric diabetes team within 24 hours of presentation. A senior member is defined as a doctor or paediatric specialist nurse with ‘appropriate training’ in paediatric diabetes. Information as to what constitutes ‘appropriately trained’ is available from the British Society for Paediatric Endocrinology and Diabetes or the Royal College of Nursing.

    (b) All new patients must be seen by a member of the specialist paediatric diabetes team on the next working day.

    (c) Each provider unit can provide evidence that each patient has received a structured education programme, tailored to the child or young person’s and their family’s needs, both at the time of initial diagnosis and ongoing updates throughout the child or young person’s attendance at the paediatric diabetes clinic.

    (d) Each patient is offered a minimum of four clinic appointments per year with a multi-disciplinary team (MDT), ie a paediatric diabetes specialist nurse, dietitian and doctor. The doctor should be a consultant or associate specialist/speciality doctor with training in paediatric diabetes or a specialist registrar training in paediatric diabetes, under the supervision of an appropriately trained consultant (see above). The dietitian should be a paediatric dietitian with training in diabetes (or equivalent appropriate experience).

(e) Each patient is offered additional contact by the diabetes specialist team for check ups, telephone contacts, school visits, troubleshooting, advice, support etc. Eight contacts per year are recommended as a minimum.

(f) Each patient is offered at least one additional appointment per year with a paediatric dietitian with training in diabetes (or equivalent appropriate experience).

(g) Each patient is offered a minimum of four haemoglobin HbA1C measurements per year. All results should be available and recorded at each MDT clinic appointment.

(h) All eligible patients should be offered annual screening as recommended by current NICE guidance.[59] Retinopathy screening should be performed by regional screening services in line with the national retinopathy screening programme, which is not covered by the paediatric diabetes BPT and is funded separately. Where retinopathy is identified, timely and appropriate referral to ophthalmology should be provided by the regional screening programme.

(i) Each patient should have an annual assessment by their MDT as to whether input to their care by a clinical psychologist is needed, and access to psychological support as appropriate.

(j) Each provider must participate in the annual Paediatric National Diabetes Audit.

(k) Each provider must actively participate in the local Paediatric Diabetes Network. A minimum of 60% attendance at regional network meetings needs to be demonstrated.

(l) Each provider unit must provide patients and their families with 24 hour access to advice and support. This should also include 24 hour advice to fellow health professionals on the management of patients with diabetes admitted acutely, with a clear escalation policy as to when further advice on managing diabetes emergencies should be sought.

(m) Each provider unit must have a clear policy for transition to adult services.

(n) Each unit will have an operational policy, which should include a structured 'high HbA1C' policy, a clearly defined DNA/was not brought policy taking into account local safeguarding children board (LSB) policies and evidence of patient feedback on the service.

[59] CG15 Diagnosis and management of type 1 diabetes in children, young people and adults (July 2004), available at http://www.nice.org.uk/CG15 and TA151 Diabetes - insulin pump therapy (July 2008), available at http://www.nice.org.uk/TA151

360. Commissioners will monitor compliance with these criteria via locally negotiated contracts, which may include local records of clinic attendances, local education programmes etc. It is expected that patient and public involvement (PPI) is used as part of this feedback and monitoring process. It is expected that compliance with all criteria will need to be demonstrated for at least 90% of patients attending the clinic.

361. If a patient is referred elsewhere for a second opinion, shared care or full transfer of care, subsequent division of funding will need to be agreed between the referring and receiving centres using a service level agreement (SLA). The precise division of funding will need to be negotiated on a local level.

362. Providers not meeting the specification in 2012-13 will be paid on the basis of the outpatient attendance tariff (first and follow-up) for TFC 263.

Policy guidance

363. These criteria are underpinned by:
    (a) DH guidance: *Making every young person with diabetes matter*[60];
    (b) NICE guidance: *CG15: Diagnosis and management of type 1 diabetes in children, young people and adults*[61] and *TA151 Diabetes – insulin pump therapy*;[62] and
    (c) NHS Diabetes guidance: *Commissioning services for children and young people with diabetes*[63].

364. It is not anticipated that all providers will be delivering services at the best practice level from April 2012. It is very important however that providers and commissioners work together to improve services in order to meet the expectation that all providers are delivering best practice care in 2013-14.

365. As the BPT does not include admitted patient care, commissioners may wish to consult the Child and Maternal Health website[64] or the National Paediatric Diabetes Audit[65] to obtain information regarding paediatric admission rates after the BPT is fully operational.

[60] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073674
[61] http://www.nice.org.uk/CG15
[62] http://www.nice.org.uk/TA151
[63] http://www.diabetes.nhs.uk/commissioning_resource/
[64] http://www.chimat.org.uk/
[65] http://www.ic.nhs.uk/nda

Existing BPTs

Fragility hip fracture

366. The fragility hip fracture BPT (illustrated in Annex A Figure 4c) will continue in the same form in 2012-13 with the following revisions:

    (a) a greater differential has been set between the base tariff and the best practice tariff; and
    (b) the best practice criteria has been expanded to include two mental impairment tests for dementia.

367. The BPT is made up of two components: a base tariff and an additional payment. The base tariff is payable to all activity irrespective of whether the characteristics of best practice were met. The additional payment is payable if all of the following characteristics are achieved:

    (a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia
    (b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon[66]
    (c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia[67]
    (d) assessed by a geriatrician[68] in the perioperative period (within 72 hours of admission)
    (e) postoperative geriatrician-directed multi-professional rehabilitation team
    (f) fracture prevention assessments (falls and bone health)
    (g) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell.

368. It is expected that a reduced AMT score of seven or below would trigger a dementia risk assessment by dementia trained staff, the outcome of which would inform a post-operative adjustment package for discharge.

369. The base tariff and the additional payment apply at the sub-HRG level with the use of BPT flag 01 (previously SSC 88) to capture the relevant

[66] To capture the joint admission, two GMC numbers are required; that of the consultant orthopaedic surgeon and consultant geriatrician authorised by the hospital to oversee admission policy. Entry of the GMC number for an individual patient indicates that the responsible consultant is satisfied that the agreed assessment protocols were followed.
[67] We recommend that providers issue their commissioners with a copy of the agreed joint assessment protocol. Examples are available at www.nhfd.co.uk
[68] Geriatrician defined as consultant, non-consultant career grade (NCCG), or specialist trainee ST3+.

activity within the associated HRGs. The BPT flag 01 is generated by the Grouper[69] and SUS PbR, where the spell meets the following criteria:

(a) patient aged 60 or over (on admission)
(b) emergency, or transfer admission method (admission codes 21-25, 28 and 81)
(c) a diagnosis and procedure code (in any position) from the list in the *tariff information spreadsheet*

370. Conventional tariffs are published for the HRGs associated with fragility hip fracture, but these are to reimburse the costs of the other procedures within the HRGs that are not related to fragility hip fracture. The BPTs (base and additional payment) are the mandatory tariffs for fragility hip fracture.

371. SUS PbR will apply the base tariff to spells with a BPT flag 01 in HRGs from the list in the *tariff information spreadsheet*.

372. SUS PbR will not apply the additional payment. Commissioners determine compliance with best practice using reports compiled from data submitted by providers to the NHFD. The report is available quarterly in line with the SUS PbR reporting timetable[70] (paragraph 717), ie the report for the April to June quarter will be available at the final reconciliation point on 31 August 2012. The additional best practice payment is therefore paid quarterly in arrears, with the base tariff paid as normal. Payment arrangements for NHFD records entered or completed outside the agreed timeframe should be negotiated locally.

373. Providers already have access to the NHFD through a lead clinician who is responsible for ensuring the quality and integrity of the data. Commissioners should nominate a data representative, an existing SUS PbR user with an NHS mail account, who will register for access at pbrcomms@dh.gsi.gov.uk.

374. Annex E lists the on-line reports available from the NHFD. Commissioners should link SUS data with NHFD data by using the NHS number. The NHS number is therefore required to enable linkage to the commissioner and, if missing or invalid, the provider should complete or correct it before a commissioner match can be made. The report also contains Date of Admission and Date of Operation, which can be compared with SUS PbR output on the spells that have a BPT flag of 01 to additionally validate matching. All records, including those for patients

[69] Note that as the Local Payment Grouper generates the flag irrespective of the HRG there may be BPT flags generated in HRGs for which the BPT does not apply. Annex A details how to handle multiple BPT flags in a spell.

[70] Prior to the final reconciliation point, providers will be given two weeks from the end of the quarter to input and edit any outstanding records. The NHS Information Centre will then match the records to responsible commissioners which will take a further two weeks. Once the commissioner data is uploaded, providers will be given another two weeks to correct any problems or omissions. The final data will therefore be available to commissioners six weeks after the end of the quarter.

aged 60 or over who fail to meet the criteria, are sent to relevant commissioners when available.

375. NHFD is currently the only source of data relevant to the BPT criteria collected on a regular basis, with professional clinical oversight. We therefore recommend participation in the NHFD although organisations may implement alternative local solutions. Further information on best practice is available from the NHFD website including advice on:

    (a) improving clinical care and secondary prevention
    (b) service organisation
    (c) how to make a case for the posts and resources necessary for the delivery of high-quality, cost-effective care.

Policy guidance

376. The differential between the base tariff and best practice has increased since the introduction of the BPT in 2010-11. Initially, the differential was £445 to pay for additional costs associated with best practice care. In subsequent years the differential has increased to further incentivise best practice. This has been achieved by lowering the base tariff by the increased additional payment, so that the level of the BPT is the same each year but payment for spells not meeting best practice has reduced. The differentials are listed below:

Financial year	Differential
2010-11	£445
2011-12	£890
2012-13	£1,335

Acute Stroke care

Operational guidance

377. The acute stroke care BPT (illustrated in Annex A Figure 4e) will continue in the same form in 2012-13 with the following revisions:
    (a) a greater differential between the base tariff and the best practice tariff.
    (b) Inclusion of the alteplase adjustment

378. The BPT is made up of four components: a base tariff and three additional payments. The base tariff is payable to all activity irrespective of whether the characteristics of best practice were met. The three additional payments, one for each of the three characteristics of best practice, are payable where:

(a) patients are admitted directly[71] to an acute stroke unit[72] either by the ambulance service, from A&E or via brain imaging. Patients should not be directly admitted to a Medical Assessment Unit. Patients should then also spend the majority[73] of their stay in the acute stroke unit.
(b) initial brain imaging is delivered in accordance with best practice guidelines as set out in *Implementing the National Stroke Strategy – An Imaging Guide*[74]. The scan should not only be done in these timescales but immediately interpreted and acted upon by a suitably experienced physician or radiologist.
(c) Patients are assessed for thrombolysis, receiving it if clinically indicated in accordance with the NICE technology appraisal guidance[75] on alteplase[76].

379. Acute stroke units should meet all the markers of a quality service set out in the National Stroke Strategy quality marker 9 which are that:

(a) all stroke patients have prompt access to an acute stroke unit and spend the majority of their time at hospital in a stroke unit with high-quality stroke specialist care
(b) hyper-acute stroke services provide, as a minimum, 24-hour access to brain imaging, expert interpretation and the opinion of a consultant stroke specialist, and thrombolysis is given to those who can benefit
(c) specialist neuro-intensivist care including interventional neuroradiology or neurosurgery expertise is rapidly available
(d) specialist nursing is available for monitoring of patients
(e) appropriately qualified clinicians are available to address respiratory, swallowing, dietary and communication issues.

380. The base tariff and the additional payments apply at the sub-HRG level with the use of BPT flag 05 (previously SSC 55) to capture the relevant activity within the associated HRGs. The BPT flag 05 is generated by the Grouper[77] and SUS PbR, where the spell meets the following criteria:

(a) patient aged 19 or over (on admission)

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[71] Due to the variety of routes into the stroke unit, we define direct admission as intending to be within 4 hours of arrival in hospital.
[72] Or similar facility where the patient can expect to receive the service set out in quality marker 9 of the National Stroke Strategy.
[73] Defined as greater than or equal to 90% of the patient's stay within the spell that groups to either AA22Z or AA23Z.
[74] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085146
[75] www.nice.org.uk/TA122
[76] This additional payment covers the drugs themselves, and the additional cost of nurse input and the follow-on brain scan.
[77] Note that as the Local Payment Grouper generates the flag irrespective of the HRG there may be BPT flags generated in HRGs for which the BPT does not apply. Annex A details how to handle multiple BPT flags in a spell

(b) emergency, or transfer admission method (admission method codes 21-25, 28 and 81)
(c) a primary diagnosis code from the list in the *tariff information spreadsheet*

381. SUS PbR will apply the base tariff to spells with a BPT flag 05 in HRGs from the list in the *tariff information spreadsheet*.

382. Of the best practice characteristics, SUS PbR will apply the additional payment for alteplase but not those for the other two characteristics of best practice. The payment applies when OPCS-4 code X833 (fibrinolytic drugs) is coded to create an unbundled HRG XD07Z (fibrinolytic drugs band 1) from AA22Z, as Annex A Figure 4e illustrates.

383. For the other two characteristics, organisations will need to agree local reporting and payment processes. The NHS Stroke Improvement Programme and associated Stroke Networks will be a useful source of information and support to organisations in establishing these processes.

Policy guidance

384. The stroke BPT is designed to generate improvements in clinical quality in the acute part of the patient pathway. It incentivises key components of clinical practice set out in the National Stroke Strategy[78], NICE clinical guideline CG68 (July 2008)[79] and the NICE quality standard for stroke[80]. Whilst not a condition of best practice, contribution to national clinical audits should be considered a characteristic of best practice for providers of high quality stroke care.

385. Patients presenting with symptoms of stroke need to be assessed rapidly and treated in an acute stroke unit by a multi-disciplinary clinical team which will fully assess, manage and respond to their complex care needs, including planning and delivering their rehabilitation from the moment they enter hospital to maximise their potential for recovery.

386. Evidence based best practice shows that outcomes are greatly improved if patients are admitted directly to a high quality stroke unit. These patients should not be admitted to a Medical Assessment Unit, but to the acute stroke unit either directly by the ambulance service, from A&E or via brain imaging.

387. Commissioners will be aware that there are a number of different models for delivering high quality stroke care. In places where, for example, a small number of hyper-acute units have been identified to admit all acute stroke patients, there will be other units providing high quality stroke care

[78] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062
[79] http://www.nice.org.uk/CG68
[80] http://www.nice.org.uk/guidance/qualitystandards/stroke/strokequalitystandard.jsp

but not qualifying for the element in this BPT for timely scanning (nor the additional payment for thrombolysis) because they admit patients who are further along the stroke care pathway. However, all acute providers of stroke care should have systems to qualify for the incentive payment for direct admission to a stroke unit.

388. The differential between the base tariff and best practice has increased since the introduction of the BPT in 2010-11. Initially, the differential was £445 to pay for additional costs associated with best practice care. In subsequent years the differential has increased to further incentivise best practice. This has been achieved by lowering the base tariff by the increased additional payment so that the level of the BPT is the same each year but payment for spells not meeting best practice has reduced. The differentials are listed below:

Financial year	Differential
2010-11	£475
2011-12	£950
2012-13	£1,425

Primary total hip and knee replacements

Operational guidance

389. The BPT for elective primary total hip and knee replacements will continue in the same form in 2012-13. Please note that a post discharge tariff applies to these procedures (see paragraphs 167 and 172).

390. The aim of the BPT is to incentivise the adoption of Enhanced Recovery principles during the hospital stay of the patient. Further information about Enhanced Recovery is available from the DH website.[81]

391. The BPT is the level of reimbursement for these procedures irrespective of whether best practice was met.

392. The BPT applies at the sub-HRG level with the use of BPT flags to capture the relevant activity within the associated HRGs. The BPT flag[82] of 20 for hip replacements and 21 for knee replacements are generated by the Grouper and SUS PbR, where the spell meets the following criteria:

    (a) patient aged 19 or over (on admission)
    (b) elective admission method
    (c) a procedure code (in any position) from the list in the *tariff information spreadsheet*

[81] http://www.dh.gov.uk/en/Healthcare/Electivecare/Enhancedrecovery/index.htm
[82] In 2011-12, the flags were SSC 85 and 86 for hip and knee replacements respectively

393. SUS PbR will automate payment[83] and apply the BPT to spells with the relevant BPT flags in HRGs from the list in the *tariff information spreadsheet*.

394. Commissioners and providers should agree in the contract the enhanced recovery improvements that will be made as well as indicators and mechanisms for monitoring quality and outcomes. It is recommended that PROMs[84] form part of any range of indicators agreed.

395. Commissioners are encouraged to promote participation of providers in the National Joint Registry (NJR)[85] and have the flexibility to make part of the tariff contingent on participation. The exact arrangements are for local agreement but the principle should be that the contingent element is proportionate.

Policy guidance

396. There are four key aspects of good clinical pathways (Annex C gives the sources of evidence):

    (a) pre-operative assessment, planning and preparation before admission
    (b) a structured approach to peri-operative and immediate post-operative management, including pain relief
    (c) early supervised mobilisation and safe discharge
    (d) structured plans for access to clinical advice and support in the period immediately after discharge, including outreach rehabilitation.

397. The BPTs only apply to the admitted patient care element of the pathway (bullets (b) and (c) above). Pre-operative appointments should be paid for separately. Note that the physiotherapy input included in the post-discharge tariff is additional to that required as part of the admitted patient care element covered by the BPT.

398. The BPTs are designed to encourage providers to optimise pathways without creating an additional administrative burden by basing prices on the conventional tariff for the relevant HRGs less £232, which is the long stay payment for HRG chapter H.

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[83] Note that as the Local Payment Grouper generates the flag irrespective of the HRG there may be BPT flags generated in HRGs for which the BPT does not apply. Annex A details how to handle multiple BPT flags in a spell

[84] Providers of these procedures are mandated in the NHS standard acute contract to offer patients a PROMs pre-operative questionnaires, with a third party organisation administering the post-operative questionnaire.

[85] The National Joint Registry (NJR) was established to define, improve and maintain the quality of care of individuals receiving hip and knee joint replacement surgery. Though not mandated, it is highly regarded in the orthopaedic community. Further information available at: http://www.njrcentre.org.uk/njrcentre/default.aspx

399. The principle behind this approach is that an optimal pathway costs less because of the reduction in length of stay. With the conventional tariff a function of the variation in clinical practice, its level is higher than if all providers were delivering optimal pathways. We expect the nominal figure of £232 is within the range of savings that providers on average can make by optimising pathways.

Transient ischaemic attack

Operational guidance

400. The BPT for TIA (as illustrated in Annex A Figure 4f) will continue in the same form in 2012-13.

401. The BPT is made up of three components: a base tariff and two additional payments. All three components are conditional on meeting best practice characteristics though they are payable separately. The components are described below:

(a) base tariff price payable to providers meeting minimum best practice criteria. Providers not meeting these will be paid the conventional tariff. It is payable for all patients presenting at a specialist TIA clinic (both high and lower risk, and regardless of final diagnosis). The criteria are:

i. all patients are assessed by a specialist stroke practitioner, who has training, skills and competence in the diagnosis and management of TIA. This should be consistent with the UK Forum for Stroke Training[86]
ii. the non-admitted TIA service has both the facilities to diagnose and treat people with confirmed TIA, plus the facilities to identify and appropriately manage (which may include onward referral) people with conditions mimicking TIA
iii. clinics are provided seven days a week, even if this is via a service level agreement with another provider
iv. all patients are diagnosed and treated within seven days of first relevant presentation of the patient to any healthcare professional regardless of risk assessment
v. all patients diagnosed with TIA have the opportunity to receive a specialist TIA follow-up within one month of original diagnosis. Patients diagnosed as non-TIA are not subject to this criterion. The nature of the follow-up should be agreed locally and it is not expected that this will necessarily be delivered in the same setting as the initial diagnosis and treatment. Where multiple follow-ups are necessary, commissioners and providers should agree the level of re-imbursement locally.

[86] http://www.ukstrokeforum.org/

(b) additional payment for investigation and treatment of high risk patients[87] within 24 hours. The timeframe is aligned with the vital sign for TIAs and mini-stroke, and is defined as follows:

i. the clock starts at the time of first relevant presentation[88] of the patient to any health-care professional (eg a paramedic, GP, stroke physician, district nurse or A&E staff).
ii. the clock stops 24 hours after this initial contact, by which time all investigations[89] and treatments[90] should be completed.

(c) additional payment for use of MRI. The base tariff payment is based upon all patients receiving CT brain imaging. However, unless the patient has a contraindication, diffusion weighted MRI should be the primary technique used for brain imaging.

402. Activity occurring in TIA services meeting the minimum best practice criteria should be reported against TFC 329 – transient ischaemic attack. Activity not meeting best practice should not be reported against this TFC.

403. SUS PbR will:

(a) apply the base tariff price to activity coded under the appropriate TFC
(b) unbundle MRI scans (where coded) and apply the relevant additional payment
(c) prevent generation of an outpatient procedure e.g. where 24 hour ECGs are performed, when reported against the TIA TFC.

404. SUS PbR will not:

(a) record risk assessment of patients
(b) assess whether providers have met the 24 hour measure for high risk patients. Providers should supply risk assessment data and compliance to qualify for the additional payment
(c) apply pricing to follow-up attendances.

Policy guidance

[87] Defined as ABCD2 score greater than or equal to 4. ABCD2 score is completed by the healthcare professional referring the patient. It is accepted that there are some additional factors which are not picked up by the ABCD2 score and it is legitimate that the assessing stroke consultant take account of these in using judgement to re-classify patients.
[88] Re-classification of patient risk does not later clock start time.
[89] Blood tests and ECG (all patients); brain scan (if vascular territory or pathology uncertain. Diffusion-weighted MRI is preferred, except where contraindicated, when CT should be used).; completion of carotid imaging (where indicated) and referral for timely carotid surgical intervention (where indicated).
[90] Aspirin, statin and control of blood pressure all where needed or alternative if contraindicated.

405. The BPT is aligned with quality markers 5 and 6 of the National Stroke Strategy (Figure 2).

Figure 2: Quality markers from the National Stroke Strategy

QM5. Assessment – referral to specialist

- Immediate referral for appropriately urgent specialist assessment and investigation is considered in all patients presenting with a recent TIA or minor stroke
- A system which identifies as urgent those with early risk of potentially preventable full stroke – to be assessed within 24 hours in high-risk cases; all other cases are assessed within seven days
- Provision to enable brain imaging within 24 hours and carotid intervention, echocardiography and ECG within 48 hours where clinically indicated

QM6. Treatment

- All patients with TIA or minor stroke are followed up one month after the event, either in primary or secondary care

406. It is widely accepted that current tariffs (primarily the geriatric medicine outpatient attendance tariff) are insufficient to cover the costs of running higher quality, specialised TIA clinics, but that where these have been set up both patient experience and outcomes have improved. We have designed the tariff to correct this, and to release savings through prevention of major stroke and improved outcomes.

407. The base tariff covers both initial and follow-up attendances, including brain imaging, carotid imaging, ECGs and echocardiograms, as appropriate. This price assumes that the brain imaging is delivered using CT rather than MRI. This reflects the fact that, for a number of reasons, it may not always be possible to perform an MRI. However, it is still strongly recommended that MRI is the primary modality used.

408. The additional payment for investigation and treatment of high risk patients within 24 hours is designed to incentivise providers to meet the ambition set out in QM5 of the Stroke Strategy[91], and has been set as a further 20% of the base tariff.

409. The additional payment for use of MRI reflects the difference in costs between the two modalities (ie the additional cost of providing an MRI scan over a CT scan) and applies regardless of the risk assessment of the patient.

[91] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

Cataracts

410. The 2011-12 cataract treatment BPT will continue in the same form in 2012-13. It applies to adults only. The tariff applies to the entire elective cataract pathway by covering the sum of the costs of the individual outpatient attendances and the surgical event (with a combined day case and ordinary elective price). For each HRG one of two prices will apply, depending on whether a patient has cataract extraction on one or both eyes.

411. The tariff corresponds to the elements of the best practice pathway (Table 19). The first eye tariff covers levels 2-5 of the pathway and the second eye tariff covers levels 6-7. Reimbursement for a patient who follows a pathway covering levels 2-7 is therefore the sum of the two tariffs. Implementation is illustrated in Annex A Figure 4a.

Table 19: Cataracts pathway

Level	Description	Events
1	Initial diagnosis of cataract	Usually done in primary care, either by GP or optometrist
2	Confirmation of diagnosis and listing for surgery	First outpatient attendance
3	Pre-operative assessment	
4	Cataract removal procedure	Most likely to be on a day case basis but could be ordinary admission in exceptional circumstances
5	Follow-up	Review by nurse, optometrist, or ophthalmologist ideally at 2 weeks. Listing for second eye where appropriate
6	Cataract removal procedure (2nd eye)	Most likely to be on a day case basis but could be ordinary admission in exceptional circumstances
7	Follow-up	Review by nurse, optometrist, or ophthalmologist ideally at 2 weeks (pathway tariff includes cost of follow-up outpatient attendance for this). Review at 4 – 6 weeks by local optometrist (pathway price does not include cost of this as it is incurred in primary care).

412. Since April 2010, additional functionality has been available in SUS PbR to help commissioners to implement this pathway tariff. Commissioners and providers can access an extract that links events along a patient pathway using the Patient Pathway ID field[92], returning records in chronological order per patient. More information is available in SUS PbR documentation available on the NHS Connecting for Health website[93]. If providers and commissioners agree, they can implement local solutions for paying for cataract pathways.

[92] This is one of the 18 weeks (referral to treatment) fields mandated for compliance since January 2010.
[93] http://www.ic.nhs.uk/services/secondary-uses-service-sus/updates-and-guidance/payment-by-results-guidance

Section 9: Exclusions

Introduction

413. The national tariff is mandatory for activity within the scope of PbR. Some services, procedures, HRGs, TFCs, drugs and devices are outside the scope of PbR and therefore subject to locally agreed payments. The *tariff information spreadsheet* includes a full exclusions list and further information, determined after wide-ranging consultation with stakeholders. In addition, the costs of services that are currently outside the scope of reference costs are, by default, also outside the scope of PbR and will not necessarily be listed on the exclusions list.

414. There are various reasons why some activity should be subject to local payment rather than a mandatory tariff. Some excluded services have not had currencies developed for them. Excluded high cost drugs and devices are typically specialist, and their use concentrated in a relatively small number of centres rather than evenly across all providers that carry out activity in the relevant HRGs. These drugs and devices would not be fairly reimbursed if funded through the tariff.

415. For all excluded activity, commissioners and providers should agree local prices, and local arrangements for monitoring activity. Non-mandatory prices are provided in Section 10 for a few services to help inform commissioning. Local prices should be paid in addition to the relevant tariff. For example, if a patient is admitted to hospital for a procedure involving an aneurysm coil, the normal HRG based tariff should be paid for the admitted patient spell, with an additional payment to cover the additional cost of the aneurysm coil itself. This additional payment is the only part of the total price subject to local determination. However, the additional payment made should take into account the amount of any tariff already paid, which may be sufficient to cover some of the costs of the excluded activity

416. In most cases, the additional payment should cover only the cost of the excluded drug, product or device and associated consumables and preparation. However, some procedures may entail additional direct costs which should also be taken into consideration in determining the appropriate additional payment.

417. In all cases, commissioners and providers will need to determine whether they wish to agree volumes and prices as part of contract agreements, or to operate on a case-by-case basis. For some excluded items, such as spinal cord stimulators or insulin pumps, it may be appropriate to agree volumes and prices in advance within a contract, while for others a case-by-case approach may be preferred. Commissioners and providers will also need to ensure that usage of any drugs or devices is in keeping with NICE and other clinical guidance.

418. There is some overlap between excluded high cost drugs and excluded services. The intention is that where services are excluded, the service as a whole is excluded. Certain service exclusions have flexibility for the method of exclusion to be determined locally (for example community services) whereas others are defined by set codes or variables. To avoid ambiguity, the list of excluded drugs therefore includes some drugs that may be used solely in services excluded from PbR.

419. Some services and procedures do not have their exclusion defined by specific codes, eg community services. We recommend that commissioners and providers discuss these exclusions using previous definitions as a starting point. These episodes can still be excluded from SUS PbR before processing by the use of the '=' exclusion.

420. Table 20 summarises the main changes to the exclusions list in 2012-13.

Table 20: Changes to the exclusions list

No longer excluded in 2012-13	Newly excluded in 2012-13
Services	
Some direct access services	
Procedures	
PETCT (for APC and direct access) SPECTCT (for APC and direct access)	Cardiovascular Computerised Tomography Balloon Assisted Enteroscopy
Admitted patient care HRGs	
HR02Z - Reconstruction Procedures Category 5 LD09A - Home Haemodialysis/Filtration with access via haemodialysis catheter 19 years and over LD10A - Home Haemodialysis/Filtration with access via arteriovenous fistula or graft 19 years and over	
Outpatient TFCs	
Drugs	
Drotrecogin alfa	Afamelanotide Aflibercept Aztreonam Lysine Belatacept Belimumab Colistimethate sodium Daclizumab Defibrotide Dexrazoxane Ecallantide Eliglustat Fibroblast growth factor 1 gene therapy Filibuvir Fluocinolone acetonide Lixivaptan Macitentan Migalastat Ocriplasmin Pasireotide

No longer excluded in 2012-13	Newly excluded in 2012-13
	Pegloticase Ruxolitinib Tafamidis Taliglucerase alfa Teduglutide Tobramycin Tofacitinib Vedolizumab Verteporfin
Devices	
Artificial Urinary Sphincter (now covered by HRG LB50Z)	Biological Mesh

Excluded services

421. Patient transport services (PTS)[94] and healthcare travel costs scheme (HTCS)[95] costs remain excluded from the tariff.

Cancer multi disciplinary teams

422. To help clarify the correct treatment for payment of cancer multi disciplinary team (CMDT) activity, the following five categories of CMDTs are excluded from tariff (these costs are collected separately in reference costs) and local arrangements for reimbursement should be made:
    (a) colorectal
    (b) local gynaecological
    (c) specialist gynaecological
    (d) breast
    (e) specialist upper gastrointestinal

423. The remaining CMDT activity is indirectly included in tariff as this is treated as an overhead across cancer services within reference costs (unless other local arrangements apply). In the future, in an attempt to clarify this area, the 2011-12 collection of reference costs will separately identify all CMDT activity, not just the five categories listed above.

Excluded procedures

424. We are continuing to exclude the following seven procedures:

    (a) soft tissue sarcoma surgery
    (b) positron emission tomography computed tomography with computed tomography (PETCT) (in outpatients only)
    (c) single photon emission computed tomography with computed tomography (SPECTCT) (in outpatients only)

[94] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373
[95] http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/DH_075759

(d) cardiovascular magnetic resonance imaging
(e) pelvic reconstructions
(f) head and neck reconstructive surgery
(g) intracranial telemetry

425. In addition we are excluding cardiovascular computed tomography and balloon assisted enteroscopy.

Soft tissue sarcoma surgery

426. This surgery is only delivered in a very small number of units and is defined in Table 21 (conditions in both columns to be satisfied).

Table 21: Definition of soft tissue sarcoma surgery procedure exclusion

ICD-10 (in any position)	OPCS-4
C40 Malignant neoplasm of bone and articular cartilage of limbs C41 Malignant neoplasm of bone and articular cartilage of other and unspecified C47 Malignant neoplasm of peripheral nerves and autonomic nervous system C48 Malignant neoplasm of retroperitoneum and peritoneum C49 Malignant neoplasm of other connective and soft tissue	Primary operation code is not missing (i.e. a surgical procedure has actually been carried out), and it is not a chapter X code (chemotherapy or amputation)

PETCT and SPECTCT

427. PETCT and SPECTCT scans that are carried out as part of an outpatient attendance will continue to be excluded in 2012-13. We will be reviewing this exclusion for 2013-14.

428. However, PETCT and SPECTCT scans that are accessed directly are included in the mandatory direct access tariffs (HRGs RA42Z and RA38Z respectively) and are therefore not excluded from PbR. PETCT and SPECTCT scans carried out as a part of an admission are included in the admitted patient care tariffs, and are therefore not excluded from PbR.

Cardiovascular magnetic resonance imaging

429. A new HRG for cardiovascular magnetic resonance imaging is being introduced in reference costs for 2011-12, with a view to the introduction a tariff for this activity in the future.

Pelvic reconstructions

430. Previously pelvic reconstructions, defined as “a pelvic/acetabular fracture requiring open reduction and internal fixation covering any significantly displaced acetabular fracture and all complex pelvic ring fractures (except those that are minimally displaced in the over 65s)” were excluded from PbR. We have updated the exclusion for pelvic

reconstruction so that it is now defined by OPCS-4 and ICD-10 codes, as per Table 22.

Table 22: Definition of pelvic reconstruction procedure exclusion

ICD-10 (primary diagnosis)	OPCS-4 (in any position)
S324 - Fracture of acetabulum OR S328 - Fracture of oth and unspec parts of lumbar spine and pelvis	Z75 – bone of pelvis, Z841 - Sacroiliac joint OR Z842 - Pubic symphysis AND Either 1. W195 - Primary open reduction of fragment of bone and fixation using screw, W196 - Primary open reduction of fragment of bone and fixation using wire system, W198 - Other specified primary open reduction of fracture of bone and intramedullary fixation, W208 - Other specified primary open reduction of fracture of bone and extramedullary fixation W209 - Unspecified primary open reduction of fracture of bone and extramedullary fixation W213 - Primary fixation of fragment of chondral cartilage of intra-articular fracture of bone, W214 - Primary intra-articular fixation of intra-articular fracture of bone NEC, W232 - Secondary open reduction of fracture of bone and extramedullary fixation HFQ, W236 - Secondary open reduction of fracture of bone and internal fixation HFQ, W245 - Closed reduction of fragment of bone and fixation using screw, W248 - Other specified closed reduction of fracture of bone and internal fixation, W654 - Primary open reduction of fracture dislocation of joint and internal fixation NEC, W655 - Primary open reduction of fracture dislocation of joint and combined internal and external fixation, or W677 - Secondary open reduction of fracture dislocation of joint and internal fixation NEC OR 2. W281 - Application of internal fixation to bone NEC AND (W211 - Primary reduction of intra-articular fracture of bone using arthrotomy as approach, W212 - Primary excision of intra-articular fragment of intra-articular fracture of bone, W215 - Primary extra-articular reduction of intra-articular fracture of bone, W218 - Other specified primary open reduction of intra-articular fracture of bone, W219 - Unspecified primary open reduction of intra-articular fracture of bone)

Head and neck reconstructive surgery

431. Head and neck reconstructive surgery for the excision and reconstruction of upper aerodigestive tract, skull base, salivary, thyroid gland malignancies and non-malignancies, is significantly more expensive than either excision or reconstruction alone and continues to be excluded.

Intracranial telemetry

432. Intracranial telemetry, which is used for some patients with complex epilepsy, is significantly more expensive than the other activity within the relevant HRGs. There is ongoing work on the coding of and subsequent HRG design for this activity, which will be excluded until the work is completed. This exclusion includes any subsequent cortical mapping and epilepsy surgery.

Cardiovascular computed tomography

433. Cardiovascular computed tomography is a new exclusion for 2012-13, following feedback that this activity is significantly higher cost than other computed tomography. There is ongoing work on the possibility of a separate HRG for this activity.

Balloon assisted enteroscopy

434. Balloon assisted enteroscopy is a new exclusion for 2012-13, following feedback that it is significantly higher cost than other enteroscopic procedures. There is ongoing work on the possibility of a separate HRG for this activity.

Excluded HRGs

435. We have reviewed HRGs excluded from PbR owing to data quality or low volumes. For those HRGs which would otherwise be excluded due to low volumes, we have considered whether a tariff can be set in any case, for example because the reference costs have been relatively stable despite the low volume. This is with an aim to reduce the fluctuation of HRG exclusions year-on-year.

Excluded TFCs

436. We exclude outpatient attendance TFCs mostly because the service is excluded from PbR (eg rehabilitation), but have also excluded others due to low volumes of activity.

Excluded drugs

437. The High Cost Drugs Steering Group has reviewed high cost drugs, including drugs raised by the UK Medicine information (UKMi) in their horizon scanning reports, and considered excluding drugs where the:

    (a) drug, and its related costs, have a disproportionately high cost in relation to the other expected costs of care which would affect fair reimbursement and
    (b) drug has, or is expected to have more than £1.5 million expenditure or 600 cases each year.

438. The exclusions list contains details of the individual high cost drugs excluded from PbR at the time of writing. Excluded drugs will also create unbundled HRGs where they are coded. To avoid obsolescence in our annual guidance, where possible we link high cost drug exclusions to British National Formulary (BNF)[96] categories and use generic names of medicines. The general principle is that the exclusion applies to both mandatory and non-mandatory tariffs.

439. In the *tariff information spreadsheet*, on the mapping of HCDs sheet, if a BNF section or sub-section is listed then all drugs in that section or sub-section are excluded, e.g. under AIDS/HIV antiretrovirals it states “5.3.1”, in this instance all drugs under BNF section 5.3.1 are excluded. If a specific drug is excluded then it is listed by name. For example, under paroxysmal nocturnal haemoglobinuria it states “9.1.3 >Eculizumab”. In this instance only eculizumab is excluded.

440. The detailed drug exclusion list is not necessarily an exhaustive list of all drugs excluded from PbR. The BNF is updated regularly but we will not be updating our list in-year. If in-year a new drug is added to a BNF section or sub-section that is wholly excluded then the new drug is also excluded. For example, if a new drug is added into BNF section 5.3.1 then it will be excluded from the tariff as the whole section is excluded, whereas if a new drug is added into BNF section 9.1.3 then it will not be excluded as currently only eculizumab is excluded in this section.

441. Most drugs are excluded for any purpose irrespective of their BNF section. However, BNF sections should be used as a broad guide to the usage and purpose of the drug. Commissioners and providers should agree locally for which indications an excluded drug will be funded. Drugs can also be stated exclusions for a specific use or purpose. For example, in 2012-13 Sildenafil is only excluded (as part of BNF section 2.5.1/7.4.5) when used for pulmonary arterial hypertension.

442. Some drugs may be excluded from PbR prior to the drugs having the appropriate licensing or NICE guidance. This does not negate their exclusion from PbR. In addition, if a drug that is excluded from PbR is

[96] http://bnf.org/bnf/index.htm

prepared as an unlicensed preparation it is still excluded from PbR. When a drug is excluded from PbR it is not an indication that the drug must necessarily be funded separately, but that the drugs costs have not been included in the published tariffs. We fully expect that commissioners and providers would discuss the usage and any associated payment for the drug through normal, established commissioning routes.

443. Where a new drug is released in-year and it is not excluded from PbR, but it is causing an issue for service delivery, it may be appropriate for commissioners and providers to consider the use of innovation payments (paragraph 684).

444. All home care drugs, where there is no associated admitted patient or outpatient activity at the provider, continue to be excluded from PbR. This includes the actual drug, transportation, delivery and any other associated costs. Please note however that there are mandatory tariffs for some home dialysis. We will be reviewing tariff arrangements for home care drugs for 2013-14.

445. As in previous years, all blood products are excluded from PbR regardless of whether or not they are listed in the BNF. Providers and commissioners should agree locally what this exclusion covers.

Excluded devices

446. The High Cost Devices Steering Group has reviewed high cost devices which are:

    (a) high cost and represent a disproportionate cost relative to the relevant HRG
    (b) used in a subset of cases within an HRG and/or used in a subset of providers delivering services under a specific HRG
    (c) relatively high cost in terms of volume and cost.

447. All three of the listed criteria need to be met in order for a device to be considered an exclusion from PbR.

448. The exclusion of high cost devices is in support of innovation, and although devices added to the list are likely to be new, exclusions are not limited to new devices. Some devices may need to be excluded for a period of time until they can be appropriately funded through a national tariff. The reference to new devices has been removed from the criteria to reflect this.

449. In some cases a device may be being used that is relatively new to the service, but which is not excluded due to low levels of use. In such cases it may be appropriate for commissioners and providers to consider the use of innovation payments (paragraph 684). On occasions where a

device is removed from the exclusion list, innovation payments can also be considered.

450. We will review the current arrangements for device exclusions for 2012-13 in light of the innovation review[97]. Commissioners should in any case take account of recommendations in the innovation review.

451. Excluded devices are reviewed on an annual basis, and will be removed from the exclusion list if they no longer meet the criteria (paragraph 446). For example an HRG design change in the future may mean that the use of a device can be identified specifically, and an appropriate tariff set. Note that a device, for the purposes of PbR, is:

    (a) used as part of patient care and generally cannot be transferred or re-used[98]; and
    (b) not considered capital equipment.

452. Table 23 summarises changes to the device exclusion list between 2011-12 and 2012-13. It does not include the new additions to, or removals from the list in 2012-13 from Table 20.

Table 23: Changes to the 2011-12 device exclusion list

Name of device in 2011-12	Change in 2012-13
Consumables associated with per oral/per anal single operator cholangioscope	Changed to consumables associated with per oral single operator cholangioscope
Percutaneous valve replacement devices	Changed to percutaneous valve replacement and repair devices
Peripheral vascular stents	Note added to say “includes peripheral vascular drug eluting stents”
Radiofrequency ablation probes	Changed to radiofrequency, cryotherapy and microwave ablation probes and catheters
Ventricular assist devices (VAD)	Changed to ventricular assist devices (VAD) & prosthetic hearts

453. The costs of services that are currently outside the scope of reference costs are, by default, not included within the mandatory or non-mandatory tariffs. We expect that commissioners and providers will negotiate locally for these services and devices in the same way as for other services and devices excluded from mandatory tariff. For example, continuous positive airway pressure (CPAP) and bi-level positive airways pressure (BiPAP) machines should be covered under local commissioning arrangements for home equipment loans.

97 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131299

98 There are a few exceptions to devices not being transferable, for example insulin pumps can be reconditioned and reused for a different patient.

454. Commissioners and providers should agree a local price for the programming and maintenance of cochlear implants and bone anchored hearing aids because the tariffs only cover the costs associated with the admitted patient spell in which the device is implanted. For bilateral procedures, the additional cost of the procedure and implant should be subject to local negotiation.

455. The tariffs for cochlear implants cover the cost of the external processor (which may be activated at a later time) as well as the cochlear implant itself.

456. When using complex cardiac ablation procedures, only one of the following exclusions can be sought for reimbursement purposes at any one time: 3 dimensional mapping and linear ablation catheters used for complex cardiac ablation procedures, or radiofrequency, cryotherapy and microwave ablation probes and catheters (when used for treating tumours).

457. In general, locally agreed payments will be to cover the cost of the excluded device. However, there are exceptions to this, whereby the price paid for excluded devices may need to take into account the tariff already received for the underlying activity (for example procedure and alternative, lower cost devices) where applicable. This allows for instances when a device can be used in different circumstances – a different core payment has already been made and may already allow for some, but not all, of the excluded costs. Three examples are given below:

    (a) the additional payment to cover the cost of a bespoke prosthesis should be that which is over and above the cost of a standard prosthesis
    (b) the additional payment for penile prostheses should allow for the tariff that has already been paid for the procedure (HRG LB47Z Penis Major Open Procedures) which covers some of the cost of the prosthesis
    (c) any additional payment agreed for biological mesh should take account of the amount of mesh used, and the tariff received for the underlying procedure.

Section 10: Non-mandatory prices

Introduction

458. We are publishing non-mandatory prices where we want to provide an indication of prices, but do not feel it is appropriate to use a mandatory tariff. There are several reasons for this:

    (a) some areas have notably different models of service provision which might make a national tariff inappropriate
    (b) it may be decided to include a service in PbR in future and so allow the NHS to make use of available data in advance of a mandatory tariff
    (c) to support direct access commissioning of diagnostics (as described in Section 5)
    (d) where there are insufficient data flows to support a mandatory tariff, but we wish to make pricing information available.

459. The following services will continue to have non-mandatory prices in 2012-13 as they did in 2011-12:

    (a) acute phase of rehabilitation
    (b) adult hearing services
    (c) non face-to-face outpatient attendances
    (d) neurology and neurosurgery outpatient attendances.

460. These non-mandatory prices may be used as part of contract negotiations and varied to reflect local circumstances. The actual approach to counting, pricing and reporting this activity should be agreed locally. Separate data flows between commissioners and providers will need to be established for the purposes of local monitoring. As with the mandatory tariff, the prices are published net of the MFF, which will need to be separately applied.

461. The following services will no longer have non-mandatory prices in 2012-13 because they are now covered by the mandatory tariff:

    (a) home haemodialysis (paragraph 328)
    (b) direct access respiratory tests (paragraph 225)
    (c) direct access diagnostic imaging (paragraph 219)
    (d) direct access echocardiograms (paragraph 224).

Acute phase of rehabilitation

462. HRG4 introduced unbundled HRGs for rehabilitation. As in 2011-12, we are not setting a mandatory tariff for these, because clarity is needed in defining where a patient's acute spell ends and where discrete rehabilitation begins. We are therefore continuing to publish non-

mandatory prices for the acute phase of care for pneumonia, hip replacement and fragility hip fracture, based on the typical length of the acute phase for the HRGs. These do not relate to discrete rehabilitation.

463. The rehabilitation ERP is reviewing the current approach to developing a tariff for rehabilitation services. The panel will also review the latest reference costs for rehabilitation to help address options for the coding of rehabilitation services, and link into the best practice tariff development for stroke (with emphasis on rehabilitation).

464. For acute stroke care, we are carrying forward guidance from 2011-12 on how organisations may wish to redistribute funds from the acute tariff to the immediate post-acute phase of rehabilitation.

465. The acute stroke care tariff is a function of the service models in place when it is calculated. In a single service model, the HRGs AA22Z and AA23Z will capture the costs of the whole pathway and therefore the tariff should adequately fund the associated costs of both the acute phase of care as well as the immediate post-acute phase of rehabilitation. As we move from a single service model to more varied patterns of stroke care delivery, a tariff based on 2009-10 costs and activity will not reflect this diversity.

466. This guidance supports commissioners and providers in developing whole stroke care pathways that best meet the needs of each patient and recognises that these pathways can include a number of separate provider organisations. The principles are that the tariff:

    (a) should not act as a barrier to local planning to provide high quality stroke care to all patients at the right time and in the right place.
    (b) should not erode existing integrated, specialist pathways
    (c) should foster local reviews and where appropriate, reconsideration of existing pathways, from both a clinical and financial perspective
    (d) acknowledges that rehabilitation begins as soon as possible after stroke
    (e) should foster increased access to evidence-based care in settings along the whole care pathway, including stroke unit care, specialist community stroke care and early supported discharge.

467. *Payment by Results for stroke and TIA services (2007)* [99] included recommendations on unbundling the tariff into an indicative acute stroke and post acute elements and was designed to help those affected by PbR understand better how it was intended to work. Since 2007, the way much of stroke care is delivered has changed significantly, in particular the time people spend in various phases of the care pathway. The National Audit Office (NAO) report *Department of Health: Progress in improving stroke care (2010)*[100] recognised a need for improved access

[99] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077130
[100] http://www.nao.org.uk/publications/0910/stroke.aspx

to specialist community stroke care and early supported discharge (ESD).

468. Because the tariff prices for AA22Z and AA23Z reflect a historic single service model of care, there is consensus that there is resource within the stroke tariff prices to provide high quality care beyond the hyper-acute part of the pathway. To reflect these changes appropriately the NHS has sought assistance to ensure that resources follow patients into the later, rehabilitation focused, elements of the stroke pathway. The NHS Stroke Improvement Programme website contains information, including case studies from health economics[101] to support organisations achieve these changes.

469. The SSNDS for specialised rehabilitation services for brain injury and complex disability categorises the rehabilitation needs of patients and the level of service provision required to meet those needs. For stroke patients, in the majority of cases, the rehabilitation needs will be classed as Category C and require Level 3 service. It is for patients with this category of needs that the NHS Stroke Improvement Programme will be developing solutions to unbundling of the tariff prices for AA22Z and AA23Z. More complex stroke patients, for example with category A or B needs, or those with sub-arachnoid haemorrhage, will have their needs best met in level 1 or 2 specialist rehabilitation settings. Funding for these service levels are currently outside of the scope of tariff. The rehabilitation ERP is currently developing costing and payment models for specialist rehabilitation under the VC chapter of HRGs for rehabilitation.

470. The current tariff structure is based on an average length of stay of 18 days for AA22Z and 17 days for AA23Z in 2009-10 (decreased from 34 days in 2001). The trim point is set at 53 day for AA22Z and 47 for AA23Z but these, by definition, apply only to outlier[102] patients and should not be a reason for not developing evidence based alternatives to extended lengths of stay in hospital, for example ESD, for those patients who can benefit. Patients with complex rehabilitation needs, however, who require admitted patient rehabilitation, and are predicted to require longer lengths of stay in order to reach the level where their needs can be appropriately met in the community, should be considered for early referral to specialist rehabilitation.

471. Stays in newer hyper-acute units may be as low as 3 days, with up to 40% of patients moving on to stroke rehabilitation units at that time, and in many stroke pathways patients are moving to different specialist care providers after 7 days in an acute unit. A better shared understanding of the financial implications of these changes is needed to ensure that the money follows the patient appropriately and to reflect the strengthening evidence base for community specialist stroke rehabilitation and ESD.

[101] www.improvement.nhs.uk/stroke

[102] Trim points are set to identify unusually long lengths of stay and represent statistical outliers. Trim point is defined as upper quartile + (1.5 x inter quartile range).

Local discussions about unbundling the tariff to foster implementation of these evidence based interventions in stroke should take place.

Adult hearing services

472. We are again publishing non-mandatory prices for direct access adult hearing services.

Cystic fibrosis

473. We are phasing in the introduction of a year-of-care tariff for cystic fibrosis (CF) by transitioning from non-mandatory to mandatory prices, with a view to introducing a national mandated tariff in 2013-14.

Currency

474. The CF currency is a complexity-adjusted yearly banding system with seven bands of increasing complexity. There is no distinction between adults and children. The banding system will be used for contracting purposes in 2012-13.

Banding

475. Bandings are derived from clinical information including cystic fibrosis complications and drug requirements. The bands range from band one, for the patients with the mildest care requirements (involving outpatient treatment two to three times a year and oral medication) to band five, for patients at the end stage of their illness (requiring intravenous antibiotics in excess of 113 days a year with optimum home or hospital support).

476. The non-mandatory tariff is designed to allow specialist CF multidisciplinary teams to direct care in a seamless, patient centred manner, removing any perverse incentives to hospitalise patients who can be well managed in the community and in their home. Furthermore, it will allow early intervention, as per international guidelines, to prevent disease progression for example through the use of anti-pseudomonas, inhaled/nebulised antibiotics and mucolytic therapy.

477. The CF banding matrix identifies the characteristics which will lead a patient to be classified into a particular band. Patients are allocated to a band by extracting data from the Cystic Fibrosis Trust national database, the UK CF Registry and feeding it into a template that produces the banding. The banding matrix and an example of how to use it is provided at Annex F.

478. Banding will be issued each February using the data input to the UK CF Registry. This information is based on a calendar year's data and will be used both to fine tune the planning assumptions made for the next financial year and for initial planning purposes for the following year.

479. Banding information, based on the 2010 calendar year, was issued in 2011. This information should be used for planning purposes for the financial year 2012-13. In February 2012 updated banding information based on 2011 calendar year will be issued. Commissioners will use this information to finalise their planning assumptions for 2012-13. The bands issued in February 2012 will be the final bands for all patients for 2012-13 and will be used for contracting purposes. There will be no movement of patients between bands during any one financial year.

Patient numbers

480. There are likely to be changes in the number of patients in each band in the cohort of CF patients at any one centre. This will be due to increases and decreases in patient numbers due to births, transition from children's to adult services, natural patient movement from one area to another, transplantation and deaths. Whilst the tariff is payment for a year of care, in reality payments are most likely to be made in twelfths as part of contract payments. Changes in patient numbers will be addressed as follows:

    (a) New births. Payment is calculated from the beginning of the month in which the patient is born. New births will be banded as 2A, which recognises the additional costs associated with diagnosis, care and treatment of a new patient. These patients will revert to the band issued through the process described above when the bandings are revised for the following year.

    (b) Transition to an adult service or to another specialist CF centre. Clinical transition or transfer to another centre may take place over a period of time. For the purposes of payment the two centres must agree a date at which responsibility of care will transfer. The date on which responsibility ceases must always be the last day of a calendar month and the date on which the new centre assumes responsibility for care must always be the first day of the new calendar month. These finalised dates will be used by commissioners to cease payment to the original centre and commence payment to the receiving centre.

        In some circumstances, such as university students or patients needing care whilst on holiday, there may not be a formal transfer of care as an individual may not wish or need to have their care transferred to a new centre. Should treatment be required away from the centre responsible for their care, the responsible centre will be expected to pay for that care. This will be a provider to provider transaction.

    (c) Deaths. Payments for patients who die will cease at the end of the month in which they die.

(d) Transplants. Heart and heart/lung, lung and liver transplants are commissioned by the Advisory Group for National Specialised Services (AGNSS). Payment of the non-mandatory CF tariff for patients receiving a transplant will cease at the end of the month in which they receive their transplant. Funding for any continuing care from a CF specialist centre following a transplant will need to be determined locally.

Information on patient number variations

481. Each provider will be responsible for informing commissioners of changes in patient numbers due to new births, transition and transfers, deaths and transplants so as to enable commissioners to reconcile payments on a regular basis. The UK CF Registry will send monthly reports to commissioners to enable them to verify the changes reported by providers.

482. It will be incumbent upon providers to agree upon payment for any patient who has not formally transferred responsibility for their care to another centre.

What is included in the non-mandatory tariffs?

483. The bandings cover all treatment **directly** related to cystic fibrosis for a patient during the financial year. This includes:

(a) Admitted patient care and outpatient attendances (whether delivered in a specialist centre or under shared network care arrangements)
(b) Home care support, including home intravenous antibiotics supervised by the CF service, home visits by the multidisciplinary team to monitor a patient's condition, eg management of totally implantable venous access devices (TIVADs), collection of mid-course aminoglycoside blood levels and general support for patient and carers
(c) Intravenous antibiotics provided during in-patient spells
(d) Annual review investigations.

484. Any episode directly related to CF specific care (admitted patient care or outpatient activity) will not attract additional activity based payments as these are included in the annual banded tariff, eg admitted for treatment of exacerbation of chest infection, admitted for medical treatment of CF distal intestinal obstruction syndrome, admitted with a new diagnosis of CF-related diabetes to establish a new insulin regimen. To help identify cystic fibrosis activity, TFCs for adult cystic fibrosis (TFC 343) and paediatric cystic fibrosis (TFC 264) were introduced in 2011. A primary diagnosis of cystic fibrosis may also be a useful way to identify CF specific care.

What is excluded from the non-mandatory tariffs?

485. The following are explicitly not included in the non-mandatory CF tariff:

    (a) High cost CF specific **inhaled/nebulised** drugs: Colistimethate sodium, Tobramycin, Dornase alfa and Aztreonam Lysine.
    (b) Insertion of gastrostomy devices (PEG) and insertion of totally implantable venous access devices (TIVADs) are not included in the annual banded tariff. Surgical procedures should be reimbursed via the relevant HRG tariff.
    (c) Neonates admitted with meconium ileus who are subsequently identified to have cystic fibrosis should not be subject to the CF tariff until they have been discharged after their initial surgical procedure. This should be reimbursed via the relevant HRG tariff. Subsequent annual banding should not include the period they spent as an admitted patient receiving their initial surgical management.

486. CF patients may require medical input from other specialties for non-CF specific care. The costs relating to non-CF specific care are not included in the annual banded tariff. These episodes of care will be covered by tariffs assigned to the relevant HRG or TFC, eg obstetric care for a female patient with CF, ENT outpatient review for nasal polyps and ENT surgery for removal of nasal polyps.

Drugs

487. Prescription of the high cost drugs Colistimethate sodium, Tobramycin, Dornase alfa and Aztreonam Lysine that are used in the treatment of CF patients will be initiated by the specialist CF centre. Continuation of the prescription, whether from the specialist CF centre or the GP, will be by local arrangement.

488. Funding of Colistimethate sodium, Tobramycin, Dornase alfa and Aztreonam Lysine will be governed by national commissioning policies. Commissioners will need to ensure that the arrangements are clear with each specialist CF centre for the continuing prescription of these drugs to enable the appropriate funding flow.

489. Where continuation of prescribing is left with the specialist CF centre, the use of home delivery systems should be encouraged.

490. GPs will continue to prescribe and fund all other chronic specific medication, for example long-term oral antibiotics, pancreatic enzyme replacement therapy and vitamin supplements.

491. There are a number of high cost antifungal treatments excluded from PbR, which are therefore not included in the CF tariff.

492. Costs associated with long-term nutritional supplementation via gastrostomy or nasogastric tube feeding are not included in the annual banded tariff and will remain within the primary care budget.

493. When looking at the cost and payment of any new high cost drugs approved for use in CF by NICE and/or commissioners, it may be appropriate for commissioners and providers to consider the use of innovation payments, to address the cost and payment of these drugs.

Tariff principles and service designation

494. CF care will be provided on the basis of the following principles:

(a) All patients will be registered with a designated CF specialist centre which will be responsible for all care directly related to the patient's CF.
(b) Designated CF centres will be responsible for ensuring that the data of all the patients for whom they are responsible are entered on the national CF database, the UK CF Registry. Patients/carers who do not wish their data to be entered on the UK CF Registry must express this wish in writing to their clinician at the specialist centre.
(c) All CF treatment and care for both adults and children will be delivered by clearly designated providers.
(d) For adults all the treatment and care will be the responsibility of the specialist centre with no shared care arrangements in place.
(e) For children, the treatment centre will initiate all treatments with treatment and care being delivered in either a centre or designated district general hospitals in the framework of a shared care network. Inter Trust service level agreements will be in place to support these arrangements.
(f) The providers of CF services – centres and shared care units – will need to comply with the relevant service specification and meet the service standards.
(g) Access to and eligibility for CF specialist drugs will be determined by national commissioning policy.
(h) The relevant CF centre will be responsible for initiating <u>all</u> current CF specialist drugs.

495. Using these principles, payment of CF tariffs will only be made to designated specialised CF centres. The formal process of designating treatment centres will take some time. For the purposes of the 2012-13 tariff, designated centres will be those which meet the following criteria:

(a) The provider trust will have agreed with the commissioner of the service that it will be a specialist centre for CF.
(b) The centre will have accepted the national service specification(s) for the provision of cystic fibrosis treatment for children and/or adults (as appropriate) and will have incorporated the specification(s) into the 2012-13 contract.

(c) The centre will either already meet the requirements contained within the service specification or will have a plan agreed with the commissioner of the service to meet those requirements by April 2014.
(d) The centre will meet the requirements for data entry into the UK CF Registry as detailed in the UK CF Registry operating procedure from 1 April 2012.

Shared / network care

496. Whilst shared care arrangements may be more appropriate for children with CF it is important to distinguish between shared care and outreach care.

497. Shared/network care is a recognised model for paediatric care. Shared/network care clinics take place in district general hospitals close to the homes of people with CF, where care is provided in partnership with the responsible Specialist CF Centre. This model of care must provide care that is of equal quality and access as full Specialist Centre care.

498. Outreach care is defined as care provided by a Specialist Centre care team who travel to a local district general hospital. Typically, but not exclusively, this may occur in geographically challenging areas so as to minimise difficult journeys that people with CF have to make. In all cases CF tariffs will only be paid to designated Specialist CF Centres.

Payment for shared/network care

499. Further work needs to be done to standardise share care and network care, including understanding how shared care is currently being funded. In the meantime payments will be subject to local arrangements.

Details of the non-mandatory tariffs

500. The non-mandatory tariffs for 2012-13 are included in the *tariff information spreadsheet*. The tariffs for bands 1A and 2 are the same, reflecting the similar costs of service provision. For 2013-2014 it is proposed to merge these two bands.

501. As cystic fibrosis is in itself a specialised service the non-mandatory tariffs are not eligible for any top-up relating to specialised services.

Neurology and neurosurgery

502. We are publishing non-mandatory prices for neurology (TFC 400), neurosurgery (TFC 150) and paediatric neurology (TFC 421) consultant-led outpatient attendances, with the intention of introducing mandatory tariffs in the future. We calculated these in the same way as other outpatient attendance tariffs, ie with diagnostic imaging rebundled.

However, we are investigating the amount and distribution of diagnostic imaging used during these outpatient attendances, and commissioners and providers may wish to take account of local scanning rates where possible when agreeing prices. We also understand that some neurology and neurosurgery outpatient clinics are run on a satellite basis, with variable contracts in place for this model. The delay in introducing mandatory tariffs gives an opportunity for such contracts to be revisited in order to put providers and commissioners in a position to use mandatory tariffs in the future.

Non face-to-face outpatient attendances

503. The non-mandatory price for non face-to-face outpatient attendances is unchanged, and is designed to support the use of convenient communication for patients.

504. The definition of a non face-to-face consultation is one which must directly entail contact with a patient or with a proxy for the patient such as a parent of a young child. A non face-to-face contact should replace a face-to-face consultation which would have attracted the relevant mandatory outpatient attendance tariff.

505. The price may be applied to TFCs that have a mandatory tariff for face-to-face activity, and to consultant led or non-consultant led activity, where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the implications of test results to a patient would warrant its use, but a telephone call, text or e-mail to report a result would not. It does not apply to telemonitoring. The funding for this activity is no longer in the outpatient attendance tariff as an overhead.

Section 11: Mental health currencies

Introduction

506. 2012-13 is the introductory year for what is a major change in the way that secondary mental health care is currently funded, a shift from block contracts to PbR currencies. The currencies are associated with individual service users, their interactions with mental health services, and the packages of care that they receive. *Equity and Excellence: Liberating the NHS*[103] commits us to introducing the mental health care clusters as the contract currency for 2012-13 with local prices. This means that prices for the currencies will be agreed between commissioners and providers, and not set at a national level. The pace of change is challenging, but the implementation timetable has been clearly signposted to providers and commissioners since April 2010.

507. The currencies cover service users accessing mental health care (post GP or other referral pathway) that have traditionally been labelled working age adults (those over 18), including early intervention in psychosis (EIP) services from age 14, and older people's services. By 31 December 2011 providers should have assessed and allocated to a cluster all service users within scope who are currently under their care. Attaining this target will not be monitored centrally, but will be something that commissioners will wish to look at, recognising that it is unlikely that 100% of service users at any one time will be clustered, due to those waiting for an initial assessment. Areas of mental health care that are currently excluded from the clusters are set out in Table 26.

508. In September 2011 providers submitted 2010-11 reference costs to the Department on a cluster basis for the first time, in addition to submitting them on the previous basis. Guidance on how to do this was published in June 2011 and has been updated for the 2011-12 collection. The cost of each cluster includes an apportionment of overheads and the methodology for doing this is set out in the NHS costing manual and PLICS costing standards. SHA mental health leads have shared the anonymised reference costs with commissioners and providers in their area. For 2012-13 we expect providers to agree local prices with their commissioners, based on the cost of the care clusters.

509. However, we understand that local cluster cost information for 2010-11 is very variable, both in terms of quality and quantity. Recognising this, providers and commissioners must work together to mitigate the possibility of any financial instability during 2012-13 as a result of developmental data quality issues. They should negotiate agreements for 2012-13 that include how any financial risks will be managed and shared. We expect that the impact of introducing care clusters as the

103 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

currency should be **cost neutral** in 2012-13. Many organisations have already put a Memorandum of Understanding (MOU) in place to help manage the changes that will occur, and to ensure that the responsibilities for them are shared. The exact wording of the MOU will vary between health economies, but an example of an MOU from the North-East is attached at Annex G. We strongly recommend that all organisations develop such an MOU.

510. We recognise that some organisations may be part way through a three-year contract period and that commissioners may have signalled their intention that these arrangements will remain in place for 2012-13. Where this is the case the PbR currencies should run alongside as such monitoring and reporting arrangements based on the currencies.

511. During 2012-13 providers and commissioners will need to carefully monitor the initial cluster costs and prices to build greater confidence in the approach. They will also need to agree prices for the initial assessment of service users and monitor these costs as a separate payment will be made for them.

512. Commissioners should apply the same tariff adjustment (ie including any efficiency requirements) for their **total** spend with each mental health provider as they do for acute providers, ie -1.8%. This is defined in the *Operating Framework for the NHS in England 2012-13*[104] and will provide the envelope within which local cluster prices for 2012-13 should be agreed. Due to historical differences in costs and or contract values, providers may initially agree different local prices with different commissioners.

513. Over the next year providers should work with all their commissioners to agree a single local provider price for each cluster. We suggest that this be achieved for use in 2013-14. The starting point for local prices in 2012-13 will be the total quantum for reference costs for 2010-11 (clustered and non-clustered) adjusted by the appropriate tariff uplift for years 2011-12 and 2012-13, and any other jointly agreed changes to services. 2011-12 cluster data can also be used to inform 2012-13 contracts.

514. In 2012-13, as well as using the clusters for contracting it will be important to make progress in other areas to ensure that the data to support mental health PbR in future years is as accurate as possible. This includes:

- continuing to cluster all service users of working age and older people's services and those using Early Intervention services, and improving the consistency and quality of data used in applying the clustering tool

104 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

- ensuring that the national maximum cluster review intervals are applied and recorded as set out in the clustering booklet, and the care transition protocols used consistently
- improving the accuracy and quality of data collection for the mental health minimum data set and submitting it to the IC in a timely manner
- improving the accuracy and data quality in attributing costs to each cluster, and in costing assessments, making use of the Mental Health Costing standards, and benchmarking with other providers to understand the reasons for differences
- continuing work to develop cluster packages of care that are based on good practice, including NICE and CQC standards, and improved service-user experience.

515. Improvements in data quality can be incentivised through CQUIN payments. Commissioners in the West Midlands have used CQUIN payments for the past two years to encourage early take-up of clustering by providers and the implementation of processes to monitor the quality of clustering. One commissioner has suggested that for 2012-13 it might be helpful to have a CQUIN in place to continue to receive activity information per service line and in an additional column the cluster information for that line (how many people and how many days for the period). This could enable safe transition from the one method to the other and inform cluster pathway development.

516. Commissioners should work constructively with providers to ensure a smooth transition to the new system in 2012-13. Providers must share relevant information with commissioners on cluster activity, cluster packages of care, and cluster costs, following the principles contained in the *Code of Conduct for PbR 2012-13*. Such information exchange can also form part of an MOU. Commissioners will need to recognise that this information will improve over time, and that some organisations that they work with will be further ahead than others.

517. Commissioners must work with the Clinical Commissioning Groups in their area during 2012-13 to ensure that they understand the new approach to funding mental health services, and to help build future commissioning capacity.

518. In deciding whether to move to a national tariff for each cluster and for initial assessments in 2013-14, DH has already said that a clear evidence base will be needed to support that move. We will not be in a position to make that assessment until after the analysis of the 2011-12 reference cost exercise in summer 2012, and when we have a better picture about how consistently cluster review periods are being applied. We will monitor how risk-sharing agreements are working in practice and where appropriate what further guidance may be required for subsequent years around negotiating spending limits.

519. The implementation of PbR in mental health needs to support the adoption of best practice in delivery of the outcomes set out in the current mental health outcomes strategy *No health without mental health: a cross government mental health outcomes strategy for people of all ages*[105], with its focus on recovery. DH and the NHS have been looking at quality and outcomes and potential indicators. These indicators are now available for use.

520. A summary of the activities that need to be undertaken by commissioners, providers and SHAs by 1 April 2012 is provided in Annex H

Mental health clustering tool

521. Unlike acute PbR, mental health PbR does not use the ICD-10 or OPCS-4 classification systems. Instead, mental health professionals rate service users using the Mental Health Clustering Tool (MHCT)[106]. This tool has 18 scales (e.g. depressed mood, problems with activities of daily living), the first 12 of which are the Health of the Nation Outcome Scales (HoNOS). Each scale is given a rating from 0 (no problem) to 4 (severe to very severe problem).

522. Based on the tool ratings, mental health professionals should be able to identify the cluster whose profile most closely matches that of the service user they are assessing. If no match is possible, but the service user requires treatment, then a variance cluster (cluster 00) can be used, but the reasons for selecting this must be recorded. An average price for the variance cluster will need to be agreed. Where cluster 00 is being used because of co-morbidities it may be helpful to use a "best-fit" approach and focus on the main problem at the time of clustering.

523. We anticipate that the use of cluster 00 will reduce over time as clinicians gain more confidence in clustering, and the clustering tool is further developed to take account of less frequently encountered complex needs. Work to identify and add new clusters to the set and reviews of the boundaries of existing clusters will also help to reduce the use of cluster 00. In the meantime, providers should identify and analyse the characteristics of those being allocated to cluster 00 so that these can be understood and discussed with commissioners.

524. The final decision on which cluster to allocate a service user to rests with the mental health professional. Because clustering is linked to payment, the Department is exploring options for auditing and validating the assignment of clusters with the Audit Commission as part of the PbR data assurance framework. The Audit Commission plans to focus on good practice in identifying cluster reference costs, governance

[105] http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm
[106] The complete Mental Health Clustering Tool and the Care Clusters can be found in the *Mental Health Clustering Booklet 2012-13.*

arrangements for data flows between providers and commissioners, and consistency of the data that underpins cluster allocation.

525. The Department has commissioned work to inform the development of a national algorithm to support the initial clustering decision. This tool will take MHCT scores and suggest the most likely cluster(s). This will help support the mental health professional's clustering decision and provide a level of validation that could also be used by commissioners. A link will be provided to the tool in early 2012. Initially this will be as a freestanding tool which can be used in conjunction with local systems.

526. MH clustering will occur at three points:

    (a) On completion of the initial assessment
    (b) scheduled reassessments
    (c) any reassessment following a significant change in need that cannot be met by the continuation of the current cluster care package[107].

527. In addition, at discharge the MHCT scores should be recorded, but service users should not be re-clustered.

528. When reviewing a service user who has already been allocated to a cluster, upon reassessment using the MHCT, he or she may have a lower score because they are receiving effective treatment. However, if this treatment were to be stopped, due to allocation to a lower cluster or discharge, their needs would increase again. Therefore, to avoid such perversities, the *Mental Health Clustering Booklet 2012-13* includes guidance on points to consider in re-assessment, known as care transition protocols. The protocols should be used before applying the MHCT and reviewing the care cluster scores.

529. This approach of using the care clusters as currency and use of the MHCT does not obviate the need for good clinical diagnosis and psychological formulation, which remain key to the management of an individual service-user's care, and in selecting the most appropriate package of interventions that are chosen to address their mental health needs.

Care clusters

530. The care clusters as a unit of currency are based primarily on the characteristics of a service user, rather than on their diagnosis alone. The clustering booklet provides likely diagnoses associated with each cluster, but the same diagnosis may be associated with several clusters, depending on the assessed level of need.

[107] A note should be made of the number and percentage of unplanned reassessments, and why these are taking place. Development work should help to identify what percentage of re-assessments will normally be unplanned, although this is likely to vary across the country due to different casemix complexity.

531. The care clusters are numbered 00-21, although cluster 9 is now a blank cluster.[108] We are future-proofing the cluster numbering system, so that new clusters and subdivisions of clusters could be added in a logical fashion. It is planned to implement these changes in 2013-14.

532. The clusters do not by themselves define the appropriate interventions and treatments to meet an individual's characteristics. Many of these interventions are already well defined in NICE/SCIE and professional guidelines and the NICE/SCIE and CQC essential standards and outcomes. The exact model of service of the care packages to meet the needs of service users in each cluster and deliver effective interventions will be decided locally, but must take account of national policy documents such as the outcomes strategy set out in *No health without mental health.* A web–based tool has been developed to provide guidance on what the content of care packages for each of the clusters might include (http://www.mednetconsult.co.uk /imhsec/). This is not prescriptive but will help both commissioners and providers to assess the appropriateness of care package plans.

533. Determining the service model to deliver the evidence-based care packages locally gives providers the flexibility to develop and agree innovative approaches to care with commissioners across the whole pathway, from home-based care with personalised care packages to more traditional care. It also allows the tailoring of care packages to individual's requirements as part of the service design and care planning process. By starting from the perspective of individuals, rather than organisations, care packages fit with and can be used to support the personalisation agenda set out in *Putting People First*.[109] For example, some providers have defined a core set of interventions that would be provided to all service users within a cluster, and a set of other interventions that would be used depending on the exact clinical and social needs of the individual. The cluster price will also include the provision of any necessary medication, and any associated services.

534. The clusters are mutually exclusive and a service user can only be allocated to one cluster at a time – if they transfer to a new cluster following a reassessment, the previous cluster episode ends.

535. The clusters are designed to be setting independent, on the premise that people should be treated in the least restrictive care setting possible. Inevitably, in a number of the clusters some people will need to be

[108] Cluster 9 originally related to substance misuse and identified those service users who did not have a significant mental health need. They would be treated by substance misuse services, which have different commissioning routes and information systems from mainstream mental health services.

[109] *Putting People First, A shared vision and commitment to the transformation of Adult Social Care* (December 2007) available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

treated as admitted patients for a period. Further development work will be checking that the currencies do not create perverse incentives with regard to the minority of mental health service users who do require admitted patient care.

Cluster payment periods

536. The clusters differ from the currencies generally in use in acute physical PbR in that they cover more extended periods of time, which will typically contain multiple different interactions with clinicians and different types of interventions. For instance, whilst in cluster 4 – non-psychotic (severe) – a service user might have several sessions of psychological therapies, contacts with a care coordinator and other types of interventions.

537. The amount of time that a service user will remain in a cluster will vary. However, for comparable contracting purposes, it is important to define payment periods. We suggest paying monthly on account, on the basis of an agreed annual contract, but to reconcile these monthly payments with the caseload across each cluster, (total number of patient days spent in cluster) on a quarterly basis, in arrears. The approach of a monthly payment on account is used for payment of acute PbR currencies. The *Code of Conduct for PbR 2012-13* includes guidance on payment periods. For the moment, a cost per cluster day per service user should be used. We anticipate that a future tariff will be based on a cluster price. Further understanding of the cluster costs is required before we move to this approach.

538. Table 24 sets out for each cluster the expected review interval. These should be seen as maximum intervals. They vary considerably between clusters as some relate to short episodes of mental illness, and others to where the mental illness needs to be monitored and reviewed over a longer period. The Care Programme Approach (CPA) review interval is annual. Commissioners may wish to consider how they monitor that the reviews are taking place as scheduled. Incentives could be built into contracts through quality accounts, contracted audits against standards, CQUIN payments, or conversely through penalties for non-compliance.

Table 24: Mental health clusters

Cluster no.	Cluster label	Cluster review interval (maximum)
00	Variance	Annual
01	Common mental health problems (low severity)	12 weeks
02	Common mental health problems	15 weeks
03	Non-psychotic (moderate severity)	6 months
04	Non-psychotic (severe)	6 months
05	Non-psychotic (very severe)	6 months
06	Non-psychotic disorders of overvalued Ideas	6 months
07	Enduring non-psychotic disorders (high disability)	Annual
08	Non-psychotic chaotic and challenging disorders	Annual
09	Blank cluster	Not applicable
10	First episode in psychosis	Annual

Cluster no.	Cluster label	Cluster review interval (maximum)
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	6 months
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical need or engagement)	6 months

Initial assessment for clustering

539. Development of the mental health care clusters has brought into focus the issue of how the initial assessment of an individual for clustering purposes should be reported, costed and reimbursed, what outcomes can be delivered, whether or not they are allocated to a cluster. This section relates to new referrals and 'one-off' assessment services, rather than to re-assessments or internal transfers between services of existing service users (paragraph 548).

What is an initial assessment

540. The initial assessment can be triggered in a number of ways, as part of the GP or mental health practitioner referral, in response to a specific request by an organisation such as the police or social services , or through self-referral.[110] These initial assessments can be classified in three ways, according to how the assessment was initiated and whether or not an individual is allocated to a care cluster:

    (a) **Assessed, not clustered and discharged**
    In this classification, an individual may be referred by their GP to a mental health provider for an initial assessment. On assessment, the mental health professional establishes that it is not appropriate for the individual to be offered specialist mental health care and hence the individual may be referred back to the GP by the mental health professional for other diagnosis or treatment, or signposted to other services. An example of this might be referral to non-mental health related substance misuse services.

    (b) **Assessed, clustered, and accepted for treatment**
    As before, an individual may be referred by their GP or through other routes to the mental health provider for an initial assessment. The assessment process establishes that the individual needs to

[110] An assessment may include electronic solutions such as telephone consultations and telemedicine, in addition to aface-to face meeting.

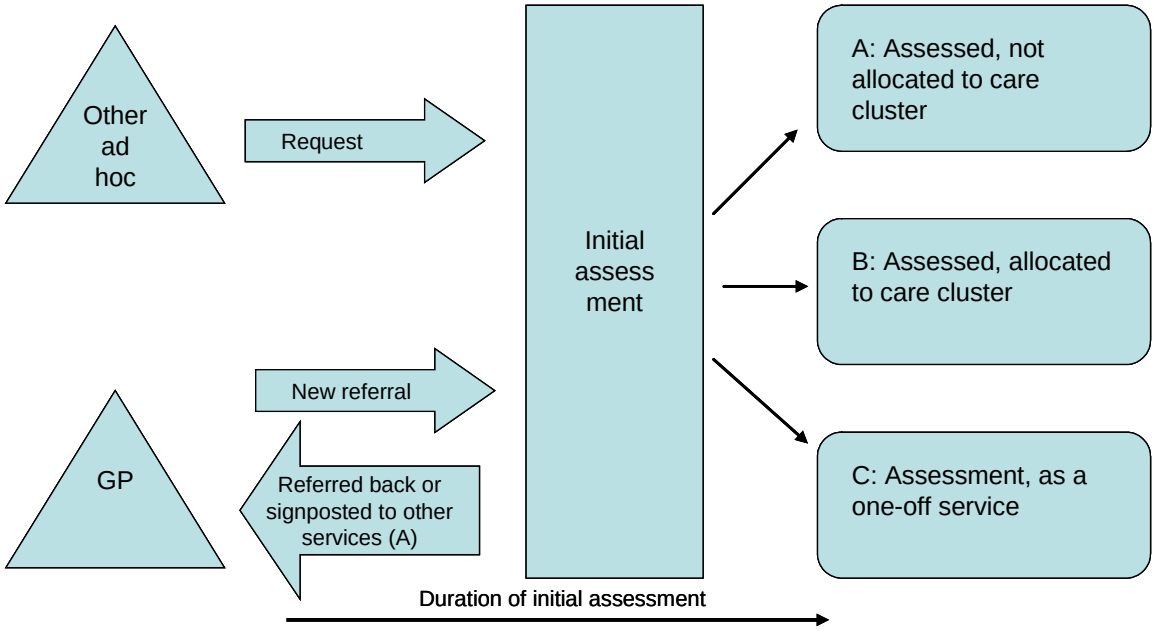
be allocated to a care cluster. In some cases, the assessment may take place over more than a single visit. The individual then comes under the care of the mental health service provider, and the model of service and package of care to deliver effective interventions are discussed and agreed with the service user.

(c) **Assessment 'service'**
This classification differs from the previous two in that it tends to be more intermittent, covering the one-off provision of mental health services, for example, providing clarification to a GP about the mental health of an individual and any further treatment that will need to be delivered by the GP, or assessments at memory clinics.

541. As it is difficult to specify the frequency with which the assessment 'service' will be utilised, the circumstances in which assessment services will apply must be agreed with commissioners**.** The risk of assessment services becoming an uncontrolled activity payment will be minimised if all parties understand what will be, and what will not be, covered within service contracts.

542. Figure 3 illustrates the three types of initial assessment.

Figure 3: Initial assessment classifications



Duration of initial assessments

543. The assessment period begins when the mental health provider receives a new referral from a GP or elsewhere. Where the assessment is to determine whether someone will be clustered or not, experience to date suggests that this should be limited to two contacts in a community setting and two days in an inpatient setting. Providers have advised us that these assessments may often be completed in a single session or

day, as are one-off assessment services such as memory clinics. The assessment is completed when the individual is either allocated to a cluster, not allocated, or the provision of the one-off service has concluded.

Funding initial assessments

544. The initial assessment of an individual will be funded as a separate activity. This is because the initial assessment and subsequent clustering of an individual by a mental health provider can be an intensive process, requiring significant professional resource. However, as described in paragraph 540(a), some individuals are referred and assessed, and then found not to need specialist mental health services, so are not allocated to a care cluster. If payment was only linked to allocation to a care cluster then the assessment of these individuals would not be reimbursed unless the costs of their initial assessments were included as an overhead in the payment for service users who are clustered.

545. This does not seem satisfactory and would provide an incentive to reduce thresholds and allocate people to clusters inappropriately. It would also distort the cost of care clusters if the costs of initial assessment for people who are allocated were included. Diagnostic tests undertaken as part of the initial assessment may need to be included in the initial assessment price where these are not separately funded by commissioners.

Pricing assessments

546. Commissioners and providers will need to negotiate local prices for initial assessments. Some assessments will be more complex than others, requiring more resources including the involvement of several professionals. Table 25 gives a matrix which could provide a framework for costing assessments.

Table 25: Costing matrix

	A: Assessed, not clustered	**B: Assessed, clustered**	**C: Assessment 'service'**
Time	N/A	Dependent upon complexity of mental health problems presented	Dependent upon the service contracted
Price	Locally negotiated and agreed price	Locally agreed price based upon to which of the seven care cluster classes the service user is allocated (1)	Locally negotiated and agreed 'set' price

(1) The seven care cluster classes are:

- Non-psychotic
  - Mild / moderate / severe (care clusters 1-4)
  - Very severe and complex (care clusters 5-8)
- Psychotic

  - First episode (care cluster 10)
  - Ongoing or recurrent (care clusters 11-13)
  - Psychotic crisis (care clusters 14-15)
  - Very severe engagement (care clusters 16-17)
- Organic
  - Cognitive impairment (care clusters 18-21)

547. Further analysis of the costs of initial assessment may make it possible to reduce the suggested number of care classes. However, there will be considerable variation in the costs of initial assessments and some sort of categorisation may be helpful, although we recognise that for 2012-13, providers and commissioners may find it simpler to agree a single price for assessment. Prices for an individual assessment should be transparent and should be published on an annual basis. The costs of reassessment also need to be identified but will form part of the cluster costs. The *NHS Costing Manual*[111] and *Mental Health Costing Standards*[112] should be used to assist with costing assessments.

Existing service users

548. The previous section is in respect of new referrals, and the provision of initial assessment 'services'. Mental health providers will re-assess and re-cluster existing service users at pre-determined and agreed intervals. To facilitate this, draft transition protocols have been developed which map to an individual's progress, and propose movement through the care clusters as an individual responds to the packages of care that they receive. The costs of re-assessment are to be included in the care cluster costs as all service users will be re-assessed at various points for the purpose of reclustering and as part of monitoring on-going care.

Clusters as contract currency

549. The clusters will become the contract currency used in the NHS Standard Contract for all service-users falling within the scope of the clusters. This means that commissioners will be paying providers on the basis of x people per day in cluster 1, y people in cluster 2 and so on.

550. Commissioners and providers may want to consider aligning the service specifications being developed as part of the standard national mental health contract with the clusters – this will enable clear identification of care packages for each cluster. We expect all providers to ensure that by the end of 2012-13 they have specified the care packages that will be available for each care cluster. The IMhSEC website tool[113] has been

[111] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132395
[112] Further information available at http://www.dh.gov.uk/en/Managingyourorganisation/NHScostingmanual/DH_126620
[113] http://www.mednetconsult.co.uk /imhsec/

developed to provide a resource for providers and commissioners. It draws together existing best practice associated with the clusters.

551. As usual, commissioners may choose to commission and/or contract through collaborative arrangements using the Health Act Flexibilities to jointly or lead commission. When contracting using the new contract currencies commissioners have a number of options, they could:

    (a) contract a lead provider to be both a clinical and contractual pathway provider, where all local health services within the cluster are either provided by or subcontracted by the lead provider. This may include the need to move patients out of area to another provider on a temporary basis, for example for a period of intensive care. In all cases the lead provider will also be responsible for managing and improving the quality, outcomes, innovation, productivity, and improving prevention along the whole pathway.

    (b) contract a principal provider to be a clinical pathway provider. Other local providers of services within the pathway remain contracted directly from the commissioner but are specified within the care pathway. The principal provider is only responsible for improvements within their part of the pathway. Commissioners would then retain responsibility for ensuring a smooth interface between providers, and for monitoring the quality of service of all of the providers. Commissioners should involve the principle provider in discussions with other providers to ensure maximum productivity, smooth transitions, and high quality along the whole pathway.

552. With a principal provider model, if there were multiple providers within the care pathway, this in effect means the tariff would be unbundled. This could lead to paying more on a fee for service basis, which may encourage providers to do more activity rather than providing holistic care over a period of time.

553. Many services are commissioned using both health and social care funds. It is for commissioners to make a judgement on whether such provision is considered health care and hence part of the MH tariff, or social care, and hence part of a personal budget for social care outside of the cluster tariff. However, in doing so they must follow national guidance in assessing whether an individual has a primary health need or otherwise.

554. It is intended that the care packages for the clusters should cover care provided by social care staff who are employed directly by the mental health provider or as part of formal Section 75 arrangements, and any others who are paid for using NHS funding. The total costs of the care packages for each cluster should be assessed and shared with commissioners, including other social care interventions, but the non-NHS costs should then be deducted to arrive at the cluster care price.

555. The funding of interactions with social care will be subject to further national work over the next year. Good practice on the joint commissioning and provision of health and social care service should continue during this time. Commissioners and providers of integrated mental health services will note the need for risk-sharing agreements for 2012-13 and cost neutrality of the clusters. During 2012-13 further work will take place to look at how mental health PbR can help in developing recovery oriented personalised services.

556. The cluster currencies should, as with PbR more generally, apply regardless of where and who delivers the care, so will also be applicable to the third sector and the independent sector as well as the NHS. We recognise that the independent sector often has a particular focus on some of the more specialist mental health care, much of which is not covered by the current clusters.

557. The payment for each care cluster will inevitably be an average payment. Commissioners and providers should be cognisant of groups of individuals who may add significant additional costs to the average service user within a cluster, for example service users with communication difficulties may have a requirement for a translator or a signer. It may be appropriate to agree additional top-up payments or alternative funding arrangements, in addition to the core cluster payment, to ensure the cost of these more specialised services are recognised. Over time, we expect the currency model will be expanded to include other specialised services.

Quality and outcomes

558. Initially developed as a single joint project between the Department and CPPP, the quality and outcomes work stream has been re-launched as a sub-group of the national mental health PbR project. It has a remit to establish outcome measures and quality indicators for the care clusters, helping to understand what is effective service provision. A set of initial indicators have been proposed. These can be used in 2012-13, and could be ready for mandating and full use in 2013-14. The approach taken by the sub-group has been to build upon data already collected by providers and tools already in use. The indicators are:

- Proportion of patients on Care Programme Approach (CPA}
- IAPT
    - The proportion of people that enter treatment against the level of need in the general population ie the proportion of people who have depression and/or anxiety disorders who receive psychological therapies
    - The proportion of those referred that enter treatment i.e. the proportion of people who are referred for psychological therapies who receive psychological therapies

    - The number of people assessed as moving to recovery as a proportion of those who have completed a course of psychological treatment
- Accommodation
    - Accommodation status – completeness
    - Percentage in settled accommodation
- Employment
    - Employment status- completeness
    - Percentage in employment
- Average number of bed days

559. The first report of the sub-group is available from the Department's website.[114] In 2012, the group will continue to test the indicators and will identify gaps where new indicators may be needed. In the longer term we would expect PbR tariffs to be linked more explicitly to quality and outcomes, and the results achieved by providers.

560. Many of the quality and outcomes which service users and their families can expect are well delineated in conditions specific Health Technology Appraisals and evidence-based best practice Guidelines. These were developed in a 10 year programme by the NICE (National Institute for Excellence and its partner SCIE (the Social Care Institute for Excellence). The care standards which will deliver optimal outcomes are set out in the NICE/SCIE new standards and CQC essential standards of care. Continuing work in this area is being commissioned by the National Commission Board. Commissioners will need to ensure that these requirements are clearly set out in contracts and that arrangements to ensure on-going monitoring are made clear in performance and assurance contract frameworks. Service user satisfaction measures are also an important aspect of measuring the provision of a good quality service.

561. The further development of quality and outcome measures will mean that for the next few years there will be further refinements and improvements to the care clusters and the clustering tool. However, these changes will build on the existing approach.

562. CQUIN payments remain an additional tool for commissioners to incentivise specific quality improvements, standards and outcomes.

Clusters and IAPT

563. *Equity and Excellence: Liberating the NHS* committed the Department to developing "payment systems to support the commissioning of talking therapies." We want the future payment system for discrete IAPT services to align with the care clusters, as the care clusters are designed to capture service user needs and to help identify an appropriate

[114] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131578

treatment response, one of which may be a course of psychological therapies. However, we recognise the good outcome information that is captured by improving access to psychological therapies (IAPT), and want to make use of this in the reimbursement mechanism.

564. The National IAPT policy team is developing a feasibility study using pilots across a number of IAPT services to test a PbR outcomes based approach for Talking Therapies. The pilots will explore the alignment of the clustering approach being rolled out for other mental health services with the available IAPT metrics supported by existing and newly mandated data flows. The pilots will not establish a national price, but will generate a robust pricing structure/currency model for local use.

565. The PbR pilots sites have been selected to represent a broad cross-section of IAPT services and localities across England. Data collected during the piloting period in 2012 will be analysed and used to test whether the current data standard and associated flows can support an outcomes based approach to commissioning IAPT services and other psychological therapies. The currency model will aim to incentivise improved equity of access, good clinical, employment, work and social adjustment scale outcomes and increased service user choice and outcomes. The currency model will be available in shadow form for the year 2013-14.

566. As part of the Any Qualified Provider workstreams a simpler approach for commissioning discrete talking therapy services has been developed, and is available for commissioners to use locally for 2012-13.[115]

Exclusions

567. The clusters cover post-GP (or other referral) care for mental health services that have traditionally been labelled working age (including early intervention services) and older people's services.

568. Table 26 lists the service areas not currently covered by the clusters.

Table 26: Mental health services areas excluded from the clusters

Service area
Child and adolescent mental health services (CAMHS)
IAPT
Forensic and secure services
Primary diagnosis of drug misuse

[115] Further information on this is available: http://www.supply2health.nhs.uk/AQPResourceCentre/Documents/111201%20PCPT_Adults_%20Implementation%20Pack.Final1.pdf

Service area
Primary diagnosis of alcohol misuse[116]
Specialised addiction services
Perinatal psychiatric services (mother and baby units)
Specialist Psychological Therapies – admitted patients and specialised out-patients
Learning disability services for non-mental health needs .
Neuropsychiatry
Autism and Asperger's
Tertiary eating disorders
Gender dysmorphia
Specialist mental health services for deaf people
Liaison psychiatry
Acquired brain injury
Complex and/or treatment resistant disorders in tertiary settings
Mental health services under a GP contract

569. Locally, there may be other specialised non-standard services that both providers and commissioners agree will for the moment fall outside the clusters.

570. Work is continuing to develop PbR currencies for forensic and secure services, and CAMHS services. There are also projects underway looking at alcohol and drug misuse services, and work is at an early stage on whether there need to be additional clusters for people with learning disabilities with specific mental health conditions. The timetable for bringing these other services into PbR will need to be confirmed by the NHS Commissioning Board and Monitor.

[116] Both the alcohol and drug work is focussing on people whose main need is their substance misuse. Substance misuse is often a complicating factor for a mental health problem, and this is covered in the clustering tool.

Non-contract activity[117]

571. The longer-term duration of mental illness means that a service user may present for urgent treatment from a provider in another part of the country. For instance, a service user is being treated by one mental health provider, but then has an incidence of mental illness elsewhere in the country that leads to their being admitted (for example under section 136 of the Mental Health Act), or needs other urgent treatment. This will need to be paid for separately by the commissioner located in the area where the service user normally resides. The commissioner will need to inform the first provider who will have to suspend the cluster episode until the service user returns to their care. If a national tariff is introduced, cross-charging between providers will need to be introduced. Further consideration will be given to guidance on this subject, and to the funding of care for those with no fixed abode.

Interaction between care cluster and acute HRGs

572. The care clusters are not mutually exclusive with acute physical healthcare HRGs. This is because a mental health service user may well need surgery or other treatment that is not related to their mental health problem, and this will be provided by an acute provider rather than a mental health service.

573. Many HRGs identify mental health problems as complicating factors in care. For instance, dementia is deemed a complicating factor in orthopaedic procedures. Consequently an HRG is generated which has a higher level of complexity and the acute provider receives a higher payment. For instance an ICD-10 code of F001, Dementia in Alzheimer's disease with late onset, would result in the generation of HRG HB23B Intermediate knee procedures for non trauma with CC rather than HRG HB23C Intermediate knee procedures for non trauma without CC. HB23B has a higher tariff than its counterpart without complications or co-morbidities**.**

574. Therefore, identification of mental health problems (eg through an assessment of mental state) and any additional costs in treating the primary physical condition, which result from the mental health problem, are included in the tariff price for the HRG. Treatment specifically for the mental health problem itself is not included in the HRG. Support for dealing with mental health issues in an acute setting is dealt with differently in different organisations.

575. In some areas liaison mental health services are in place. These currently fall outside of the scope of the mental health PbR project and

[117] This section is in line with *Who pays? Establishing the responsible commissioner* (2007), available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634

are subject to separate arrangements. In other areas there may be no formal arrangements and a local mental health provider will be called in on an ad hoc basis to deal with any issues. In the case where a patient is not currently under a mental health provider, commissioners will need to ensure that the provider who is giving this service is appropriately reimbursed. Where a patient in an acute hospital is already under the care of a mental health provider, commissioners will need to ensure that they are not paying twice.

576. Conversely, mental health providers often provide physical healthcare to patients on an ongoing basis, for example for service-users with long-term conditions. The treatment may be carried out by paying for primary care services or by qualified ward-staff. This work is not reimbursed through reference to HRGs, but the physical co-morbidities can be recorded in the MHMDS. Commissioners will need to agree with providers how to fund this care, either through embedding it into the price of clusters or through a separate payment for physical healthcare. The price paid must be transparent, fair and representative of the actual costs incurred.

577. One area that we will give further consideration to is who should fund admissions and treatment in acute physical healthcare that are primarily driven by an underlying mental health problem, eg self-harm presentations at A&E, or re-feeding and managing physical health in anorexia nervosa. Current funding arrangements continue for now, and this activity is for the moment outside of the scope of Mental Health PbR.

Data sources for Commissioners

578. Commissioners will want access to the Open Exeter Bureau Service Portal for MHMDS in order to be ready to download extracts of MHMDS data, once these become available. These will include records for patients for whom they are the commissioner (or recorded as the commissioner organisation) and these will probably be from more than one provider. These include records from independent and third-sector providers contracted via the standard contract. Commissioners must register for access to the Bureau Service Portal for MHMDS on Open Exeter to gain access to MHMDS version 4 data extracts.

579. Your organisation may already be registered for Open Exeter, in which case individuals simply need to apply for access to the Bureau Service Portal:

    1. Go to https://nww.openexeter.nhs.uk/nhsia/index.jsp and click on the blue box at the bottom that says Caldicott Guardian. Register and check that the correct name is given for the Caldicott Guardian of your organisation.

    2. If the name is incorrect or missing, download and complete the http://www.connectingforhealth.nhs.uk/systemsandservices/ssd/prod

serv/aldicottcert.pdf form to register the correct Caldicott Guardian and send this back to the address on the form.

3. Complete the form http://www.connectingforhealth.nhs.uk/systemsandservices/ssd/prodserv/bspducform.doc to request access to Open Exeter for MHMDS v 4 and send it to the address on the form (Note: the addresses for the two forms are different).

4. If the name of your organisation's Caldicott Guardian is correct then just complete the following form http://www.connectingforhealth.nhs.uk/systemsandservices/ssd/prodserv/bspducform.doc to request access to Open Exeter for MHMDS v4 and send it back to the address on this form.

580. Please note that once issued, accounts must be activated within a short period of time. Instructions on how to get a user login are on the IC website and in the user guidance. www.ic.nhs.uk/services/mhmds/spec (Section 8). Data will be available at CCG level. For further help please contact the Information Centre via: exeter.helpdesk@nhs.net.

581. Providers already have access to the MHMDS data that they submit to the Information Centre. The Information Centre will include guidance on using MHMDS v4 data with their IC publications. MHMDS will provide a rich source of data, and providers must routinely submit all required data to it.

Further information

582. Further information to support preparations for mental health PbR can be found on the DH website,[118] but is also available via on the mental health QuickR sites, a web-based collaborative tool, which brings together those with particular interests. We invite all commissioners and providers to register and join. For further details e-mail pbrcomms@dh.gsi.gov.uk.

[118] http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_4137762

Section 12: Introduction of new currencies for contracting

Introduction

583. A number of currencies are being provided for use in 2012-13 on either a mandatory or non-mandatory basis.

584. The use of currencies (but not prices) for contracting for the following services will be mandatory:

    (a) ambulance services
    (b) critical care
    (c) chemotherapy delivery
    (d) external beam radiotherapy.

585. The use of currencies for contracting for the following services will be non-mandatory:

    (a) smoking cessation
    (b) HIV outpatient services.

586. A maternity pathway system for payment will be introduced in shadow form in 2012-13, with the intention of mandating its use in 2013-14.[119]

Ambulance services

587. We are publishing currencies for the contracting of emergency and urgent ambulance services.

588. These currencies will be mandatory for the 2011-12 reference cost collection and mandatory for contracting in 2012-13. Prices will be agreed locally but with the potential to transition to a national tariff in 2013-14.

589. Four currencies have been developed and agreed over the last four years with ambulance trusts and commissioners.

Ambulance service currencies

590. The currencies are:

    (a) Urgent and Emergency Calls Answered (AMB10)

        The number of emergency and urgent calls presented to switchboard and answered.

[119] Further information available at http://www.dh.gov.uk/health/2011/07/maternity-services-and-pbr/

Include 999 calls, calls from other healthcare professionals requesting urgent transport for patients, calls transferred or referred from other services (such as other emergency services, 111, NHS Direct, other third parties).

Include hoax calls, duplicate/multiple calls about the same incident, hang-ups before coding complete, caller not with patient and unable to give details, caller refusing to give details, response cancelled before coding complete.

Exclude calls abandoned before answered, patient transport services requests, calls under any private or non-NHS contract.

The unit is the price per call.

(b) Hear and Treat/Refer (AMB20)

The number of patients – following emergency or urgent calls – whose issue was resolved by providing clinical advice by telephone or referral to a third party

Include patients whose call is resolved - without despatching an vehicle or where a vehicle is despatched but is called off from attending the scene before arrival - by providing advice through a clinical decision support system or by a healthcare professional providing clinical advice or by transferring the call to a third party healthcare provider.

An ambulance trust healthcare professional does not arrive on scene.

The unit is the price per patient.

(c) See and Treat/Refer (AMB30)

The number of incidents resolved with the patient(s) being treated and discharged from ambulance responsibility on scene; there is no conveyance of any patient.

Include incidents where ambulance trust healthcare professionals on scene refer (but do not convey) the patient(s) to any alternative care pathway or provider.

Include incidents where, upon arrival at scene, ambulance trust professionals are unable to locate a patient or incident.

Include incidents despatched by third parties (such as 111, NHS Direct or other emergency services) directly accessing the ambulance control despatch system.

The unit is the price per incident.

(d) See, Treat and Convey (AMB40)

The number of incidents – following emergency or urgent calls – where at least one patient is conveyed by ambulance to an alternative healthcare provider

Alternative healthcare provider includes any other provider who can accept ambulance patients, such as A&E, MIU, walk-in centre, major trauma centre, independent provider etc.

Include incidents despatched by third parties (such as 111, NHS Direct or other emergency services) directly accessing the ambulance control despatch system.

Exclude patient transport services and other private or non-NHS contracts.

The unit is the price per incident.

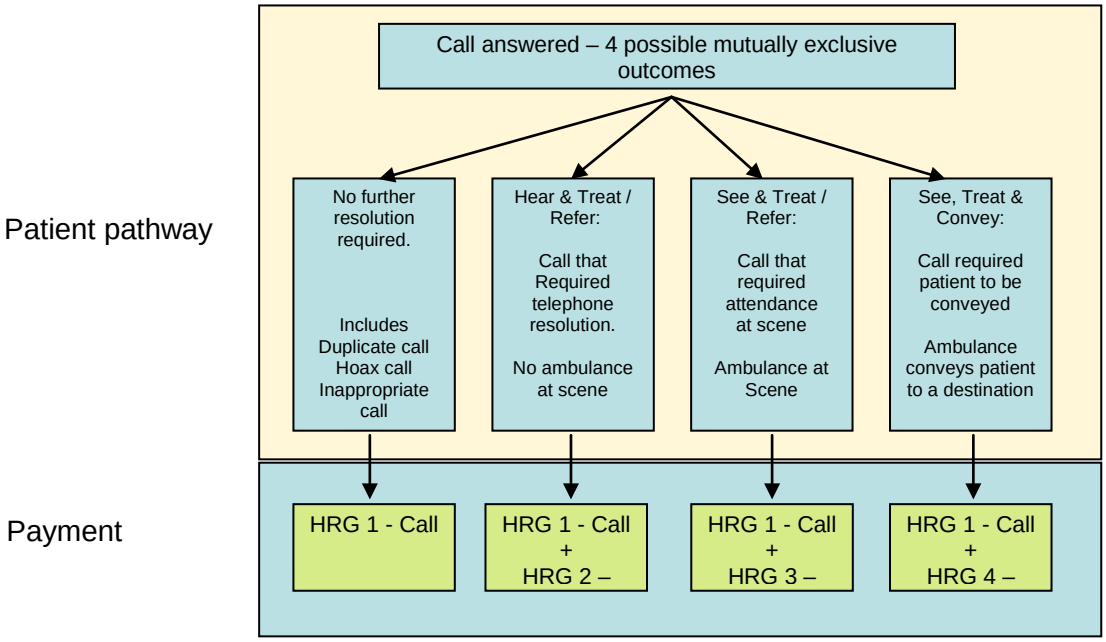
System of payment

591. The system of payment will be a suite of locally agreed prices on the basis that every emergency and urgent call answered will be paid, and where further resolution is required – hear and treat, see and treat/refer, or see treat and convey – a further payment is made.

592. Only the latter two currencies will be payable where resolution activity is caused by third parties who are able to generate direct despatch for the ambulance service (such as NHS Direct or 111).

593. Figure 4 summarises this system.

Figure 4: Summary of ambulance PbR patient and payment pathways



Where a third party organisation undertakes the initial call and directly accesses the ambulance despatch system, only the resolution HRG will be payable

Contracts - Outcomes, quality, patient experience

594. Commissioners will need to agree with provider organisations what they are attempting to incentivise for the local population in terms of an emergency and urgent service, taking into account the need to provide the highest quality service for patients as well as value for money.

595. Organisations should use the relevant Standard NHS Contract to agree a suite of local outcome, quality and patient experience indicators, and the financial penalties and incentives of achieving or not achieving specified levels.

596. Services provided by other organisations – such as 111 or NHS Direct – should be taken into account to prevent duplication of services (and therefore costs) across organisations, with an understanding of the capacity for these services to be delivered and an understanding of the organisation that takes ultimate responsibility for patient experience.

597. Commissioners should judge providers on what they have achieved, not on how they choose to deliver their service.

Commissioner Risk Sharing

598. Ambulance NHS Trusts and NHS Foundation Trusts cover a much larger area than any one commissioner.

599. It is the responsibility of commissioners to determine whether they wish to agree their own contract prices (leading to differential prices according to geographical incident) or pool their budgets to allow a single price and an agreed risk-sharing protocol.

600. The Department suggests that commissioners should collectively agree a risk-sharing budget allocation model that allows a single price to be agreed.

Scope

601. All emergency (999), healthcare or other emergency service professional, and urgent transport calls, the resolution of all of those calls that require a resolution, and the resolution activity caused by third parties who are able to generate despatch for the ambulance service (such as NHS Direct or 111).

602. Resolution includes:

(a) Hear and Treat / Refer: resolving the call without despatching a vehicle ambulance, or where a vehicle is despatched but is called off from attending the scene before arrival.

(b) See and Treat / Refer: resolving the call where a vehicle (or more than one vehicle) arrives at the scene but there is no subsequent conveyance of any patients. Includes instances where no further activity is needed or where there is no indication that an incident actually occurred.

(c) See and Convey (includes Treatment): resolving the call where a vehicle (or more than one vehicle) arrives at the scene and there is subsequent conveyance of a (or more than one) patient to any destination.

(d) No action: call was a duplicate, inappropriate, did not complete or a hoax.

603. Examples of service activity that are not included in the scope of these currencies and would require separate contracts are:

(a) air ambulance service
(b) clinical audit and research unit (CARU)
(c) chemical biological radiological and nuclear (CBRN)
(d) cross-border activity
(e) decontamination units
(f) emergency bed service (EBS)
(g) emergency planning
(h) GP out-of-hours services
(i) hazardous area response teams (HART)
(j) logistics or courier transport service eg collecting clinical waste

(k) neonatal transfers
(l) patient education
(m) patient transport services (PTS)
(n) single point of access telephony services (eg 111, NHS Direct).

Critical care

604. Adult critical care (HRG sub-chapter XC) and neonatal critical care (HRG sub-chapter XA) currencies continue to be mandated for contracting these services in 2012-13. NHS organisations must follow the definitions in the relevant critical care minimum datasets (CCMDS) when contracting, recording and counting activity by the HRG currencies. Prices will remain for local negotiation.

605. This "national currency: local price" model described in *Guidance on NHS commissioning and contracting of adult and neonatal critical care services in 2011-12*[120] will allow local variations to be taken into account, transitions to be phased and incentives to be implemented without any cliff-edges. All organisations will use the same currency, and basis for deriving the currency, for commissioning, for benchmarking, for consistency, and for developing transferable incentives. All NHS organisations need to develop their contracts using the CCMDS and HRG definitions to ensure consistency across the country.

606. Commissioners of smaller units may prefer a fixed and variable funding model to ensure capacity and availability of beds, whereas commissioners of larger units may prefer a per-patient funding model to incentivise efficiency or movement of beds to meet other strategies (e.g. major trauma). We do not expect any contracts to be agreed on a 100% fixed model (ie a block contract).

607. Comparative benchmark activity and costing information for adult critical care HRGs based on 2009-10 reference costs is shown in Table 27. The Department has recently published 2010-11 reference costs, which are a more recent source for comparable information.

120

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119959

Table 27: Adult critical care benchmark data

HRG code	Number of organs supported	Average casemix (ii)	Days that >80% of patients stay in critical care (i)	Proportion of patients that stay for one night only (i)	Benchmark bed day data (ii) (1,2,3) (2012-13 prices)
XC01Z	6	0.7%	NA	NA	£2,182
XC02Z	5	3.2%	NA	NA	£1,685
XC03Z	4	12.0%	13	19%	£1,483
XC04Z	3	22.8%	9	29%	£1,320
XC05Z	2	30.9%	5	33%	£1,097
XC06Z	1	27.4%	3	50%	£816
XC07Z	0	3.0%	2	67%	£246 (4)

Sources:
(i) Department of Health critical care project 2007
(ii) Department of Health reference costs 2009-10 (uprated to 2012-13 prices)

Notes:
(1) Includes the total cost of outreach services, as submitted in reference costs
(2) Excludes critical care activity in specialist burns units, spinal cord injury units and specialist hepatic (liver) critical care units; high cost drugs and blood products published as exclusions to PbR; and MFF
(3) Bed day is defined in the CCMDS; it is not the basis of a midnight count
(4) XC07Z price has been suppressed to a hotel cost price, with the costs transferred into the prices for 3 or more organs supported, XC01Z to XC04Z

608. Benchmark bed day costs for the neonatal critical care HRGs, based on 2009-10 reference costs, are shown in Table 28. Commissioners may wish to consider reduced prices for HRGs XA04Z and XA05Z, to take into account that there is a payment made for every baby under the core admitted patient care HRG. The core HRG is paid for the explicit purpose of covering the costs of normal care for patients, irrespective of age.

Table 28: Neonatal critical care benchmark data

HRG code	Description	Benchmark bed day data (1) (2009-10 prices)
XA01Z	Neonatal critical care – intensive care	£979
XA02Z	Neonatal critical care – high dependency care	£713
XA03Z	Neonatal critical care – special care without external carer	£421
XA04Z (2)	Neonatal critical care – special care with external carer	£393
XA05Z (2)	Neonatal critical care – normal care	£393

Source: Department of Health reference costs 2009-10

(1) Excludes MFF
(2) Costs have been equalised to remove relativity issues

609. Further work has been undertaken to refine 2011-12 reference cost guidance for collecting comprehensive and consistently defined

information on paediatric critical care from the right organisations. At present, the costs of delivering high dependency paediatric critical care outside discrete units (ie, on children's wards, etc) are included in the prices of admitted patient care HRGs.

610. In 2014, the costs for all paediatric critical care, whether in a discrete unit or high dependency paediatric critical care undertaken closer to home on a children's ward, will be removed from admitted patient care HRGs. This will signal that all paediatric critical care, irrespective of setting, will require dedicated commissioning by both SCGs and local commissioners.

Chemotherapy

611. Chemotherapy is split into three parts, a core HRG (covering the primary diagnosis or procedure) and the unbundled HRGs (for the chemotherapy drug procurement and delivery).

612. For 2012-13 along with the core HRG already included within tariff, the delivery element of the unbundled chemotherapy is now a mandated currency (with the exception of regular attenders). The procurement element of chemotherapy remains excluded from the scope of tariff; therefore both delivery and procurement HRGs are subject to local prices.

613. In a change for 2012-13 a new HRG, solely for the purpose of delivery of chemotherapy (HRG SB97Z) has been introduced (paragraph 623).

Structure

614. The procurement HRGs are for the procurement of chemotherapy drugs for regimens split into bands. There are currently ten cost bands covering adult and paediatric regimens.

615. The costs of each of the procurement HRGs contain all costs associated with procuring each drug cycle, including supportive drugs and pharmacy costs (indirect and overheads).

616. The chemotherapy delivery HRGs are assigned for each attendance for treatment to reflect the complexity of treatment and resource usage.

617. The table below summarises the design of the delivery HRGs (not including oral):

Table 29: Chemotherapy delivery HRGs

Definition	Explanation
Deliver simple parenteral chemotherapy	Overall time of 30 minutes nurse time and 30 to 60 minutes chair time for the delivery of a complete cycle.
Deliver more complex parenteral chemotherapy	Overall time of 60 minutes nurse time and up to 120 minutes chair time for the delivery of a complete cycle.
Deliver complex chemotherapy, including prolonged infusional treatment	Overall time of 60 minutes nurse time and over two hours chair time for the delivery of a complete cycle.
Deliver subsequent elements of a chemotherapy cycle	Delivery of any pattern of outpatient chemotherapy regimen, other than the first attendance, i.e. day 8 of a day 1 and 8 regimen or days 8 and 15 of a day 1, 8 and 15 regimen.

618. The delivery HRGs can be generated for day cases, outpatients and regular attenders (although regular attenders are currently excluded from PbR as a whole). For ordinary admissions, the costs of chemotherapy delivery are included in the costs of the core HRG.

619. We will be reviewing the exclusion of regular attenders, for chemotherapy and radiotherapy, for 2013-14.

Payment arrangements

620. Alongside the mandation of the use of the chemotherapy delivery currencies for 2012-13, we have also published non-mandated tariff prices. These are published as an indicator and commissioners and providers will want to work together to manage the impact and potential risk of introducing both contract currencies and local prices for chemotherapy delivery.

621. The prices should be used carefully and local information should be used in negotiations, in particular around the use of SB97Z (detailed below), to ensure stability for commissioners and providers. SB97Z attracts a zero price for this year in line with reference costs.

622. Previously, organisations needed to adjust their local reimbursement arrangements for chemotherapy to take into account the core HRG that was generated for the chemotherapy diagnosis. This is no longer the case.

623. As noted above, a new HRG to reflect a same day attendance or admission, solely for the purpose of delivery of chemotherapy (HRG SB97Z), has been introduced. This is generated where:

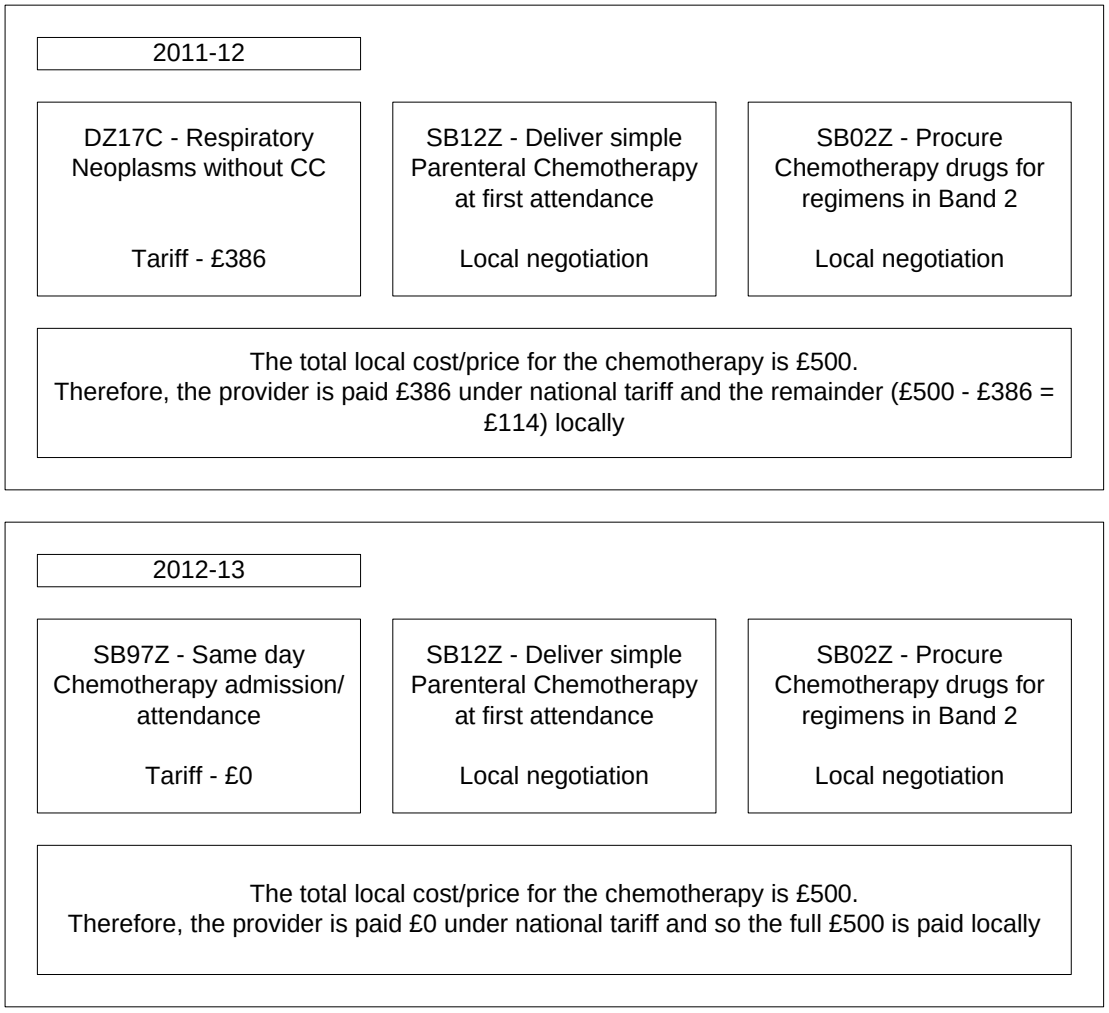
    (a) chemotherapy has taken place
    (b) the activity has a length of stay less than one day

(c) the core HRG which would otherwise be generated is a diagnosis driven HRG (with no major procedures taking place).

624. This HRG will attract a zero (£0) tariff because it is designed to ensure appropriate overall reimbursement where a patient attends solely for the purpose of delivery of chemotherapy.

625. Figure 5 illustrates this change, comparing 2011-12 and 2012-13 payment arrangements.

Figure 5: Chemotherapy payment arrangements



626. The following table details the full payment arrangements for chemotherapy HRGs.

Table 30: Payment arrangements for chemotherapy HRGs

	Core HRG	Unbundled Chemotherapy Procurement HRG	Unbundled Chemotherapy Delivery HRG
Ordinary admission	e.g. LB35B Within tariff – includes cost of delivery	e.g. SB03Z HRG generated – excluded from tariff. Local prices agreed	No HRG generated
Day case and outpatient	SB97Z (generated if no other activity occurs)	e.g. SB03Z HRG generated – excluded from tariff. Local prices agreed	e.g. SB14Z Within scope tariff Local price for 2012/13
Day case and outpatient	If other activity occurs e.g. LB35B	SB03Z HRG generated – excluded from tariff. Local prices agreed	e.g. SB14Z Within scope tariff. Local price for 2012-13
Regular day and regular night admissions	Excluded from PbR, so subject to local agreement; currencies should be used locally as day case and outpatient activity above.		

627. Please note that delivery codes do not include the consultation at which the patient consents to chemotherapy, nor does it cover any outpatient attendance for medical review required by any change in status of the patient. These activities would generate an appropriate outpatient HRG.

628. Please be aware that for chemotherapy regimens not on the national regimen list, the delivery HRG SB17Z should be negotiated locally as, by the nature of new regimens and potentially differential delivery methods, the costs will vary.

Additional drugs

629. Drugs which are excluded from the tariff when used for chemotherapy may also be prescribed for other indications. When used for non-chemotherapy indications they may or may not continue to be excluded. For example, Rituximab is listed on both the regimens list and the high cost drugs exclusion list and as such will be excluded as a high cost drug and not just when used as a chemotherapy drug.

630. Work is ongoing to resolve and clarify issues regarding the treatment of hormonal therapies and high cost supportive drugs. The table below shows the current treatment of such drugs.

Table 31: Treatment of hormonal therapies and high cost supportive drugs

Method of delivery	Hormone treatments	Supportive drugs
As an intrinsic part of a regimen	If included within a regimen, ignore	If included within a regimen, ignore
By itself	Code to the relevant admission / outpatient attendance/procedure core HRG generated (not chemotherapy specific)	Apportion over procurement bands, potentially extra delivery time/costs
As part of supportive drug	Include costs within supportive drug costs	N/A

631. Therefore, if a hormone treatment is not used as an intrinsic part of a regimen, or as a supportive drug to a regimen, it is only excluded from PbR when the drug is explicitly listed on the exclusion list, or if it is included in a BNF section or sub-section that is wholly excluded from PbR.

Radiotherapy

632. Radiotherapy can be split into two broad areas:

    a) external beam radiotherapy
    b) brachytherapy and liquid radionuclide administration.

633. For 2012-13, the use of the currencies for external beam radiotherapy has been mandated. Brachytherapy remains excluded from PbR and work is ongoing to develop HRGs for this area and as such it is not subject to the following guidance.

634. The unbundled radiotherapy HRGs are similar to the design of the unbundled chemotherapy HRGs, in that an attendance may result in more than one HRG; ie both preparation and treatment delivery. The radiotherapy dataset (RTDS), introduced in 2009, should be used by all organisations.

635. In a change for 2012-13, a new HRG to reflect same day attendance or admission, solely for the purpose of delivery of external beam radiotherapy (HRG SC97Z) has been introduced (paragraph 640).

Structure

636. It is expected that in line with the RTDS and clinical guidance, that external beam radiotherapy treatment will be delivered in an outpatient setting. This is to acknowledge that patients do not need to be admitted to receive teletherapy/external beam radiotherapy and all can be given on an ambulatory basis.

Payment arrangements

637. Alongside the mandation of the use of the external beam radiotherapy currencies for 2012-13, we have also published non-mandated tariff prices. These are published as an indicator and commissioners and providers will want to work together to manage the impact and potential risk of introducing both contract currencies and local prices for external beam radiotherapy.

638. The prices should be used carefully and local information should be used in negotiations, in particular around the use of SC97Z (detailed below), to ensure stability for commissioners and providers. SC97Z attracts a zero price for this year in line with reference costs.

639. Previously, organisations needed to adjust their local reimbursement arrangements for radiotherapy to take into account the core HRG that was generated for the radiotherapy diagnosis.

640. As noted above, a new HRG to reflect same day attendance or admission, solely for the purpose of delivery of external beam radiotherapy (HRG SC97Z) has been introduced. This is generated where:

    (a) external beam radiotherapy has taken place
    (b) the activity has a length of stay less than one day
    (c) the core HRG which would otherwise be generated is a diagnosis driven HRG (with no major procedures taking place).

641. This HRG will attract a zero (£0) tariff because it is designed to ensure appropriate overall reimbursement where a patient attends solely for the purpose of delivery of external beam radiotherapy.

	Core HRG	Unbundled Radiotherapy Planning HRG (one coded per course of treatment)	Unbundled Radiotherapy Delivery HRG
Ordinary admission	e.g. LB35B Within tariff	Treat as per RTDS (RT treatment delivered as OP)	Treat as per RTDS (RT treatment delivered as OP)
Day case and outpatient	SC97Z (generated if no other activity occurs)	e.g. SC45Z HRG generated – within scope tariff. Local price for 2012/13	e.g. SC22Z HRG generated – within scope tariff. Local price for 2012/13
Regular day and regular night admissions	Excluded from PbR, so subject to local agreement		

642. Planning codes do not include the consultation at which the patient consents to radiotherapy, nor does it cover any outpatient attendance for medical review required by any change in status of the patient. These activities would generate an appropriate outpatient HRG.

643. Delivery codes will be assigned to each attendance for treatment (only one fraction (HRG) per attendance should attract a tariff). The only exception to this rule is if two different body areas are being treated when a change in resources is identified, rather than treating a single site. The delivery of hyper-fractioned radiotherapy, where two doses are delivered six hours apart, would generate two delivery attendances.

644. Preparation codes are applied to and reported on the day of the first treatment (all set out within the RTDS). A tariff will be applied to each preparation HRG within a patient episode.

Smoking cessation

645. Following work by NHS West Midlands who ran a pilot project under the PbR Development Sites Phase 1, we introduced a non-mandatory currency for smoking cessation in 2011-12. This will continue in 2012-13.

646. The aim of the project was to increase the supply of stop smoking services by introducing local currencies and tariffs. Accredited providers can recruit and deliver services to eligible patients without referral or authorisation from the PCT. Services are delivered to a detailed service specification.

647. Providers receive payments for both 4 and 12 week quitters, with higher payments available to those providers that support individuals from defined targeted populations such as those from deprived areas, routine and manual workers, people from black and minority ethnic groups, those with mental health issues, communication difficulties and people aged under 25. Higher payments are also paid to providers that incur the costs of stop smoking medications supplied to patients. Separate currencies and tariffs have been developed for stop smoking services delivered to pregnant women.

648. Providers are required to submit monthly invoices and a patient level, minimum dataset. This dataset is used to verify provider payments, enable PCTs to complete their statutory returns for stop smoking services and allow PCTs to audit provider activity. Provider returns are received, validated and processed by Healthcare Commissioning Services, a NHS commissioning and commercial support agency.

649. The Department's tobacco control policy team is supporting this initiative and has expressions of interest from several local and regional level commissioners to introduce the tariff based payment system in their regions. The database requirements are being supported and provided centrally, reducing the implementation costs to early adopter areas.

HIV outpatient services

650. 2012-13 is a shadow year for the HIV Adult Outpatients currency, allowing for testing of the proposed currency and a phased roll out of the new CDS to providers.

651. The developed HIV outpatient currency is a clinically designed clinical pathway for each of three groupings of HIV Adult patients (>18 years) that supports an annual year of care tariff approach. The groupings are:

- Category 1: (newly diagnosed or newly started on ARV drugs)
- Category 2: (stable patients)
- Category 3: (medically complex patients)

652. As HIV is a long term condition where clinical management of care does not always require attendance at a HIV service, especially with on-going changes in service delivery, a ‘Year of Care’ was considered the most appropriate currency.

653. A dataset to provide pseudonomised patient numbers to support commissioning, outcomes and the epidemiology of HIV Adult outpatient activity will be rolled out during 2012-13.

654. It is important that patients requiring complex psychosocial needs receive the right level of support at the right time and place from the right services. The nature of HIV disease means that patients may have a range of complex psychosocial needs, which go beyond the remit of the hospital-based HIV team to meet. Local pathways of care will need to be designed to meet these needs with appropriate referral to social care, community services, mental health services and voluntary sector services such as advice and advocacy.

655. To allow both providers and commissioners to monitor the impact of patients with complex social needs, there is an identified field in the dataset. This will allow the opportunity for commissioners and providers to work together to ensure the appropriate access to support services.

656. As per the national contract in place for the relevant year, annual contract values will be agreed and paid on a monthly basis and pro-rata’d for the length of time a provider treats a patient for.

657. There will then be a quarterly reconciliation process where actual patient case mix and volumes will be used to calculate the actual value of care provided and this will be compared to the amount already paid/received.

Exclusions

658. The HIV Outpatient Currency currently excludes the provision of any antiretroviral (ARV) drugs cost.

659. Further work is being done to review the local pricing of antiretroviral (ARV) drugs, considering a national banding of ARV (first, second & subsequent, complex). Any decision to incorporate ARV will be made during 2012-13 and changes to the currency will be made to be reflective of this.

660. It is useful to read this guidance in tandem with the HIV Outpatient Clinical Care Pathway v10 and the HIV Adult Outpatient Services Simple Guide on the PbR website, which will be available shortly.

Any Qualified Provider

661. The PbR team has been supporting the any qualified provider team and NHS partners in developing a set of implementation packs for eight currency areas for 2012-13.[121] These currencies can be used locally by commissioners to open up services in the following areas to any qualified provider:

(a) musculoskeletal services
(b) wound care
(c) continence
(d) improving access to psychological therapies (IAPT)
(e) diagnostics
(f) wheelchairs
(g) adult hearing aids
(h) podiatry

Podiatry – nail avulsion / ablation

662. The Department has been working with clinicians to look at currencies for podiatry. An approach for an episode of care has been developed, which has been specifically applied to nail avulsion (removal). This is currently being piloted and evaluated.

663. For those organisations that have selected podiatry as one of their AQP areas, the approach set out in the implementation pack builds on the nail avulsion example.

Maternity pathway system

664. In 2012-13 we will be introducing a maternity pathway system for payment, in shadow form, with the intention of mandating its use in 2013-14.

665. The payment system will be split into three modules, each of which is paid separately: antenatal care; the birth spell; and post natal care. The

[121] Further information available at http://www.supply2health.nhs.uk/AQPResourceCentre/Pages/AQPHome.aspx

clear incentive is to implement proactive, best practice antenatal care in order to prevent the onset of avoidable conditions or complications throughout the whole maternity pathway.

666. The shadow year will allow provider organisations the time to develop their information systems to collect the relevant information against which they can base their contracts, and to test the impact of the proposals against their current income. Commissioners and providers will also need the time to develop and agree local contract metrics to evaluate their outcomes, quality and patient experience against which financial penalties and incentives should be applied.

667. Further information on the payment system is available on the PbR pages of the Department of Health website[122] defining the currencies, the business rules, the methodology developed for producing prices, and draft 2012-13 prices to allow organisations to test the financial impact.

Currencies and tariffs in future years

668. Work is underway to develop currencies and tariffs for new services which may be included in the scope of PbR in future years. Areas we are working on include:

    (a) Child and Adolescent Mental Health Services (CAMHS) – DH recently appointed a consortium of London Trusts to lead the CAMHS development work, building on the good work that has already been done in different areas of England. We anticipate that draft currencies will be available for use in 2014

    (b) Secure and forensic psychiatric services – a way forward has been agreed which will combine use of the 21 mental health currencies with five forensic pathways. Pilots will run in 2012-13 with currencies available for use in 2013

    (c) Integrated sexual health – covering levels 1, 2 and 3 for sexual reproductive health (SRH); levels 1 and 2 for sexually transmitted infection (STI) services; and integrated SRH and STI care in a non-GUM setting and GUM clinic STI services at levels 1 to 3. We will be building on work undertaken in London to develop a set of currencies over the next year to ensure that we have currencies with potential for national applicability

    (d) In 2012-13 the AQP programme will be looking at a number of other areas which may be suitable for currency development:

[122] http://www.dh.gov.uk/health/tag/maternity-pbr/

- very specialist services for children with complex speech, language and communication needs (but not including assertive equipment and aids)
- services for adults with long term neurological disease (such as motor neurone disease, Parkinson's and multiple sclerosis)
- IAPT (for children) - aligned with the national CAMHS currency development work
- chemotherapy in the community
- long term conditions self management support programmes
- preparation for pregnancy services (outside the new national maternity PbR tariff)

(e) podiatry - building on the methodology for the development of the currency for nail avulsion / ablation we intend to work with stakeholders to apply the methodology to a number of other podiatric interventions

(f) chemotherapy – we are mandating the use of currencies for chemotherapy delivery HRGs in 2012-13 and will continue development work on procurement

(g) radiotherapy – we are mandating the use of currencies for external beam radiotherapy HRGs in 2012-13. Brachytherapy will continue to be excluded as work continues on developing currencies.

669. In addition, we will explore ways in which tariff can better support the promotion and conduct of research, which continues to be a core NHS function.

670. Please contact us if you are interested in getting involved in this work.

Assistive technology - telehealth and telecare

671. In line with the Operating Framework for the NHS in England 2012-13, PCT clusters working with local authorities and the emerging CCGs should spread the benefits of innovations such as telehealth and telecare as part of their ongoing transformation of NHS services. They should also take full consideration of the use of telehealth and telecare as part of any local reconfiguration plans.

672. We will be looking to develop tariffs for telehealth and telecare in the future.

Section 13: Flexibilities

Introduction

673. This guidance and the accompanying PbR Code of Conduct describe one system and one set of rules for England that are mandatory. A national pricing structure can never reflect the reality of the most innovative care delivered locally, so where commissioners and providers find the rules prevent them from doing the best for patients, then local variation is permitted. Within PbR, variation to a national currency or tariff is referred to as a flexibility. Such variations needs to be exercised within clear guidelines, and any variations which in effect enable the continuation of poor-quality, inefficient models of care or restrict patient choice are not valid.

674. We are introducing the following new flexibilities in 2012-13:

    (a) Commissioners and providers can agree to vary the outpatient procedure or attendance tariffs in some circumstances (see paragraph 677).
    (b) Building on the existing 'Service Redesign' flexibility, and in response to concerns about 'cherry picking' of patients, commissioners will now be able to adjust tariff prices if the type of patients that a provider treats results in it incurring lower costs than the average of the tariff category (see paragraph 703).

675. Other flexibilities continue to apply.

676. The following principles for the application of local flexibilities will ensure that we continue to protect the benefit of national tariffs and currencies, whilst allowing for local innovation and material redesign of services:

    (a) **the flexibility supports the provision of care that is better for the patient and the NHS** – obviously, any local flexibility should be supporting better care for patients, whether it is closer to home, more convenient or of higher quality: examples include one-stop shops or see and treat services. A flexibility may also benefit the NHS as a whole, by reducing the costs to the whole health system
    (b) **the flexibility supports material service redesign or more efficient pricing** – local flexibilities can be a means of driving further efficiency as long as quality, choice or competition are not compromised. This should not negate the benefits of national pricing
    (c) **the flexibility is the product of local agreement** – with due regard to the PbR Code of Conduct, flexibilities should be agreed in advance by commissioners and providers and, where appropriate local discussions can be supported by SHAs
    (d) **the flexibility is clearly established and documented** – an audit trail for the agreed flexibility is necessary and it should be documented as part of contract negotiations

(e) **the flexibility should be time limited and reviewed as appropriate** – flexibilities are not set indefinitely. For instance, innovation payments apply for three years. It may be that a local innovation becomes the national norm and the tariff changes to recognise this.

Outpatient procedures and day cases

677. Where the activity data supports it, we have provided tariffs for similar services in a variety of settings. This helps to encourage the movement of those services to less acute settings where this is appropriate. In some cases however, particularly where intermediate levels of care are involved, tariffs based on the average costs of previous patterns of service provision may disadvantage some types of provider to the detriment of patient services. An example may be a GP provider offering an intermediate level procedure where the average outpatient procedure tariff would not cover costs or, equally, within an acute trust the movement of a service from day case to outpatient. In these cases commissioners and providers can agree to vary the outpatient procedure or attendance tariff. We would expect this to be a time limited shift to allow reference costs to adjust to new patterns of service provision.

Additional outpatient procedure HRGs

678. Where commissioners and providers agreed local prices in 2009-10 for procedures in outpatients that are not covered by the mandatory list in 2012-13, they may agree to continue using these. In these circumstances we would expect that the local outpatient procedure price would be paid instead of and not in addition to the national outpatient attendance tariff. Commissioners may wish to reduce the prices negotiated in 2009-10 to reflect the national bundling of outpatient procedures (except those with mandatory tariffs) into the outpatient attendance tariffs in 2012-13. We do not expect this flexibility to apply to diagnostic imaging.

Antenatal admissions

679. We know that there is a problem nationally with the classification of maternity non-delivery events (NZ04 to NZ09). Where the published tariffs are clearly over-reimbursing actual local costs, commissioners should consider the use of a payment flexibility to manage the situation until the provider has time to review and adjust coding, reporting and costing practices. Where revised categorisation of admission methods leads to a significant change of income, commissioners and providers should consider a time limited transition from one level of payment to the other.

Bundling for pathways

680. We are committed to developing and implementing pathway and year of care tariffs and 2012-13 sees an acceleration in this work, for example through the introduction in shadow form of a pathway payment system for maternity services (paragraph 664). Commissioners and providers may wish to explore options for the local bundling of care into pathways, especially for patients with long term conditions and named patients with frequent admissions.

Complex diagnostic imaging

681. Where a specialist provider can demonstrate that it carries out more complex and costly diagnostic imaging than the average, which may particularly be the case for specialist orthopaedic providers, commissioners should consider if there is a case for paying more than the mandatory tariffs for outpatient attendances.

Dialysis away from base

682. In 2012-13 two new local flexibilities are being made available that relate to the additional costs that may be incurred by providers of dialysis away from base. The flexibilities that are available are described at paragraph 312 in the best practice tariff section of this guidance.

Infectious disease isolation units

683. Commissioners can provide additional funding for infectious disease isolation units. The same arrangements apply as for innovation payments, with the exception of the time limit.

Innovation payments

684. Innovation payments allow additional payments for new devices, drugs, treatments and technologies or a new application of existing technologies. They give the commissioner the flexibility to make an additional payment for care that provides a step change from the standard care covered by the national tariff. This additional payment may have longer-term efficiency benefits, eg reducing the likelihood of the need to repeat a procedure. We suggest commissioners avoid setting a blanket minimum threshold of cost for consideration of an innovation payment as appropriate thresholds are likely to be widely different for the different categories: drug, device, treatment or technology.

685. It may also be appropriate to use innovation payments if new technology allows procedures, currently done in an admitted patient care setting, to be carried out in an outpatient setting. The innovation payments would cover costs over and above the existing outpatient tariff, for example the cost of a necessary device.

686. The following criteria and conditions apply:

(a) the payment should be fixed for a maximum period of three years only from the date at which funding first applies (this could be mid-way through a financial year). In exceptional circumstances, commissioner and provider may agree to extend these arrangements
(b) where appropriate, commissioners should have regard to the existing cost effectiveness evidence, such as NHS Evidence, or other relevant national guidance, such as the NICE list of interventional procedures[123]
(c) the price should be agreed in advance and should only relate to the additional costs associated directly with the device or technology and its use relative to the cost of the alternative treatment
(d) commissioners should have due regard to the procurement arrangements for these drugs, devices, technologies or treatments identified as being suitable for funding.

687. The NHS Technology Adoption Centre (NTAC) "How to Why to" guides[124] may help inform discussions between commissioners and providers on implementing and funding specific technologies.

688. The NHS Chief Executive's Innovation Report *Innovation, Health & Wealth – accelerating adoption and diffusion in the NHS*[125] published in December 2011 sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. It includes a number of actions that will deliver significant improvements in the quality and value of care delivered in the NHS. They are designed as an integrated set of measures that together will support the NHS in achieving a systematic and profound change in the way the NHS operates.

689. A number of actions are aimed at aligning financial, operational and performance incentives to support the adoption and diffusion of innovation. NHS organisations should consider how to best make use of existing local tariff flexibilities to incentivise delivery of Innovation, Health and Wealth. The Department plans to publish supplementary guidance later this year.

690. Please e-mail us at pbrcomms@dh.gsi.gov.uk with details of agreed innovation payments, with "'innovation payments" as the subject heading, so that we can consider how best to incentivise the spread of innovation in the next phase of PbR development.

[123] http://www.nice.org.uk/aboutnice/whatwedo/aboutinterventionalprocedures/about_interventional_procedures.jsp
[124] www.ntac.nhs.uk
[125] Document available at: http://www.dh.gov.uk/health/2011/12/nhs-adopting-innovation/

Service redesign

691. Service redesign to support better care for patients, whether it is closer to home, more convenient or of higher quality, can include initiatives such as ‘one stop shops’ or ‘see and treat’ services. These initiatives may also benefit the NHS as a whole, by reducing the costs to the whole health system.

692. The tariff is based on the average mixture of complexity of services. Where a particular service being delivered is so different from the normal casemix range, perhaps because of contractually agreed patient exclusion criteria, commissioners will be able to pay at less than the tariff price if the difference is so significant that it amounts to a change in service provision.

693. We anticipate that organisations may wish to make use this flexibility in support of new methods of service delivery coming on stream as a result of an expansion in patient choice.

SHA flexibilities

694. SHAs will retain the flexibility to manage risks and pressures associated with PbR.

Specialised cardiac services

695. Although there is no specialised services top-up for cardiac services, there is a flexibility to enable commissioners to support specific services where the tariff may not provide sufficient reimbursement. These services are 24 hour primary percutaneous coronary intervention (PPCI) services (primary angioplasty), grown up congenital heart disease (GUCH) services, and management of arrhythmias (catheter ablation and implantation of ICDs).

Variations to tariff

696. Tariff is a fixed price, however in exceptional circumstances providers and commissioners can seek approval to operate an agreed variation of the regulated price which is lower, but not higher, than the published tariff, provided that there is no adverse impact on quality, patient choice or competition. Variations to tariff which help to improve the quality and availability of services would be appropriate. Variations to tariff which in effect enable the continuation of poor quality, inefficient models of care or restrict patient choice are not valid.

697. This does not mean replacing the regulated price with a local price, but it does mean agreeing a variation within the tariff rules. Such a reduction could be in the form of a simple unit price reduction or a marginal rate

above an agreed threshold but any variation must be operated within the overall framework of the tariff.

698. Providers will continue to be subject to inspection on quality from the Care Quality Commission (CQC) and commissioners will be responsible for ensuring that the quality of services purchased using a variation to the tariff is at least equal to, if not better than, services purchased at full tariff price. All services will remain free at the point of use to patients, and patients must be able to choose between providers regardless of price.

699. Where a commissioner and provider agree on a variation to the published tariff price, the commissioner must seek SHA approval before it can be implemented. Approval for any variation can only be given where a commissioner is able to demonstrate how they will measure quality of service. SHAs must monitor the impact of any agreed variations to tariff.

700. This flexibility does not signal a move to price competition. The flexibility cannot be imposed through a competitive tender process. It is intended to create the opportunity for commissioners and providers to agree together, in exceptional circumstances, a variation to the regulated price that enables the provision of services to patients which would not otherwise be possible without some flexibility on price.

701. An example of an exceptional circumstance in which a variation might be considered would be when, as part of their contract discussions, a provider and commissioner would like to take steps to incentivise their health economy's desired outcomes. Building on the example of the 30% marginal rate for emergency activity over and above a baseline of the value of 2008-09 activity, they agree to apply marginal rates across more areas of PbR activity, using a variety of different baselines.

702. An example of where it would not be appropriate to consider a variation would be a commissioner seeking to secure reduced tariff payments by guaranteeing a provider greater volumes of elective activity if they agree to be paid at a price lower than the published tariff. This arrangement would risk distorting patient choice, and so would not be permitted.

'Cherry picking'

703. The Government's response to the NHS Future Forum report included a commitment to tackle the 'cherry picking' of patients. Building on the existing 'Service Redesign' flexibility described at paragraph 691 above, we are introducing a new flexibility in 2012-13 designed to ensure fair reimbursement for the services delivered to patients. Under this new flexibility, commissioners should adjust the tariff price if a provider limits the type of patients it treats resulting in lower costs than the average of the tariff category.

704. We recognise that ‘cherry picking’ may happen on justifiable safety grounds, such as where providers are bound by contract terms which prevent them from treating patients of a certain age or with complications or comorbidities. Consideration of price adjustments under this flexibility will be limited to where contractually-agreed patient exclusion criteria exist. Before any adjustment agreed under this flexibility can be implemented, the commissioner must inform their SHA.

705. The introduction of this flexibility is not an opportunity for providers to seek to make a case for payment above tariff in order to maximise income, nor is it an opportunity for commissioners to seek to arbitrarily drive down tariff prices. Going forward, it may be feasible to provide guidance around specific HRGs for which this flexibility may be particularly appropriate.

Unbundling

706. The following principles for determining whether a service should be unbundled for payment under PbR apply:

    (a) unbundling should only take place where a substantive case can be made that it is necessary to achieve significant policy objectives
    (b) the approach to unbundling for payment should be based on the principles set out in *Options for the Future of PbR* that “the acute tariff should be unbundled only for service items that are commissioned directly from primary care. By contrast, where secondary care clinicians are making the decisions on interventions, we propose to expand the use of casemix based funding and to unbundle only high-cost, low-volume items”
    (c) a further criterion should be added that would allow unbundling of a service where the costs of a particular activity cannot be predicted from standard casemix measures.

707. Commissioners and providers may continue to unbundle services where it is consistent with these principles.

Section 14: Other operational issues

Market forces factor

708. The MFF payment is calculated from the tariff price, and any tariff adjustments, multiplied by the MFF payment index for each unit of activity within the mandatory scope of PbR and paid directly to the provider by the commissioner. MFF payments should be itemised separately in the contract value and the monthly reconciliation accounts. SUS PbR includes the final tariff value to facilitate this process.

709. The MFF is also payable for non-mandatory prices and non-contract activity. Commissioners and providers should agree whether the MFF is appropriate for locally agreed prices.

710. Organisations should use the relevant MFF payment index in the *tariff information spreadsheet*. Independent sector providers take the MFF of the NHS trust or NHS foundation trust nearest to the location where the care was delivered. The MFF applies to ISTCs as set out in contracts.

711. Following the introduction of new MFF values in 2009-10 and the update for 2011-12, we are continuing with a 2% capping policy to the MFF underlying index[126]. By this we mean that the underlying MFF index value of an organisation will move towards the target value, but by no more than 2% from the 2011-12 value.

712. Organisations merging on 1 April 2012 will have a new MFF payment index from this date. Those that merge during the financial year will have a new MFF from 1 April 2013 and SHAs should put in place arrangements to ensure a neutral impact across the health economy for the remainder of the year. Organisations should notify the PbR team of any planned mergers so that we can calculate and confirm the new MFF value.

713. In line with the Transforming Community Services programme, the MFF payment index has been updated to reflect re-organisations of services previously provided by PCTs. We have removed MFF values for all PCTs from the payment index and, where we have been notified, we have calculated MFF values for newly created community trusts but have not amended the MFF values of existing acute trusts that have taken on responsibility for any community services. Please refer to the MFF Technical Guidance for further information. Organisations should notify the PbR team via their SHA PbR leads of any changes to the organisation of community services that may impact on the MFF index.

[126] As the minimum value changes by less than -2.0% capping the underlying index has the same effect as capping the payment index.

714. Patient choice is paramount and the requirement on commissioners to pay the relevant rate of MFF, which is an integral part of the tariff price, must not in any way impede free choice of provider for the patient.

Monthly reporting

715. The 2012-13 standard NHS contract for acute services sets out the terms for providers to submit national data sets to SUS. The four key stages in the process are as follows:

    (a) inclusion date – means date by which the provider needs to submit data for the month in question for inclusion in the report available for monthly reconciliation
    (b) first reconciliation point – means date when the PbR activity is available to the commissioner to facilitate reconciliation between provider and commissioner
    (c) post-reconciliation inclusion date – means date by which the provider and the commissioner need to have resolved any issues relating to the data submission for the month in question. The time between the inclusion date and post-reconciliation inclusion date can be used by providers to submit any late or amended data
    (d) final reconciliation point – means date when the final reconciliation report is available for the month in question.

716. Commissioners should be diligent in checking the completeness of CDS data submitted to SUS by providers, including the NHS number.

717. Table 32 sets out the timetable for monthly activity reporting and report availability for 2012-13.

Table 32: Monthly reporting dates

Month	Inclusion date	First reconciliation point	Post-reconciliation inclusion date	Final reconciliation point
April 2012	Fri 18 May	Mon 28 May	Thu 21 June	Fri 29 June
May 2012	Thu 21 June	Fri 29 June	Fri 20 July	Mon 30 July
June 2012	Fri 20 July	Mon 30 July	Wed 22 August	Fri 31 August
July 2012	Wed 22 August	Fri 31 August	Fri 21 September	Mon 1 October
August 2012	Fri 21 September	Mon 1 October	Fri 19 October	Mon 29 October
September 2012	Fri 19 October	Mon 29 October	Thu 22 November	Fri 30 November
*October 2012	Thu 22 November	Fri 30 November	Fri 21 December	Thu 3 January
*November 2012	Fri 21 December	Thu 3 January	Wed 23 January	Thu 31 January
*December 2012	Wed 23 January	Thu 31 January	Fri 22 February	Mon 4 March
*January 2013	Fri 22 February	Mon 4 March	Thu 14 March	Fri 22 March
*February 2013	Thu 14 March	Fri 22 March	Fri 19 April	Mon 29 April
*March 2013	Fri 19 April	Mon 29 April	Wed 22 May	Fri 31 May

Notes:
(1) Dates in the months marked * are subject to possible change during the processing year.
(2) The post-reconciliation inclusion date and final reconciliation point for January are earlier in March than normal, to accommodate implementation of planned 2013-14 PbR release. February's inclusion date and first reconciliation point are also earlier in March than normal, for the same reason.

718. For activity outside the scope of the mandatory tariff, we recommend that commissioners and providers seek to agree an 'inclusion date', a reporting process and timeline for when data can be reviewed, amended and reconciled. This will allow the provider to correct or amend information they have submitted within an agreed timeframe prior to final sign off and payment being scheduled.

Non-contract activity

719. *Who pays? Establishing the responsible commissioner* (September 2007)[127], in setting arrangements for payment for non-contract activity (NCA), stated "providers should invoice responsible commissioners for NCA quarterly, within 30 days of the quarter end". This advice has been superseded and the reporting arrangements for NCA activity is now in line with monthly reporting dates in the NHS standard contract as set out in Table 32 above. Reporting requirements for cross-border activity which occurs outside of SLAs or contracts is covered separately in this Guidance, from paragraph 723 under the heading 'Devolved administrations'.

720. Where part of an invoice is in dispute, then payment should be made for the non-disputed activity within ten operational days of its receipt. Non-Contract Activity shall be invoiced on a monthly basis and shall be paid by the responsible commissioner on the basis of the NHS standard contract within ten operational days of its receipt, unless (part of) the invoice is disputed or subject to the emergency readmissions business rule.

721. Providers should make every effort to ensure NCA invoices are sent to the correct commissioners. Where an invoice has been inadvertently sent to the incorrect commissioner, the provider is permitted one further re-invoice for this activity prior to the post-reconciliation inclusion date. Commissioners are responsible for reviewing data at the first reconciliation point and notifying providers without delay where they are not the responsible commissioner so that the provider has sufficient time to re-invoice for the activity prior to the post-reconciliation inclusion date.

722. The prices for NCA in 2012-13 will be as follows:

    (a) the mandatory national tariff (including any adjustments) and MFF
    (b) where there are no mandatory national tariffs, then locally agreed prices, ie prices agreed by the provider with their coordinating commissioner

[127] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466

(c) where there are neither mandatory national tariffs nor locally agreed prices, then 2009-10 national average reference costs minus 3.3%[128].

Devolved administrations

723. The Department is discussing a further renewal of the *Interim protocol on cross border commissioning between England and Wales* with officials from the Welsh Government. The current protocol applies to patients in Gloucestershire, Herefordshire, Shropshire County and West Cheshire, and Betsi Cadwaladr University, Powys Teaching and Aneurin Bevan Local Health Boards (LHBs).

724. The Department of Health and the Welsh Government have agreed that Welsh commissioners will commission work from English providers as per the PbR rules set out in guidance, eg tariff plus MFF. Where there is no applicable tariff, the agreed protocol encourages Welsh commissioners to follow, as near as reasonably practicable, the provider's pricing arrangements agreed by their English commissioning consortium.

725. Separate to the *Interim protocol*, in 2006 the Department entered into an agreement with Wales, Scotland and Northern Ireland (the devolved administrations) covering reimbursement arrangements for emergency treatment provided outside of Service Level Agreements (SLAs) or contracts for patients who fall ill away from their home country. Information issued in 2007 in support of the agreement covered reimbursement arrangements for elective (planned) care provided outside the patient's home country which is outside SLAs/contracts. The agreement does not cover A&E attendances, which are dealt with in the following section on dehosting (paragraph 742).

726. The Department published information notes relating to the agreement in September 2006 (Gateway ref 7057) and June 2007 (Gateway ref 8409). The guidance set out below updates these two information notes and brings relevant pieces of guidance together in one place.

727. For guidance on establishing the responsible commissioner for cross-border treatment, please refer to paragraphs 58 to 62 of the document *Who pays? Establishing the responsible commissioner*[129].

Emergency treatment

728. This guidance covers the following categories of emergency treatment outside of SLA/contracts:

[128] The -3.3% figure represents a combination of the 0.0% adjustment to prices in 2010-11, -1.5% in 2011-12 and -1.8% in 2012-13.
[129] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466

- Patients registered with a GP in England (except Welsh residents) or resident in England and treated by providers in the devolved administrations (DAs)
- Patients resident in the DAs treated by providers in England
- Patients resident in the devolved administrations treated by providers in another of the DAs

729. For the above categories, the following arrangements must be adhered to:
    - No pre-treatment agreement needed
    - Treating provider to invoice the patient's responsible commissioner directly
    - Invoices to be sent as soon as practicable (ideally monthly), and at least quarterly, with in that instance the invoice raised within 30 days of the quarter end
    - The trust to issue one invoice per responsible commissioner, not one invoice per patient
    - Invoices to be accompanied by the contract minimum data set or agreed information which is sufficient to enable the receiving commissioner to be able to confirm that it is responsible for payment
    - Supporting information to be appropriately cross-referenced to the invoice lines
    - Payment to be made within 30 days of receipt of invoice, with any queries raised without delay
    - Where an element of an invoice is disputed, this should not delay payment for the activity not subject to dispute
    - Dispute resolution to be between provider and commissioner, in line with HMT/PSPP guidance

730. For patients whose responsible commissioner is in the DAs and who are treated by providers in England, the amount to be charged for planned treatment outside of SLA/contracts is set out in Table 33.

Table 33: Charges for emergency treatment outside of SLA/contracts

Activity	Price payable
Within scope of mandatory tariff	(Mandatory tariff + any appropriate adjustment or top-up) * Market Forces Factor (MFF) of the provider
Where activity is outside the scope of the mandatory tariff but there is an agreed local price for the activity between the provider and its lead commissioner	Local price
Where activity is outside the scope of the mandatory tariff and there is **no** agreed local price for the activity between the provider and its lead commissioner, but there is a non-mandatory tariff	(Non-mandatory tariff + any appropriate adjustment or top-up) * Market Forces Factor (MFF) of the provider
Where activity is outside the scope of the mandatory tariff and there is **no** agreed local price for the activity between the provider and its lead commissioner and there is **no** non-mandatory tariff	2009-10 average reference cost * -3.3%[130]

Note: the 'appropriate adjustments' referred to in the table above do not include CQUIN payments, The CQUIN framework applies only to services that are financed by the NHS in England. Therefore it is not mandatory for commissioners in the DAs to contribute to CQUIN schemes for English providers. However they may wish to be involved in the development and finance of CQUIN schemes for English providers if they agree locally that it is appropriate.

731. For patients whose responsible commissioner is in England and who are treated by providers in the DAs, the amount to be charged is the local price usually paid to the provider of the treatment.

732. For patients whose responsible commissioner is in one of the DAs and who are treated by a provider in another of the DAs, the amount to be charged is the local price usually paid to the provider of the treatment.

733. Commissioners should not use this mechanism and the associated prices in place of SLAs/contracts where they exist.

Elective (planned) treatment

734. Where cross-border elective admitted patient or outpatient referrals occur outside of SLAs/contracts, prior approval must be sought and obtained by providers. Referral by a GP or consultant does not in itself constitute prior approval. Where DA patients have been receiving

[130] The -3.3% figure represents a combination of the 0.0% adjustment to prices in 2010-11, -1.5% in 2011-12 and -1.8% in 2012-13.

ongoing care in England which commenced before the requirement for prior approval was introduced in 2006-07, and it is clinically appropriate for the care to continue, it would not be appropriate for the DA commissioner to seek to introduce retrospective approval as a means of avoiding responsibility for payment.

735. Prior approval should be sought in a timely fashion to prevent approval to treat decisions being made at inappropriate times for patients. If providers have been unable to obtain prior approval, for example where an outpatient attendance needs to be arranged the day after an A&E attendance, then the commissioner should honour payment, however providers will need to demonstrate that reasonable attempts were made to secure approval.

736. Ideally, where prior approval is sought and obtained on the initial referral, this should cover all admitted patient and outpatient care required to treat the condition outlined on the initial referral. Providers should however seek to clarify expectations in this regard with the commissioner in the devolved administration so as to minimise the risk of payment being refused.

737. The following arrangements must be adhered to.

- Treating provider to invoice the patient's responsible commissioner directly
- Invoices to be sent as soon as practicable (ideally monthly), and at least quarterly, with in that instance the invoice raised within 30 days of the quarter end
- The trust to issue one invoice per responsible commissioner, not one invoice per patient
- Invoices to be accompanied by the contract minimum data set or agreed information which is sufficient to enable the receiving commissioner to be able to confirm that it is responsible for payment
- Supporting information to be appropriately cross-referenced to the invoice lines
- Payment to be made within 30 days of receipt of invoice, with any queries raised without delay
- Where an element of an invoice is disputed, this should not delay payment for the activity not subject to dispute
- Dispute resolution to be between provider and commissioner, in line with HMT/PSPP guidance

738. Different commissioning arrangements may exist for cross-border specialised services. For example, an English provider should contact a Welsh patient's Local Health Board (LHB) of residence if they are unsure whether the LHB or the specialist commissioner (Welsh Health Specialised Services Committee) is responsible.

739. For patients whose responsible commissioner is in the DAs and who are treated by providers in England, the amount to be charged for planned treatment outside of SLA/contracts is set out in the table below.

Table 34: Charges for planned treatment outside of SLA/contracts

Activity	**Price payable**
Within scope of mandatory tariff	(Mandatory tariff + any appropriate adjustment or top-up) * Market Forces Factor (MFF) of the provider
Where activity is outside the scope of the mandatory tariff but there is an agreed local price for the activity between the provider and its lead commissioner	Local price
Where activity is outside the scope of the mandatory tariff and there is **no** agreed local price for the activity between the provider and its lead commissioner, but there is a non-mandatory tariff	(Non-mandatory tariff + any appropriate adjustment or top-up) * Market Forces Factor (MFF) of the provider
Where activity is outside the scope of the mandatory tariff and there is **no** agreed local price for the activity between the provider and its lead commissioner and there is **no** non-mandatory tariff	2009-10 average reference cost * -3.3%[131]

Note: the 'appropriate adjustments' referred to in the table above do not include CQUIN payments, The CQUIN framework applies only to services that are financed by the NHS in England. Therefore it is not mandatory for commissioners in the DAs to contribute to CQUIN schemes for English providers. However they may wish to be involved in the development and finance of CQUIN schemes for English providers if they agree locally that it is appropriate.

740. For patients whose responsible commissioner is in England and who are treated by providers in the DAs, the amount to be charged is the local price usually paid to the provider of the treatment.

741. For patients whose responsible commissioner is in one of the DAs and who are treated by a provider in another of the DAs, the amount to be charged is the local price usually paid to the provider of the treatment.

Dehosting

742. Dehosting (or cross charging) for services previously provided on an all-comers basis, mainly A&E and GUM services, continues to apply in England in 2012-13. This does not extend to the devolved administrations, which means that a patient whose responsible

[131] The -3.3% figure represents a combination of the 0.0% adjustment to prices in 2010-11, -1.5% in 2011-12 and -1.8% in 2012-13.

commissioner is in one of the devolved administrations and who is treated in an English A&E department is paid for by the host commissioner in England, and vice versa.

743. Patient confidentiality means it is not always possible to identify the host commissioner. The underlying principle is that patient identifiable data should not be necessary for commissioning purposes in relation to any health service. This is particularly so for sexual health services, where the data is sensitive and in some circumstances controlled by additional legislation. The Patient Information Advisory Group (PIAG) support the following process for safeguarding confidentiality whilst facilitating cross charging:

    (a) clinics should collect contact details where patients are willing to provide them, including full postcode. Where patients are unwilling to provide their postcode, they could be asked for the name of their commissioner if they know it or record that the patient was unwilling to provide their details
    (b) clinics should use the postcode to look up the commissioner (or relevant DA commissioning body)
    (c) clinics should provide to the relevant commissioners (or relevant DA commissioning body) an accurate indication of numbers of patients seen and whether first or follow-up appointment
    (d) commissioners must accept this on trust. Under no circumstance is any postcode data to be disclosed, as in some instances this will be identifiable and will constitute a serious breach of confidentiality.

744. Genito-urinary medicine monthly access monitoring (GUMMAM) collects attendance at GUM clinic by commissioner of residence and can be used for dehosting and cross charging purposes. This dataset is based on national rules for collection and SHA auditing arrangements may be undertaken to validate the data. In the rare circumstances where GUMMAM data cannot be used, providers can allocate postcodes using at least the first 3 or 4 digits in the postcode (the district or sector digits). commissioners could provide look up tables to facilitate accurate allocation of commissioner.

745. It may not be possible to identify the commissioner in all instances. Commissioners will wish to agree local arrangements, e.g. the host commissioner charges neighbouring commissioners a proportion of the unallocated patients on an annual block basis based on the numbers of allocated patients seen from that commissioner. SHAs have a role in ensuring that commissioners comply with these arrangements.

Never events

746. Never events are serious patient safety events that are largely preventable. PCTs should use the list of never events which are

published on the Department's website[132] as part of their contract agreements with providers. The focus of this policy remains on promoting clear reporting and discussion mechanisms for never events as part of a programme of commissioning for safety.

747. Commissioners have the discretion to decide to make no payment for treatment that results in one of the national never events, and/or for treatment to deal with the consequences of a never event. The final decision to withhold payment will rest with commissioners who will wish to discuss the appropriateness and the level of payment that is withheld with providers.

748. SUS PbR will still calculate reimbursement, which should be adjusted locally through contracts. Where a national tariff does not apply for the episode of care in which the never event occurred, commissioners may wish to discuss appropriate alternative cost recovery mechanisms.

NHS number

749. In line with the Operating Framework for the NHS in England 2012-13, NHS organisations are expected to use the NHS number consistently in 2012-13 and commissioners should link the use of the NHS number to contractual payments in line with guidance. Over 99% of patients treated by the NHS have an NHS number. However, it is recognised that there are a minority of patients for whom it may not be possible or practical for organisations to hold an NHS number.

750. For patients who fall into the specific confidentiality rules, SUS PbR is able to calculate an HRG and tariff where appropriate. Where the NHS number is missing from the CDS submission for other reasons, SUS PbR will still attempt to group and apply tariff using other supplied data items. Users may find the extract attribute "Match Criterion Indicator"[133] helpful in differentiating between confidential patients and those for whom no NHS number was submitted. Due to the complexity of rules, local negotiation will be required to determine where commissioners will withhold payments. There are patients for whom it may not be possible or practical for organisations to hold an NHS number. Further guidance on the NHS number can be found on the Connecting for Health website.[134]

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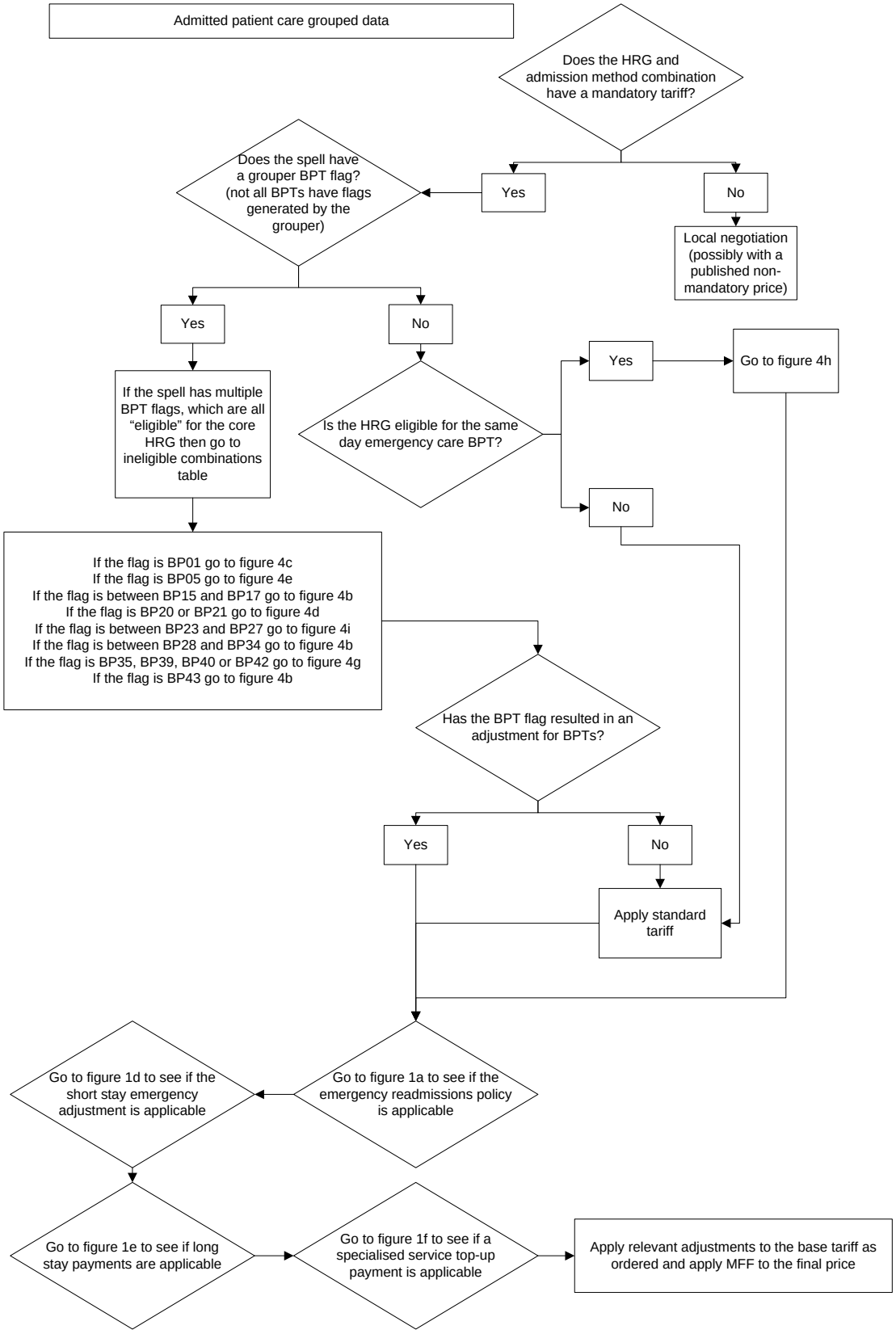
132 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124552

133 http://www.ic.nhs.uk/webfiles/SUS/PBR/release_9_spec_version_1.1.xls

134 http://www.connectingforhealth.nhs.uk/systemsandservices/nhsnumber/staff/commissioning

Annex A Figure 1: Admitted patients



Annex A: Ineligible Combinations

In the cases where a spell has multiple BPT flags, SUS PbR will apply the relevant tariff to only one of the flags. It does this using a hierarchy of the BPT flags, picking the BPT flag that is highest in the hierarchy from the multiple BPT flags generated for the given spell. Users of the Local Payment Grouper will need to apply the hierarchy in order to determine which BPT flag to use.

The potential BPT flags for each HRG are listed below in rank order, from highest to lowest.

For example, in HRG JA07B, SUS PbR would use BP43 irrespective of which other BPT flags were generated in the spell as it is the highest in the hierarchy. If the spell had BP30 and BP29 then SUS PbR would use BP30 as this is higher in the hierarchy than BP29.

Note that some of these rankings are different to those set out in the 2012-13 PbR Guidance issued for the Roadtest exercise.

HRGs: JA07B, JA07C

BP43	Simple mastectomy with axillary surgery
BP28	Simple mastectomy without axillary surgery
BP32	Axillary clearance
BP30	Excision of breast with sentinel lymph node biopsy or axillary sample
BP29	Excision of breast

HRG: JA09B

BP30	Excision of breast with sentinel lymph node biopsy or axillary sample
BP29	Excision of breast
BP31	Sentinel lymph node biopsy/Axillary sample
BP27	Percutaneous excision of benign breast lesions

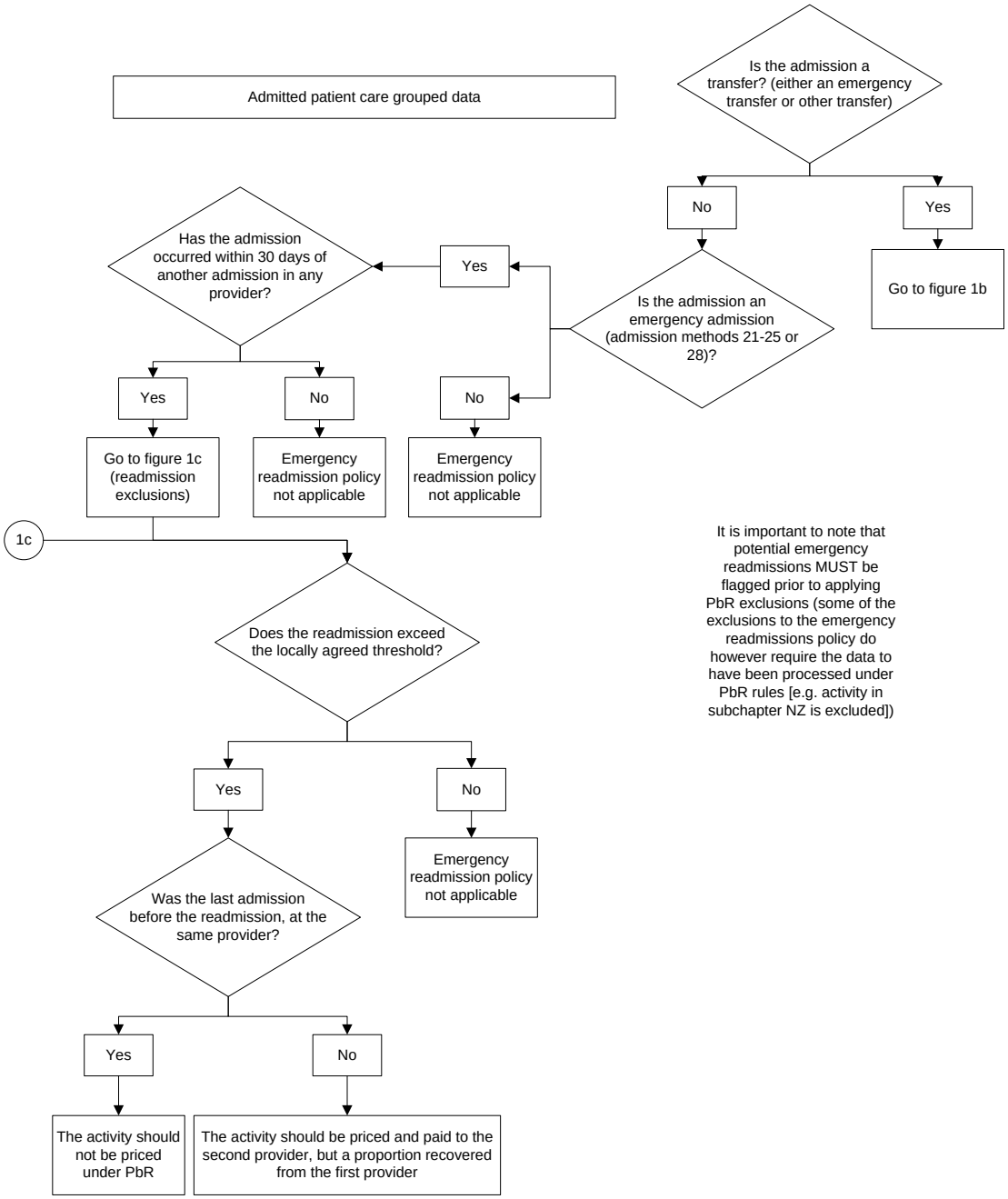
HRG: JA09D

BP31	Sentinel lymph node biopsy/Axillary sample
BP27	Percutaneous excision of benign breast lesions

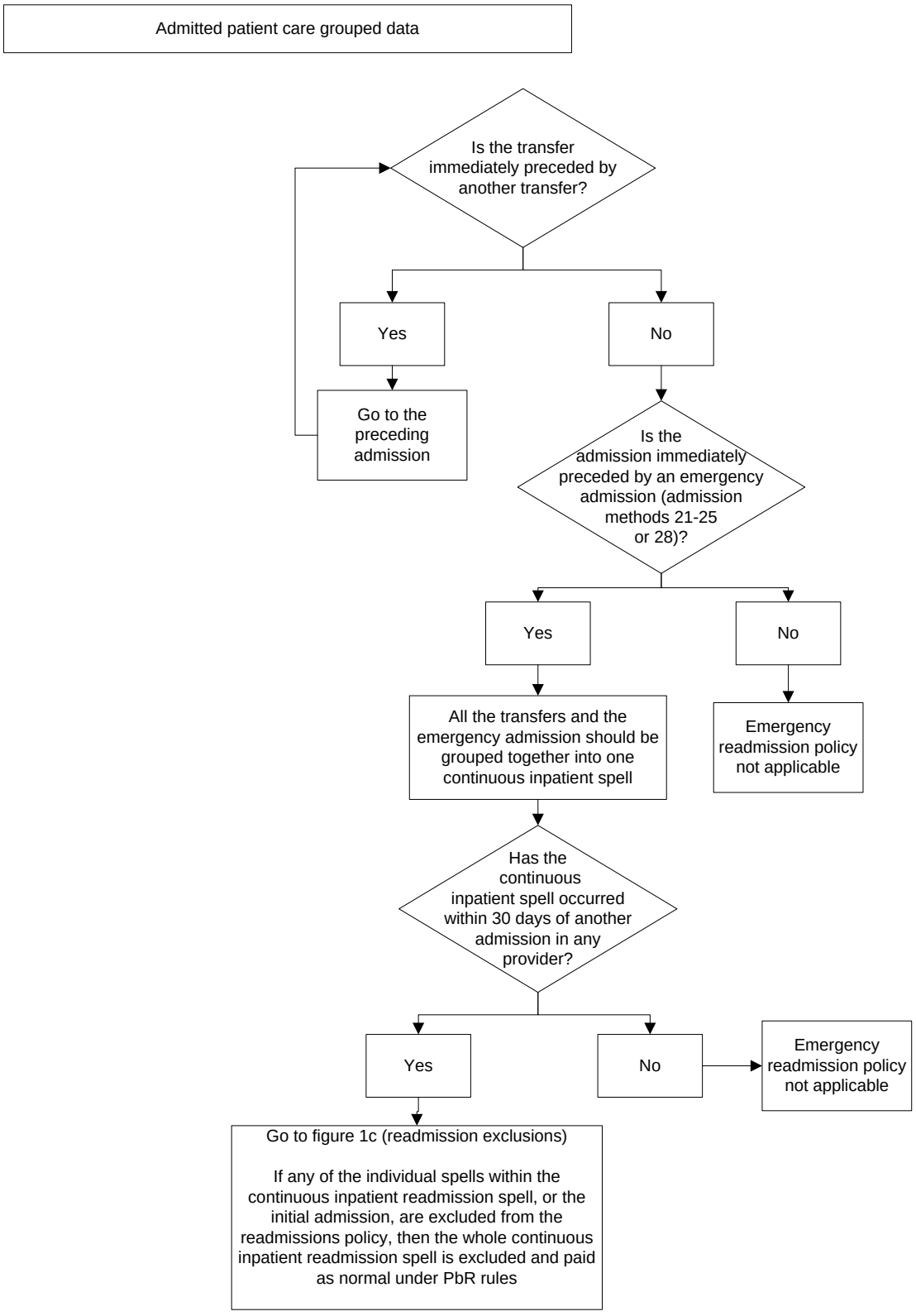
HRGs: QZ15B, QZ15C

BP25	Angioplasty and stenting for diabetic foot disease
BP24	Angioplasty and stenting for peripheral artery disease

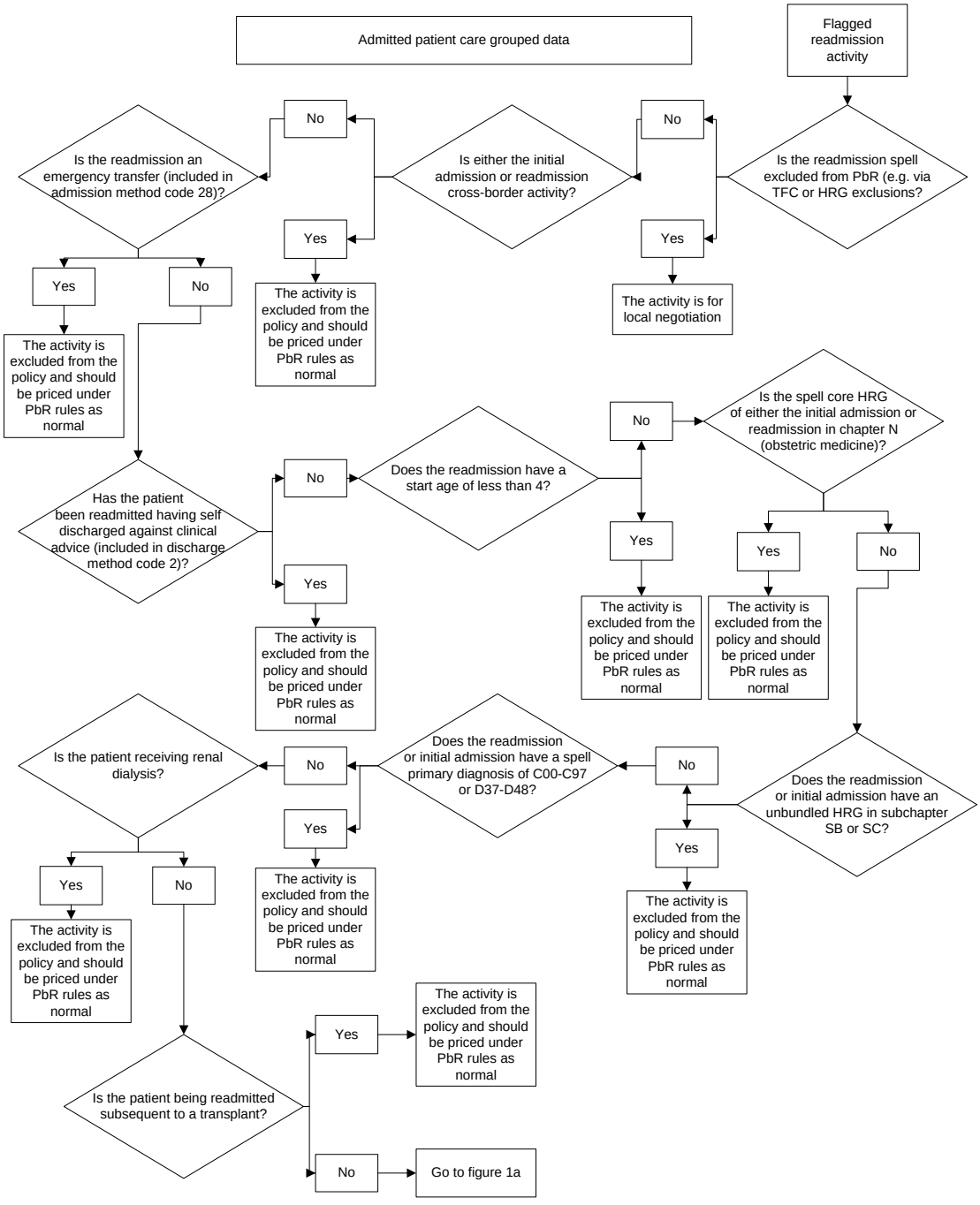
Annex A Figure 1a: Emergency readmissions rule



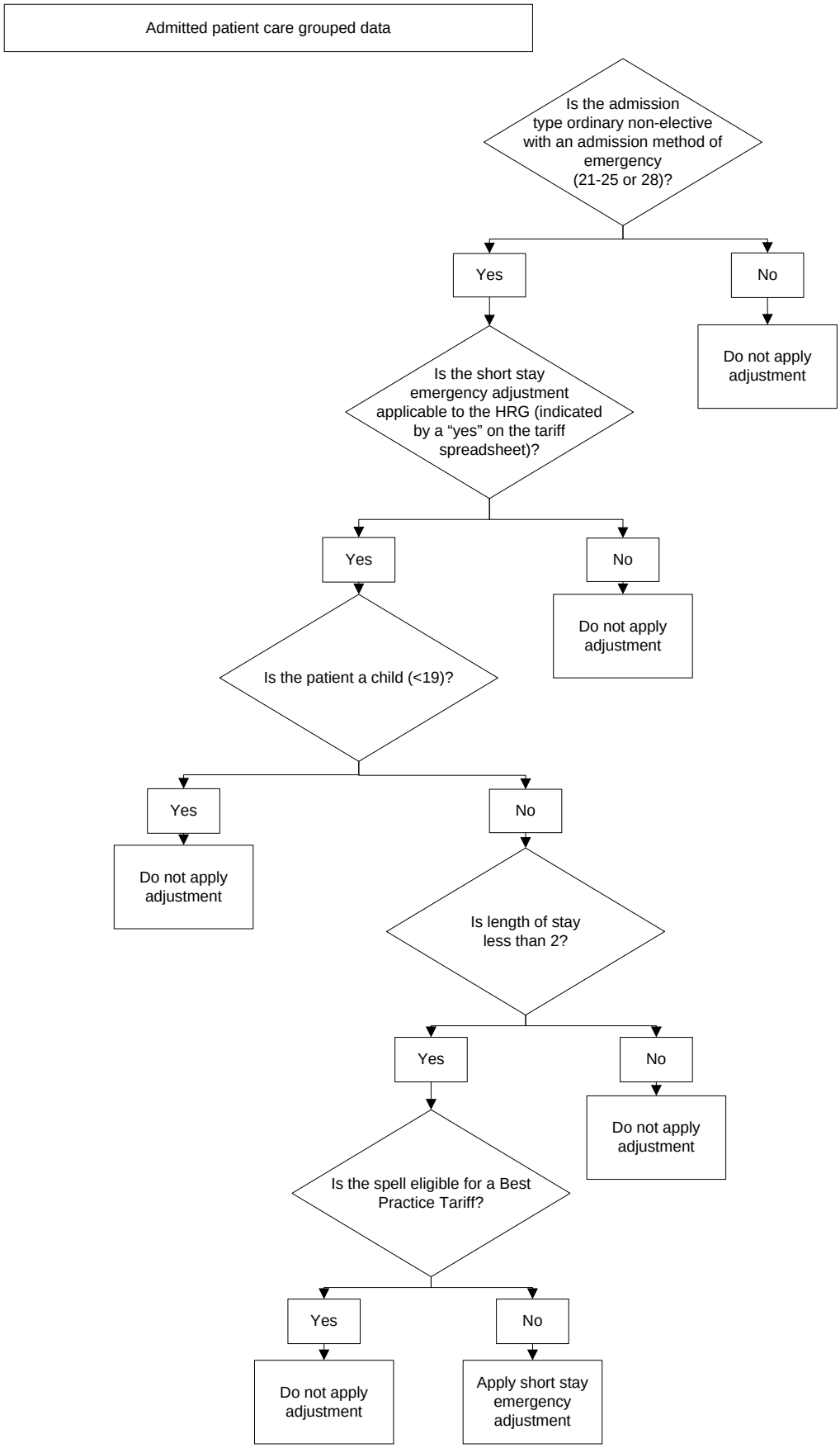
Annex A Figure 1b: Emergency readmissions rule and transfers



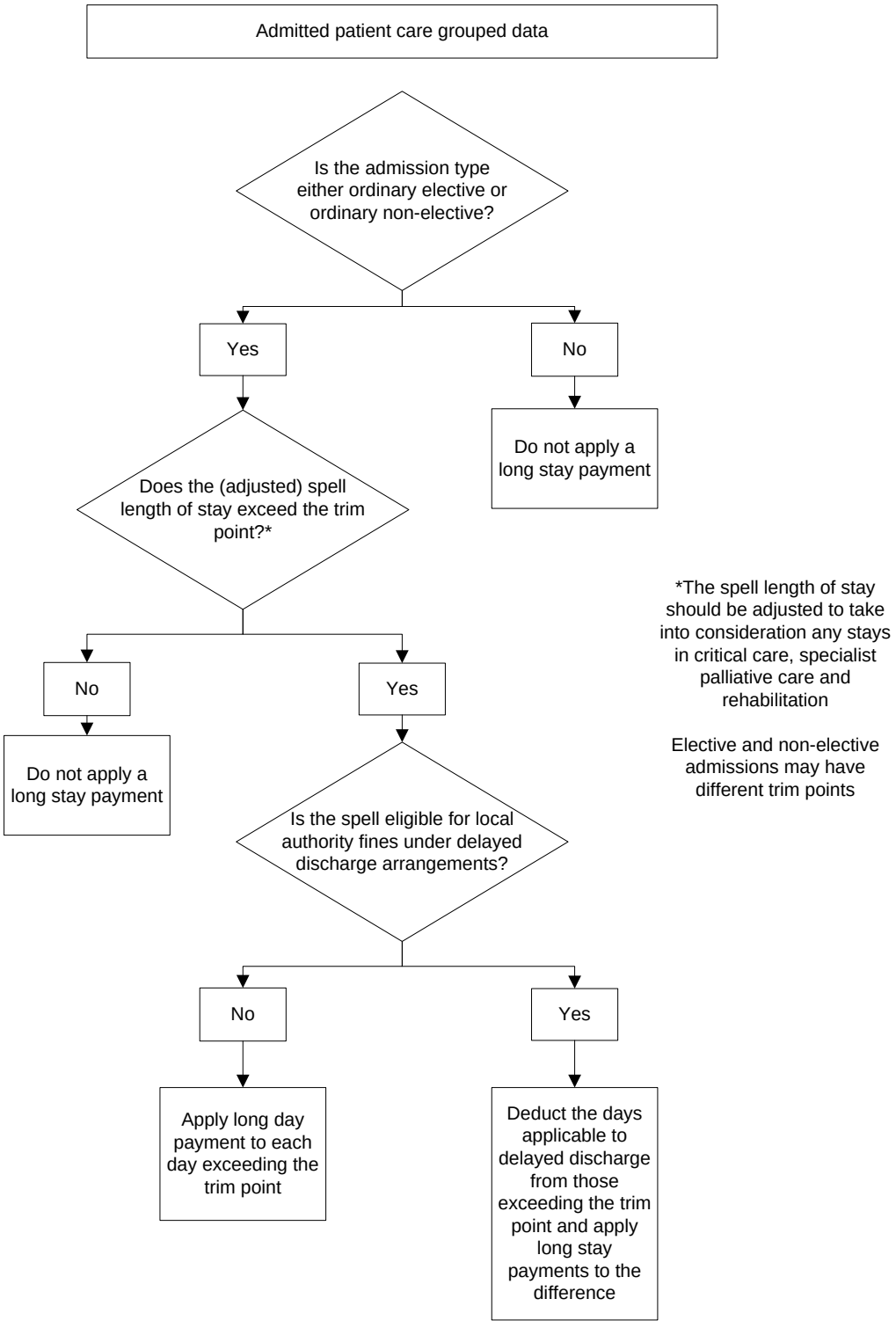
Annex A Figure 1c: Emergency readmissions rule and exclusions



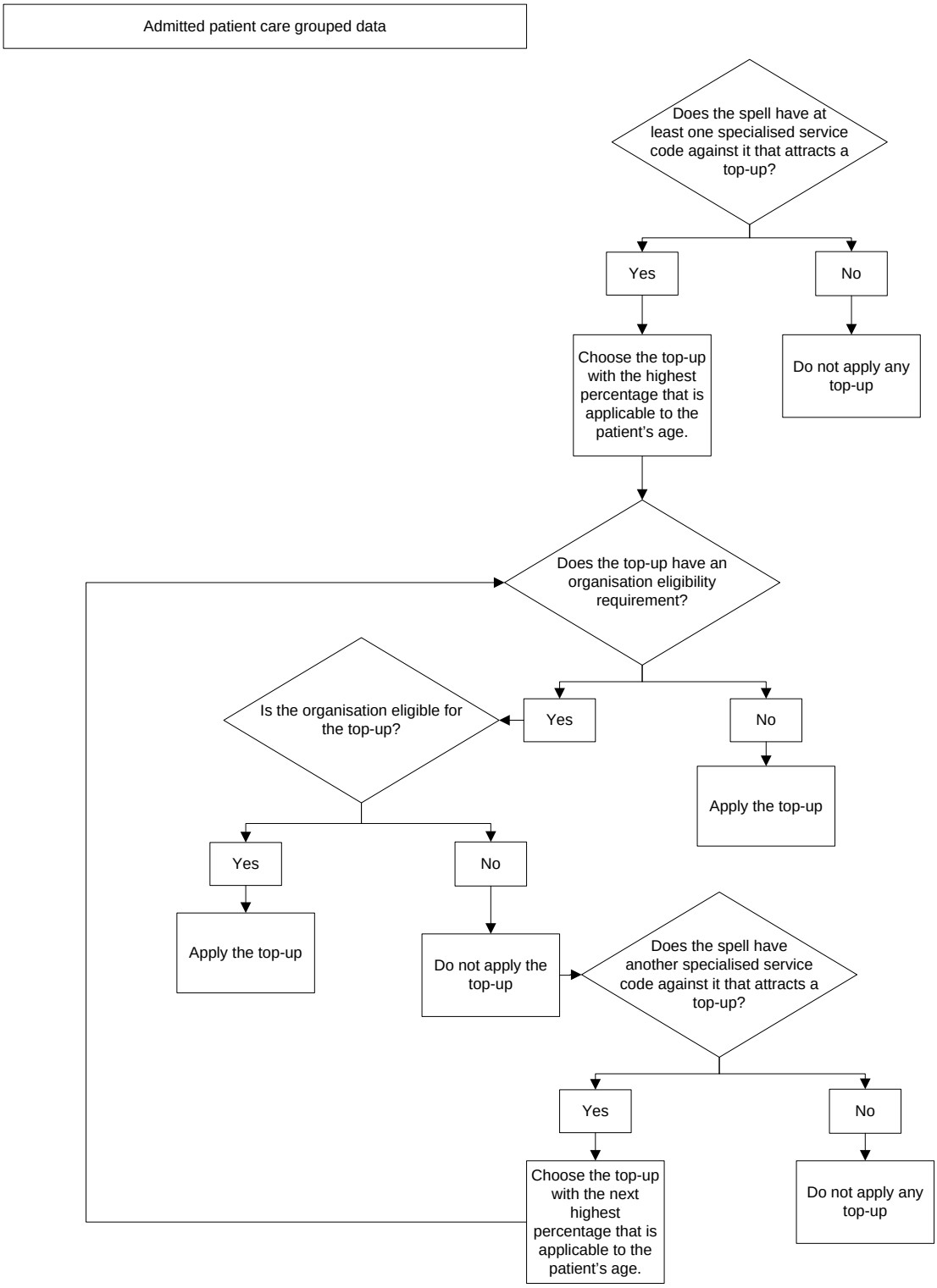
Annex A Figure 1d: Short stay emergency adjustment



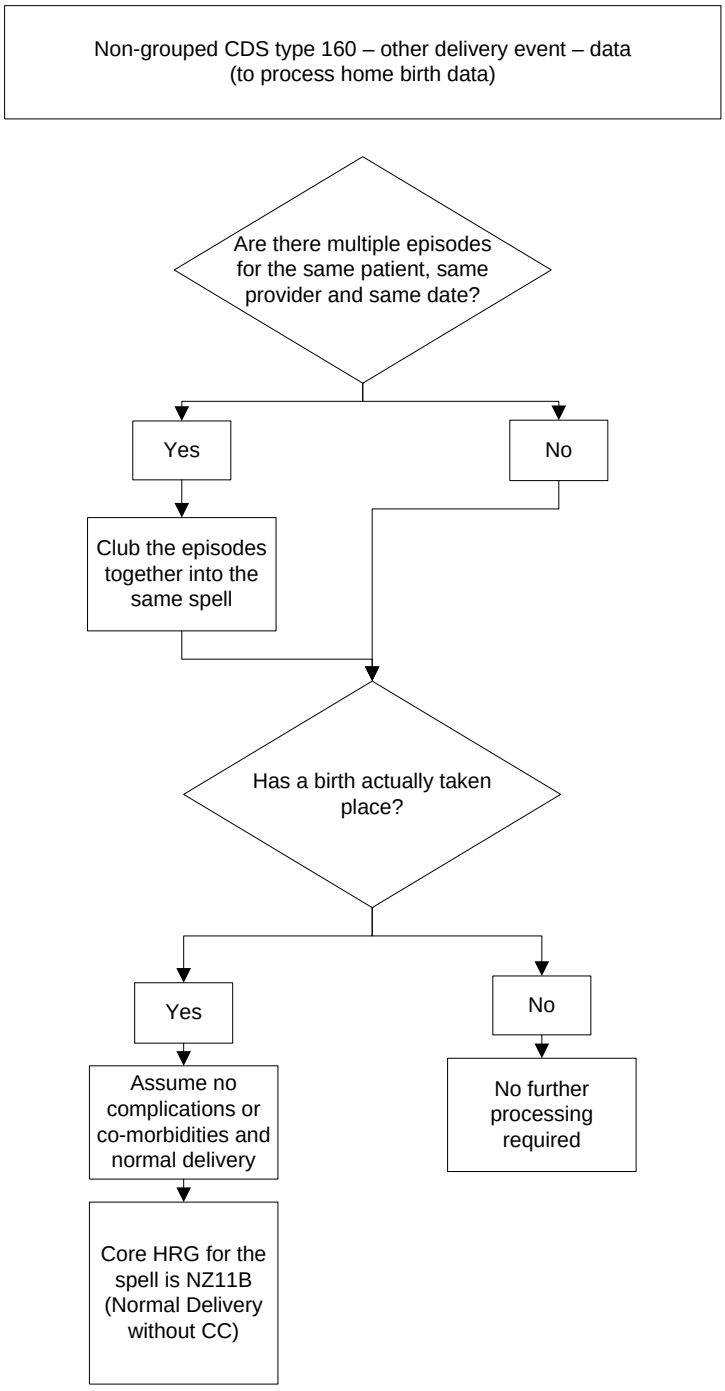
Annex A Figure 1e: Long stay payments



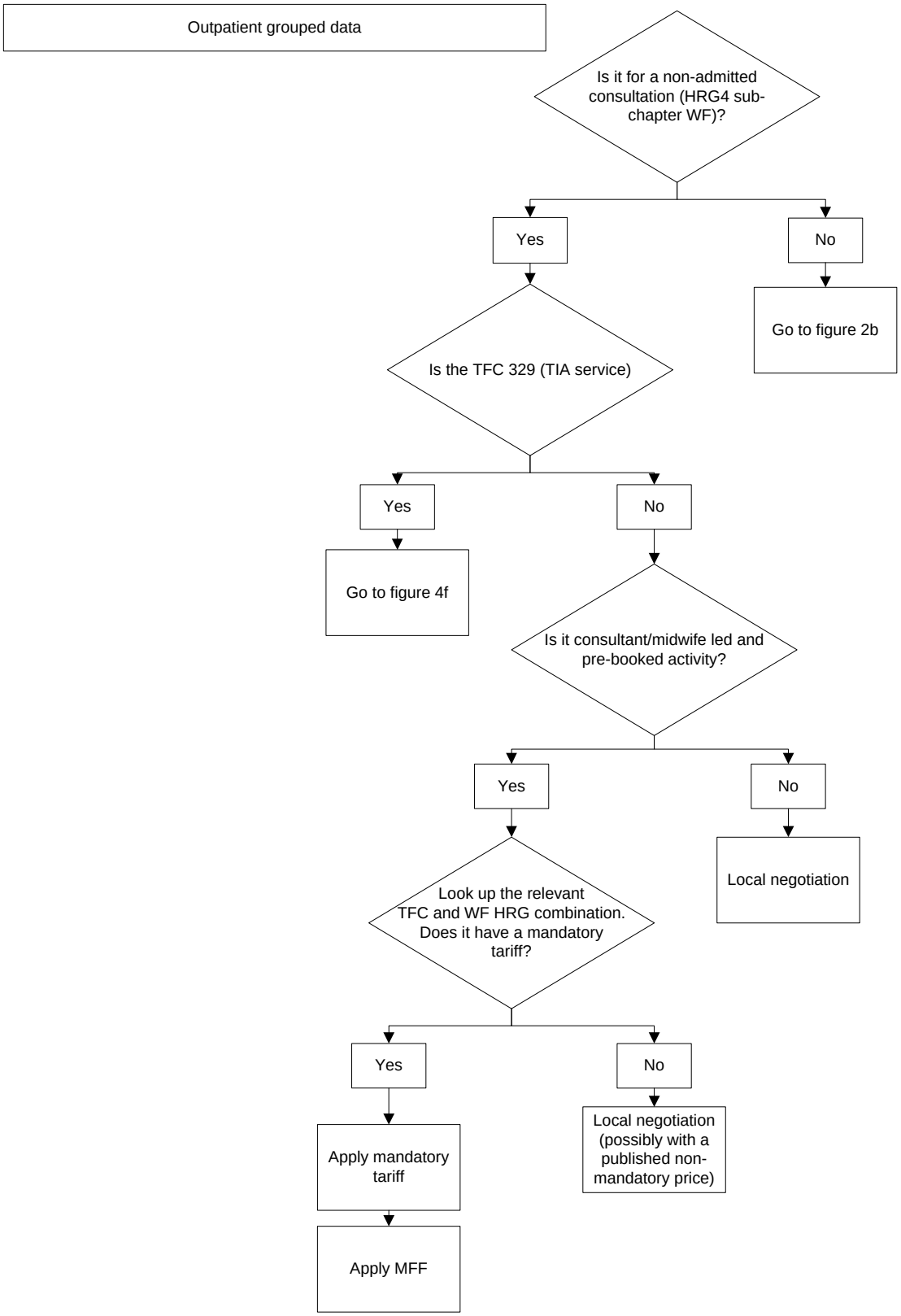
Annex A Figure 1f: Specialised services top-ups



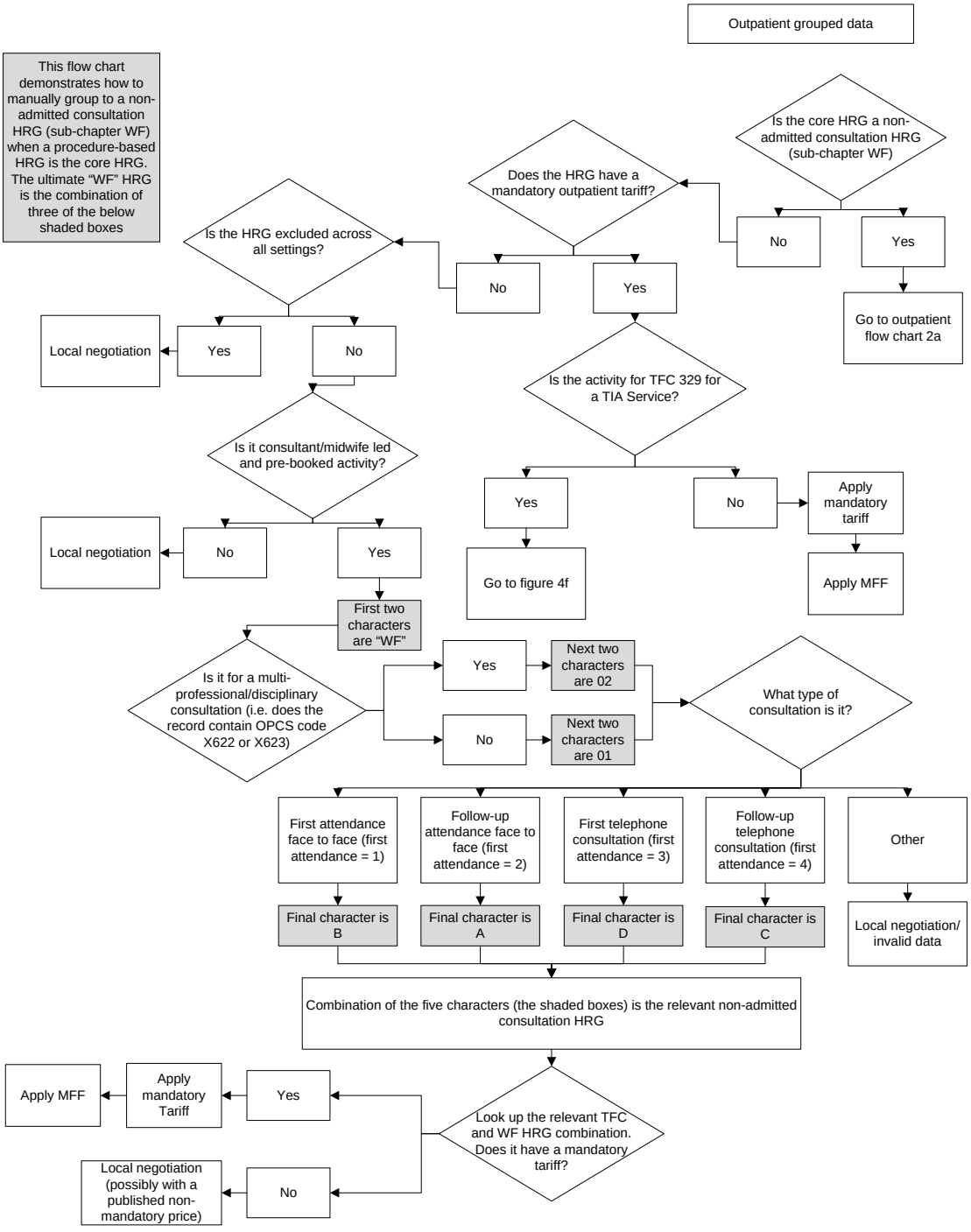
Annex A Figure 1g: Home births



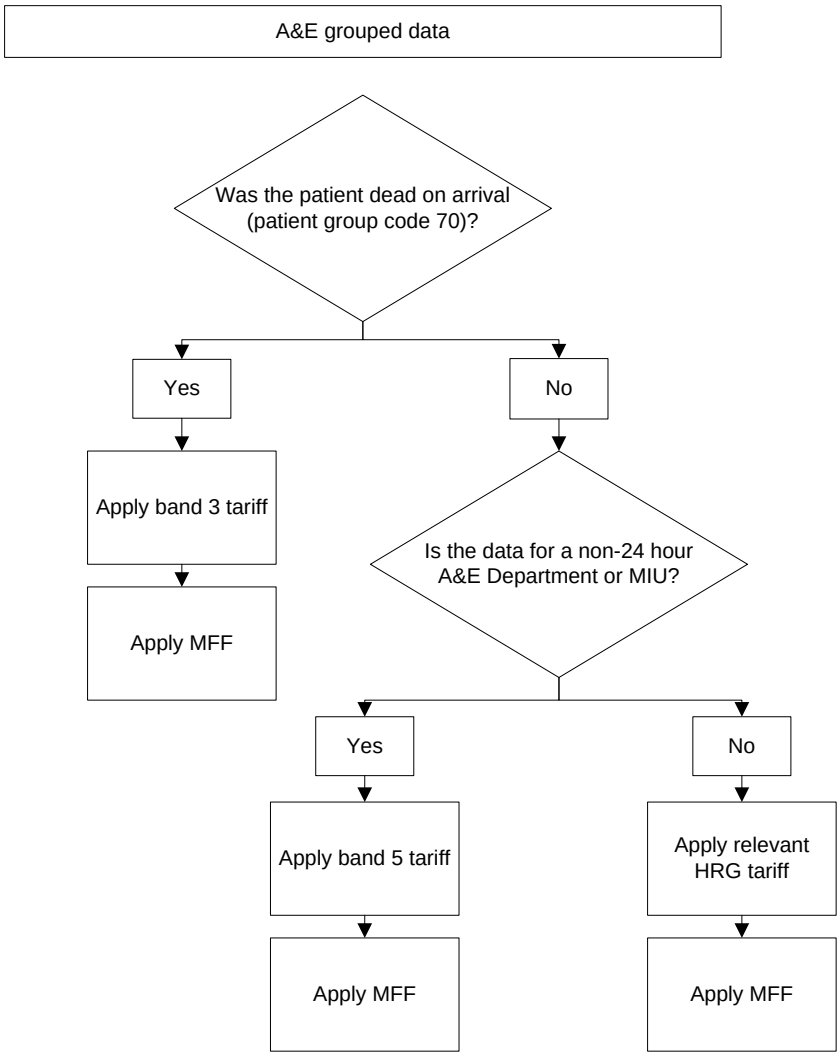
Annex A Figure 2a: Outpatient attendances



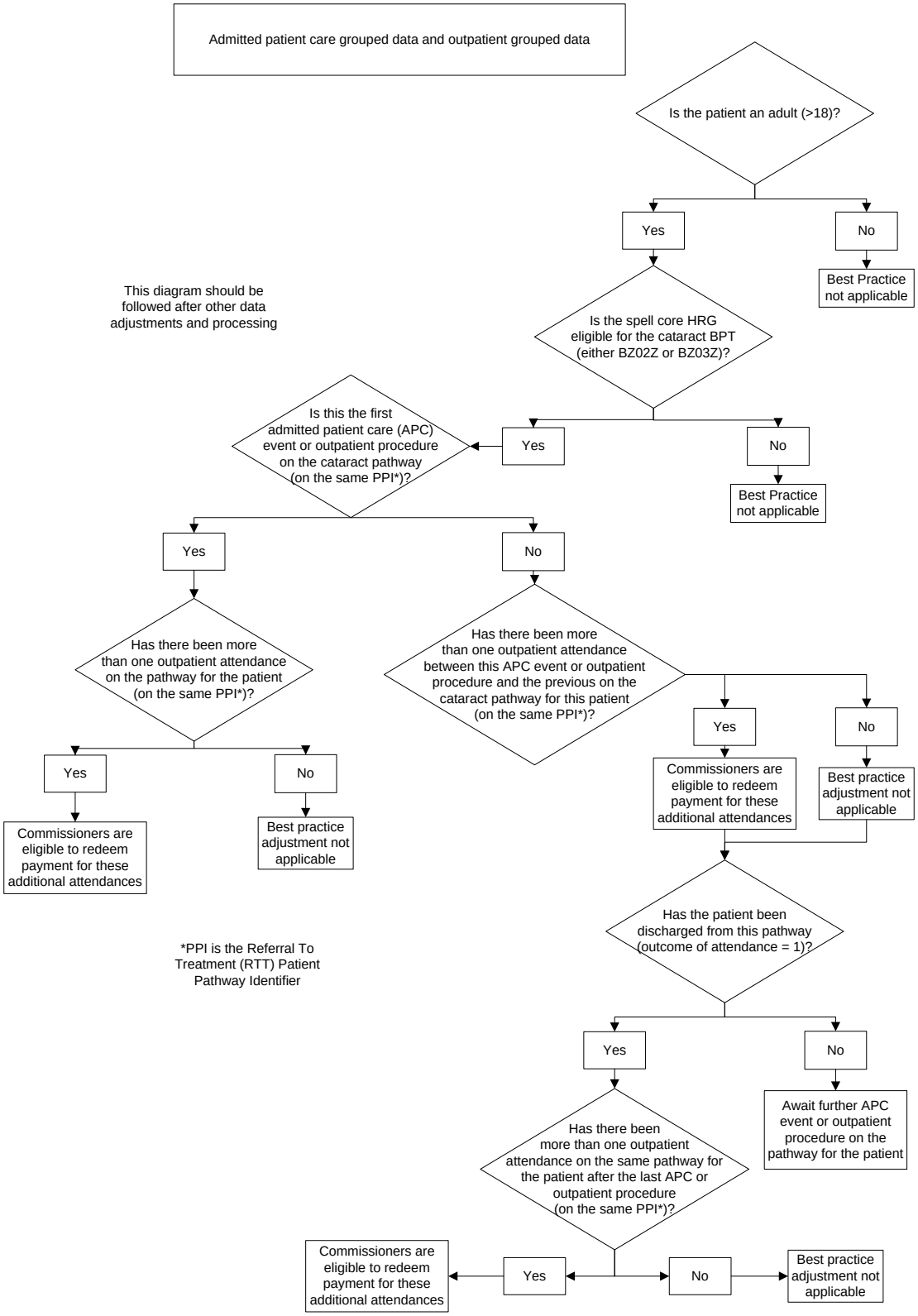
Annex A Figure 2b: Outpatient procedures (and determining appropriate attendance)



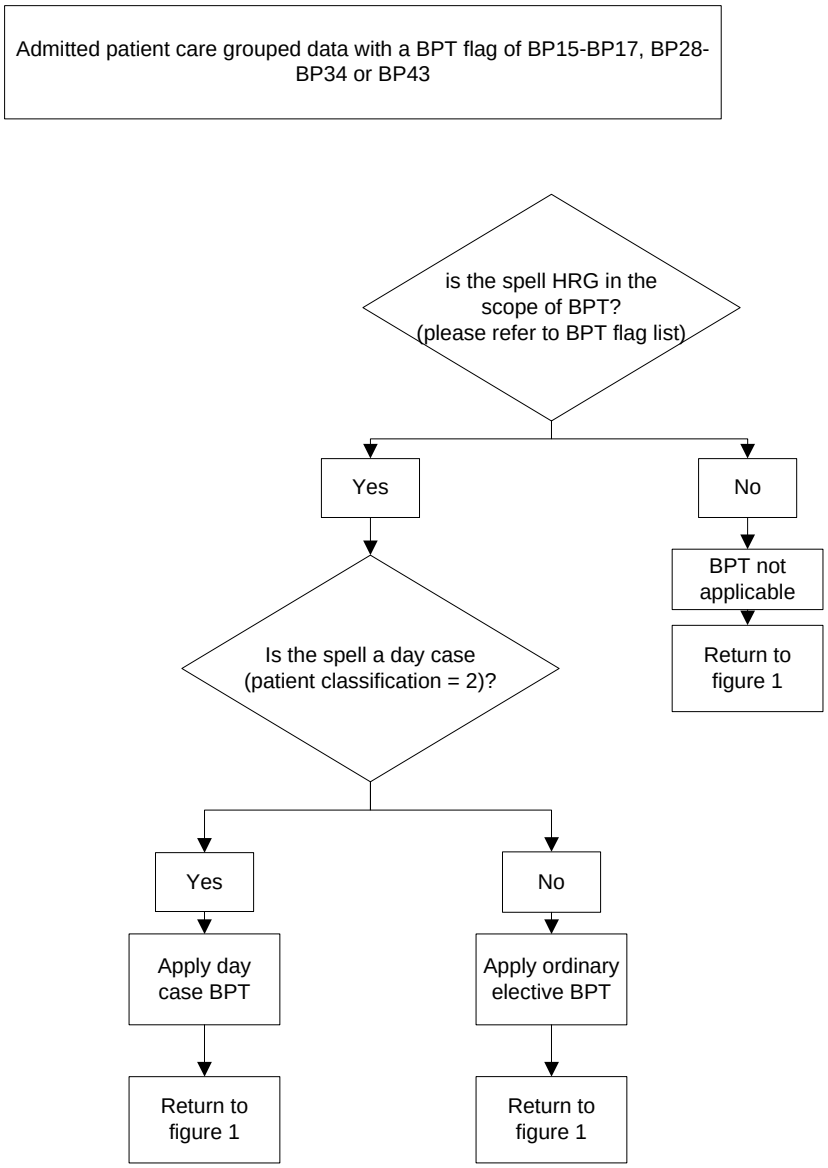
Annex A Figure 3: A&E



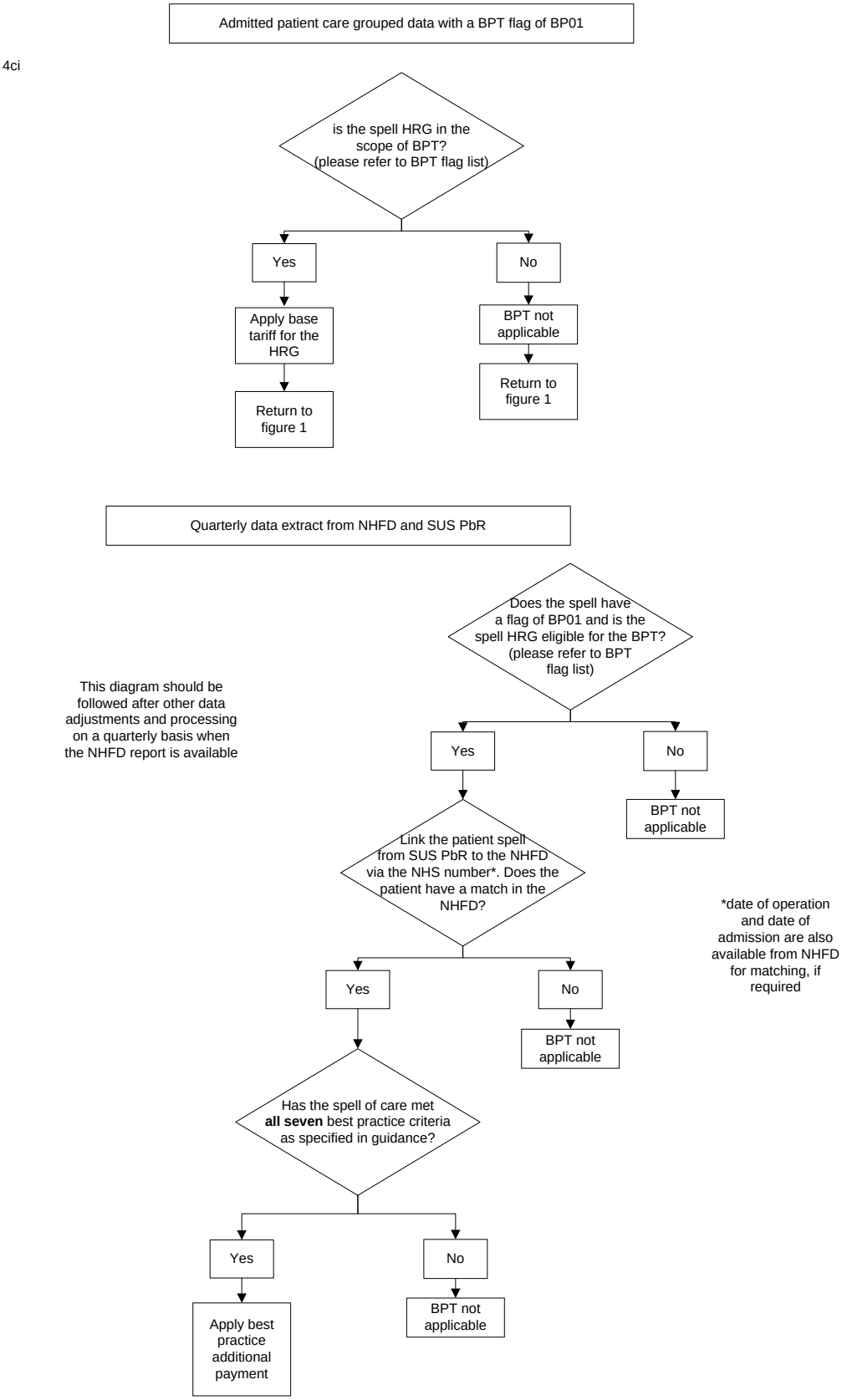
Annex A Figure 4a: Cataracts best practice tariff



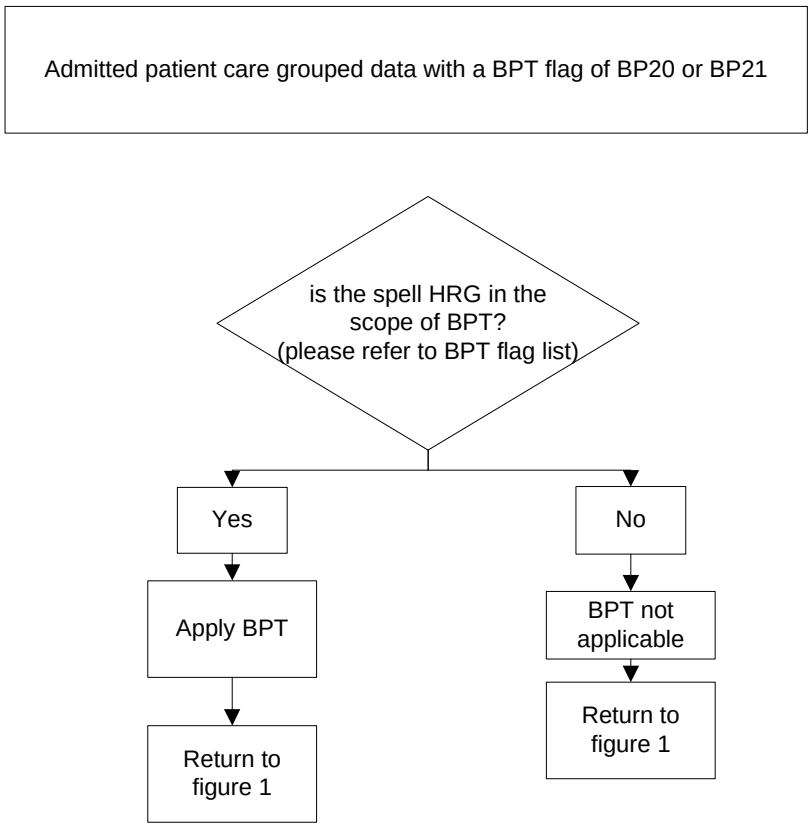
Annex A Figure 4b: Day case best practice tariffs



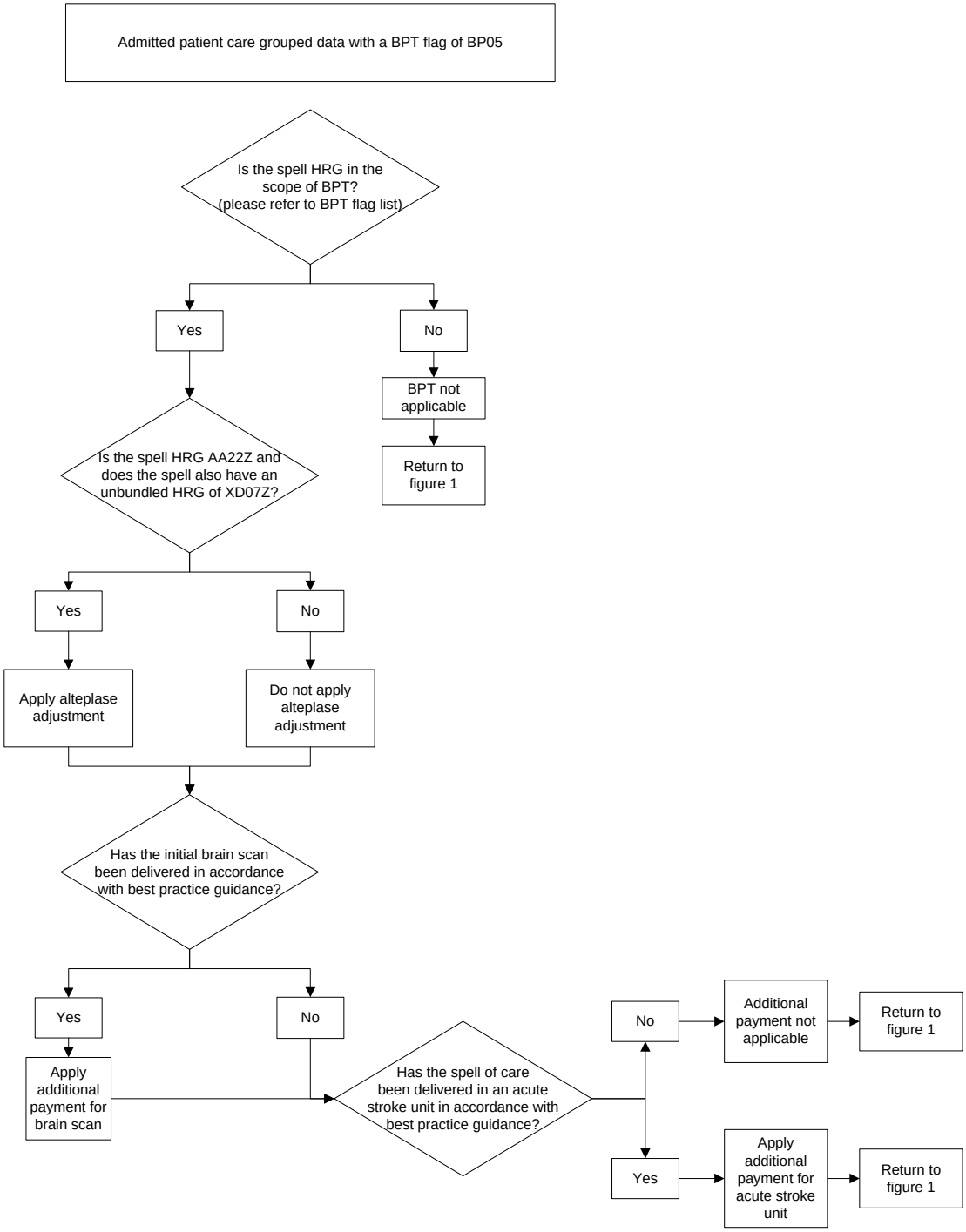
Annex A Figure 4c: Fragility hip fracture best practice tariff



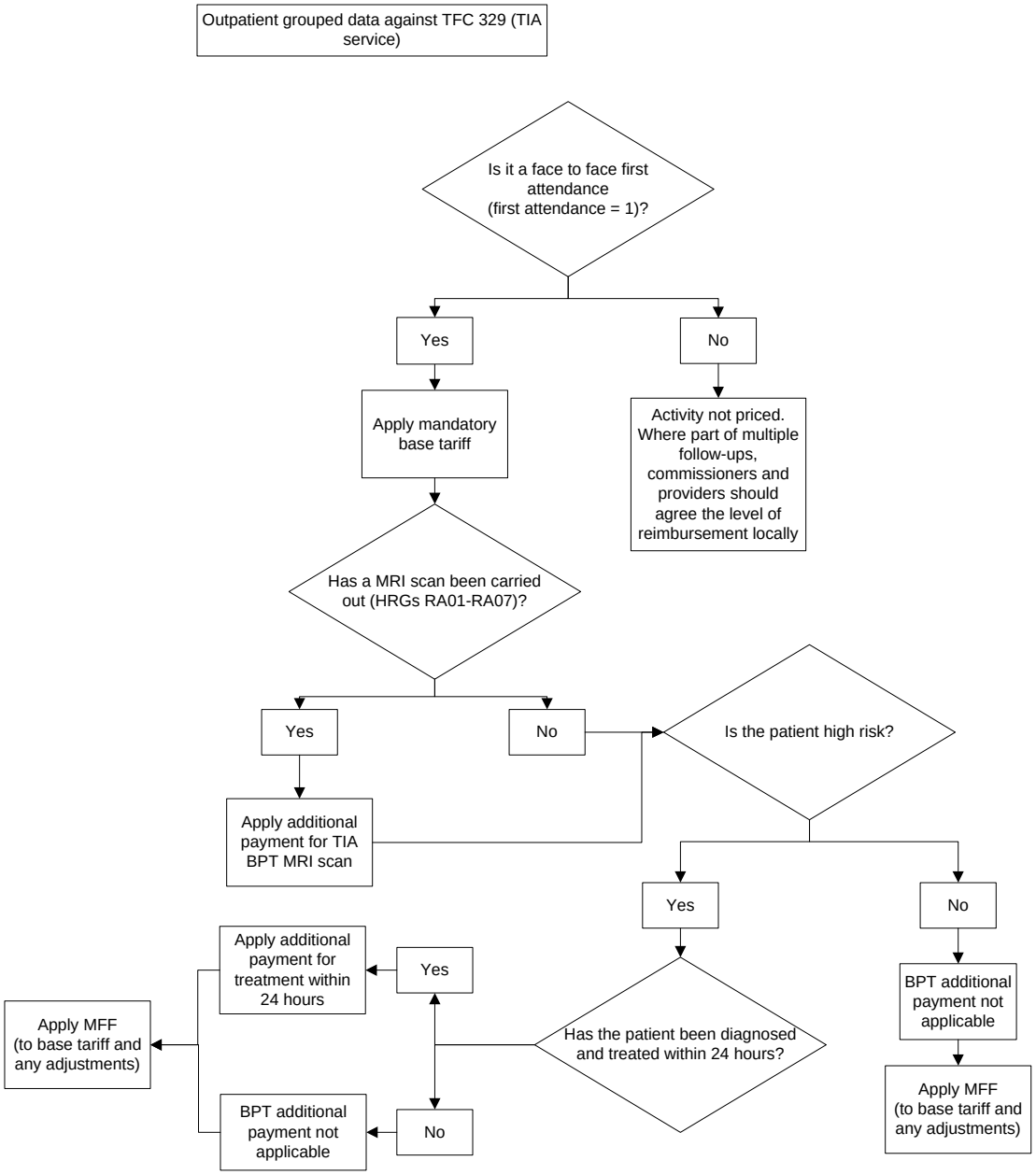
Annex A Figure 4d: Primary total hip and knee replacement best practice tariffs



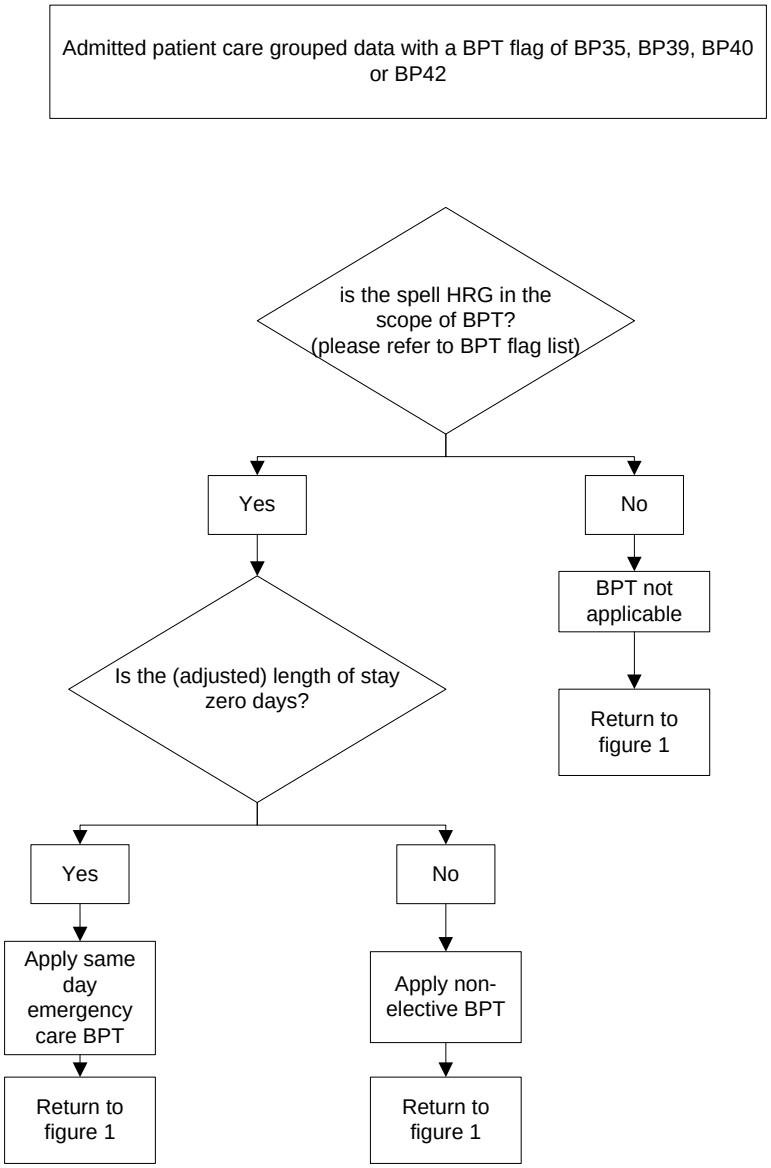
Annex A Figure 4e: Stroke best practice tariff



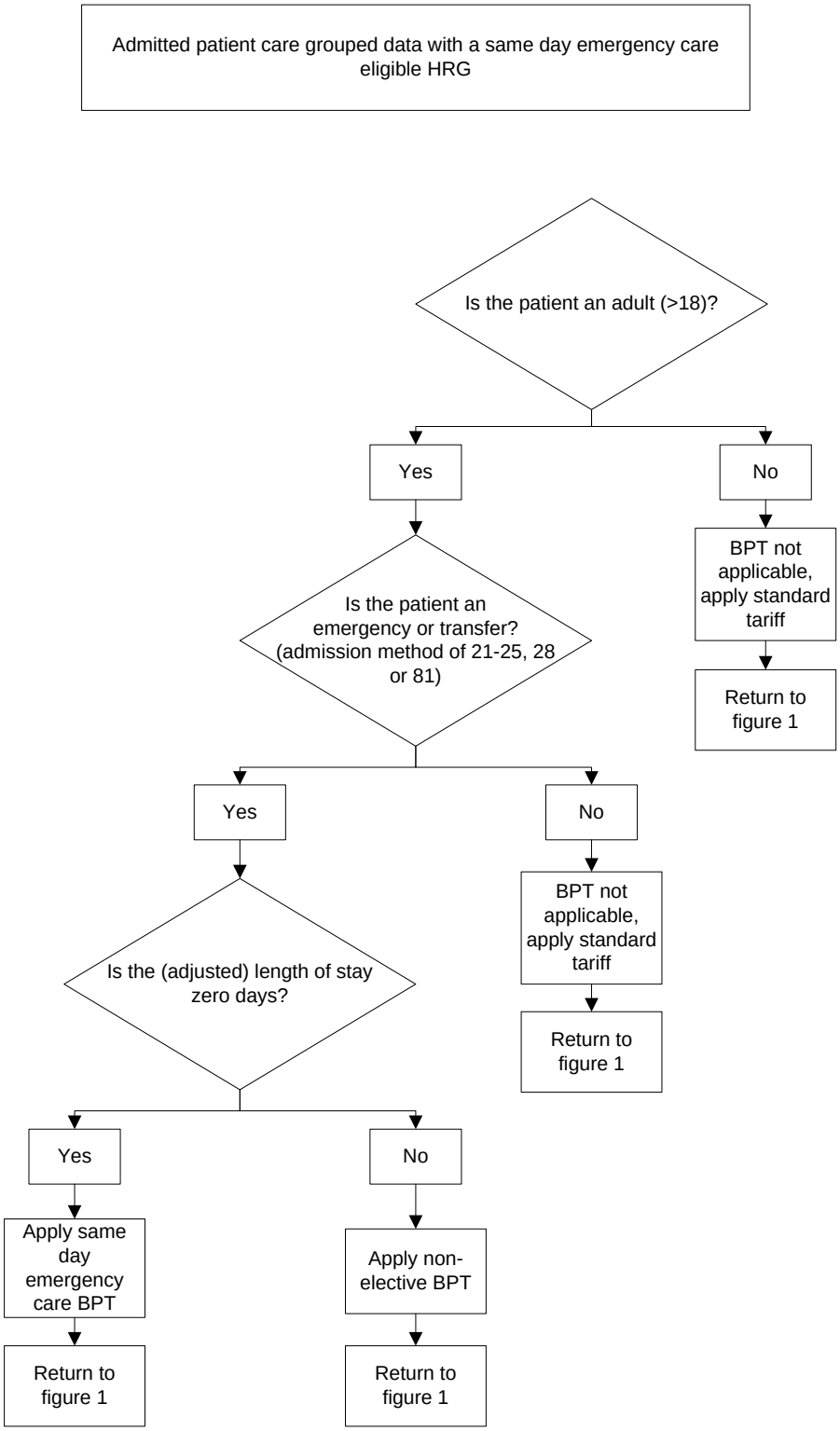
Annex A Figure 4f: TIA best practice tariff



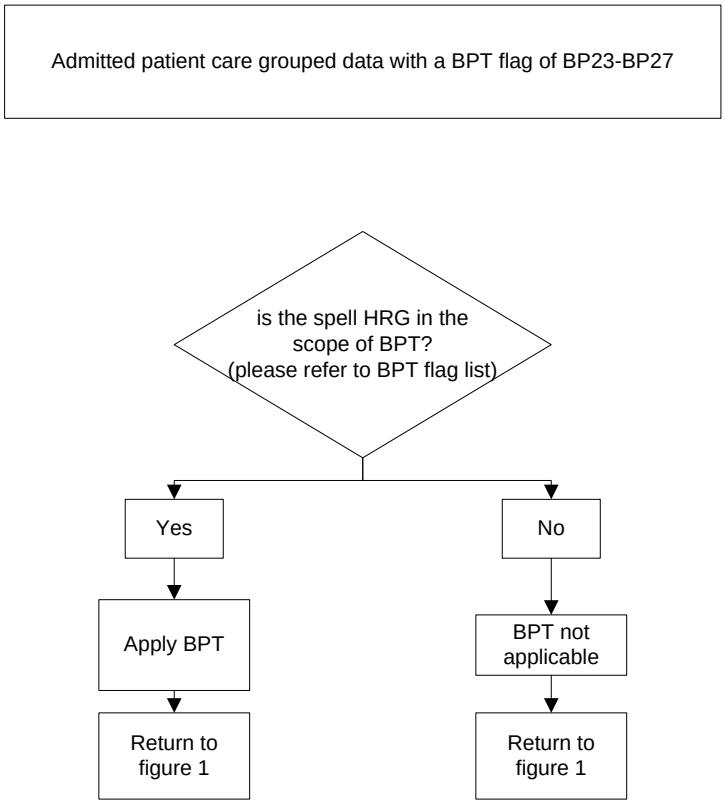
Annex A Figure 4g: Same day emergency care best practice tariffs – Flag



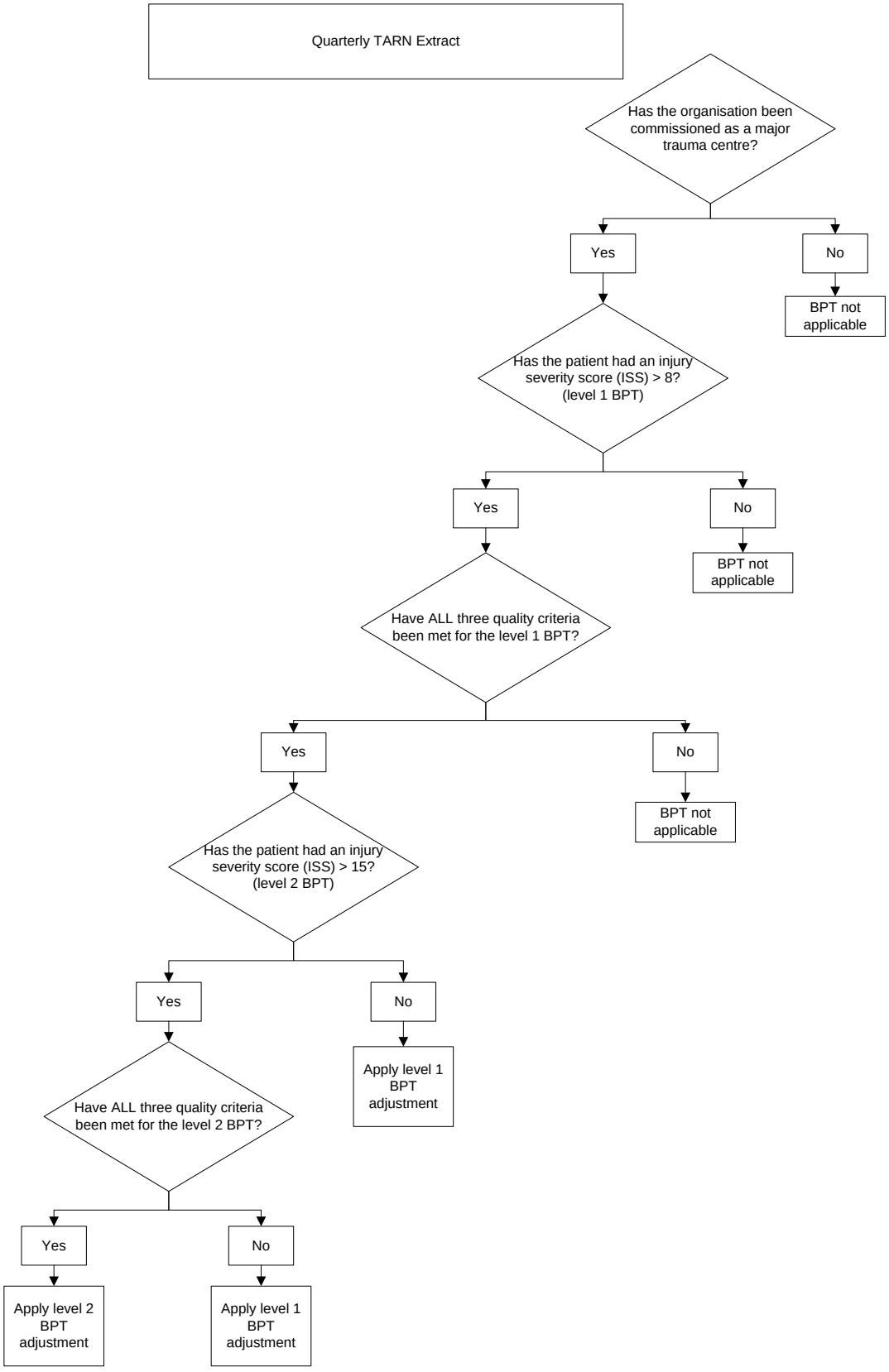
Annex A Figure 4h: Same day emergency care best practice tariffs – HRG



Annex A Figure 4i: Interventional radiology best practice tariffs



Annex A Figure 4j: Major trauma best practice tariff



Annex B: Coding guidance to generate BPTs for EVAR and UFE

Classification codes for EVAR

ICD-10 codes

I710 Dissection of aorta [any part]
I711 Thoracic aortic aneurysm, ruptured
I712 Thoracic aortic aneurysm, without mention of rupture
I713 Abdominal aortic aneurysm, ruptured
I714 Abdominal aortic aneurysm, without mention of rupture
I715 Thoracoabdominal aortic aneurysm, ruptured
I716 Thoracoabdominal aortic aneurysm, without mention of rupture
I718 Aortic aneurysm of unspecified site, ruptured
I719 Aortic aneurysm of unspecified site, without mention of rupture
I358 Other aortic valve disorders (Includes but is not limited to aneurysm of aortic valve)
Q254 Other congenital malformations of aorta (Includes but is not limited to congenital aortic aneurysm)
A520 Cardiovascular syphilis
I790 Aneurysm of aorta in diseases classified elsewhere

OPCS-4 codes

L271 Endovascular insertion of stent graft for infrarenal abdominal aortic aneurysm
L272 Endovascular insertion of stent graft for suprarenal aortic aneurysm
L273 Endovascular insertion of stent graft for thoracic aortic aneurysm
L274 Endovascular insertion of stent graft for aortic dissection in any position
L275 Endovascular insertion of stent graft for aortic aneurysm of bifurcation NEC
L276 Endovascular insertion of stent graft for aorto-uniiliac aneurysm
L278 Other specified transluminal insertion of stent graft for aneurysmal segment of aorta
L279 Unspecified transluminal insertion of stent graft for aneurysmal segment of aorta

Codes in category L27 require the addition of a code from O20 - Endovascular placement of stent graft to identify the number and type of stents used. If the type and number of stents is unknown, the code O209 Unspecified endovascular placement of stent graft should be assigned:

O201 Endovascular placement of one branched stent graft
O202 Endovascular placement of one fenestrated stent graft
O203 Endovascular placement of one stent graft NEC
O204 Endovascular placement of two stent grafts
O205 Endovascular placement of three or more stent grafts
O208 Other specified endovascular placement of stent graft

O209 Unspecified endovascular placement of stent graft

A supplementary code from category Y78 - Arteriotomy approach to organ under image control is assigned in addition to the codes given above to indicate that an arteriotomy has been performed under image control:

Y781 Arteriotomy approach to organ using image guidance with fluoroscopy
Y782 Arteriotomy approach to organ using image guidance with CT
Y783 Arteriotomy approach to organ using image guidance with ultrasound
Y784 Arteriotomy approach to organ using image guidance with image intensifier
Y785 Arteriotomy approach to organ using image guidance with video control
Y786 Arteriotomy approach to organ using image guidance with MRI control
Y788 Other specified arteriotomy approach to organ under image control
Y789 Unspecified arteriotomy approach to organ under image control

For example:

Insertion of one endovascular stent graft into infrarenal abdominal aortic aneurysm using fluoroscopic guidance via femoral artery incision would be coded:

L271 Endovascular insertion of stent graft for infrarenal abdominal aortic aneurysm
O203 Endovascular placement of one stent graft NEC
Y781 Arteriotomy approach to organ using image guidance with fluoroscopy

Classification codes for UFE

The new HRG for UFE is included in the Grouper. Activity will be grouped to this HRG for the following OPCS-4 codes.

Note: All three must be coded simultaneously for the Grouper to generate the UFE HRG.

L713 Percutaneous transluminal embolisation of artery
Y53 Approach to organ under image control (Fourth character is dependent upon which type of image control is used)
Z966 Uterine artery

Relevant references to OPCS-4.5 Clinical Coding Instruction Manual - EVAR

Guidance regarding OPCS-4.5 codes which relate to endovascular procedures for the treatment of aortic aneurysms and the codes that are used to specify the type and number of stents/stent grafts within these procedures, can be found on pages L-14 to L-15 and L-25 of the OPCS-4.5 Clinical Coding Instruction Manual (Version 3).

Further guidance on the assignment of additional codes to identify the approach used for operations on arteries and veins can be found on pages L-3, L-6, L-7, L-15, L-18 and L-28 of the OPCS-4.5 Clinical Coding Instruction Manual (Version 3).

Relevant references to OPCS-4.5 Clinical Coding Instruction Manual - UFE

Guidance that specifically relates to this procedure which includes an explanation of the procedure and how it should be coded can be found on page L-23 of the OPCS-4 Clinical Coding Instruction Manual (Version 3).

Annex C: Evidence base for interventional radiology and primary total hip and knee replacements BPTs

Interventional radiology evidence base

Abdominal EVAR is identified by NICE guidance (Technology Appraisal 167)[135] as a possible alternative to open surgery for patients diagnosed with abdominal aortic aneurysms where clinically appropriate, and where the aneurysm has not ruptured.

NICE guidance (Interventional Procedure Guidance 94)[136] states that UFE is "efficacious for symptom relief in the short and medium term" for women with uterine fibroids.

Thoracic EVAR is suggested as a "suitable alternative" to open surgery for patients with thoracic aortic aneurysms by NICE guidance (Interventional Procedure Guidance 127)[137]. As with other procedures, this is on the proviso that patients are appropriately selected.

NICE guidance (Interventional Procedure Guidance 156)[138] for 'vacuum assisted percutaneous excision of benign breast lesions' states that this procedure can "reduce the need for open surgical biopsy or excision". The guidance supports the use of this procedure to remove breast lesions which tests have shown to be benign.

Evidence of best practice for TIPS, angioplasty and stenting and many other IR procedures can be found in the National Imaging Board's report, 'Interventional Radiology: Guidance for Service Delivery'[139].

This report includes a literature review which states that "TIPS is the treatment of choice for portal hypertension".

The National Imaging Board's report also supports the use of angioplasty and stenting for PAD, and notes that the prevalence increases in patients with diabetes.

Primary total hip and knee replacements

Source of evidence: the enhanced recovery programme

The enhanced recovery programme (ERP) provides detailed information on the characteristics of best practice along the full patient pathway for hip and

[135] www.nice.org.uk/TA167
[136] http://www.nice.org.uk/IP20
[137] http://guidance.nice.org.uk/IPG127
[138] http://guidance.nice.org.uk/IPG156
[139] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122191.pdf

knee replacements (amongst other procedures). The ERP splits the enhanced recovery pathway into the following areas:

- Getting the patient in the best possible condition for surgery.
- Managing patients' expectations.
- Pre-referral from primary care: Optimising a patient's condition; identify peri-operative risk; and pre-operative assessment and preparation.
- Admission: Day of surgery admission; avoidance of pre-medication; nutrition; and avoidance of oral bowel preparation where appropriate.
- Ensuring the patient has the best possible management during their operation.
- Anaesthetic factors: Individualised goal-directed fluid therapy; use of anaesthetic agents; prevent hypothermia; effective opiate-sparing analgesia; and minimise the risk of post-operative nausea and vomiting.
- Surgical factors: Surgical techniques; laparoscopic surgery; minimise complications; minimise the use of drains; and minimise use of nasogastric tubes in abdominal surgery.
- Ensuring the patient has the best post-operative rehabilitation: Early nutrition; early mobilisation; removal of catheters as soon as possible following surgery; post-operative training and support; early planned discharge; and follow-up and support.

Further information on the ERP can be found at:
http://www.dh.gov.uk/en/Healthcare/Electivecare/Enhancedrecovery/index.htm

The ERP report, *Delivering enhanced recovery*, can be found at:
www.dh.gov.uk/publications

Source of evidence: British Orthopaedic Association's guides to good practice

The BOA have published guides to good practice for total hip and knee replacements. The guides cover the entire pathway from indications for referral for the operation to follow-up of patients. Both guides can be downloaded from BOA website:
http://www.boa.ac.uk/site/showpublications.aspx?ID=59

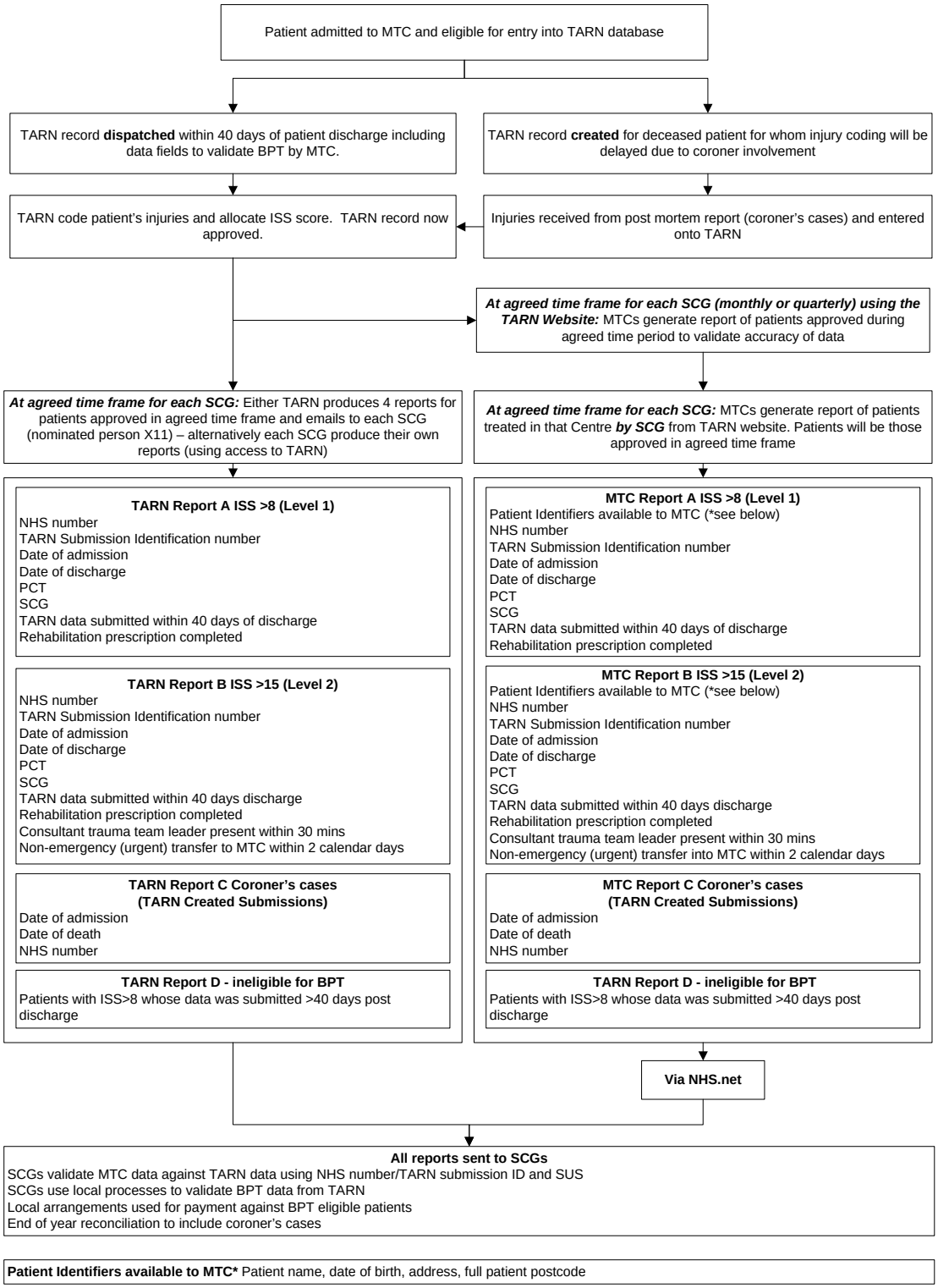
Source of evidence: NHS Institute

The NHS Institute's report, *Focus on: Primary Hip and Knee Replacement*, identified a range of clinical factors which are considered best practice, for example:

- day of surgery admission.
- early mobilisation.
- patient preparation leading to realistic patient expectations.
- postoperative pain management.

The report can be found at:
http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,191.html

Annex D: flow of information to enable validation of major trauma best practice



Annex E: NHFD reports for the fragility hip fracture best practice tariff

Roles and responsibilities

NHFD

- Ensure data is collected in a safe environment
- Determine responsible commissioner prior to generating the on-line report
- Produce quarterly on-line reports for commissioners and providers (report content detailed below)
- Ensure that registered users are notified when the report is available
- Undertake random trend analysis to monitor integrity of data

Commissioners

- Access report from NHFD database when available
- Link NHFD data to SUS-PbR data to validate BPT qualification
- Ensure that additional payments are made to those cases that meet the BPT criteria
- Resolve any queries about the data with relevant provider

Providers

- Ensure quality and integrity of NHFD data recorded – this will be the responsibility of the NHFD lead clinician for the provider.
- Confirm the BPT on-line report is correct prior to releasing to commissioners
- Liaise with commissioners to resolve any queries and solve any problems

NHS Information Centre

- Issuing user name and passwords to commissioner data representatives
- Linkage of NHS numbers to responsible commissioners

PbR

- Coordinating requests from commissioners for access to NHFD report
- Coordinating any queries from commissioners regarding the reporting process notified through pbrcomms@dh.gsi.gov.uk

Ongoing BPT-NHFD provider report

This report is continuously available to hospitals and includes patients that have been discharged by quarter. It includes the following fields:

- Hospital number
- Patient name
- NHS number
- Hours to surgery

- Orthopaedic GMC number
- Geriatrician GMC number
- Admitted using a jointly agreed assessment protocol (Yes/No)
- Geriatrician grade (Consultant, SAS or ST3+)
- Hours to geriatrician assessment
- Multidisciplinary rehabilitation team assessment (Yes/No)
- Specialist falls assessment
- Bone protection medication
- BPT uplift qualification (Yes/No)

BPT-NHFD provider report

This report is created quarterly after matching to commissioners. It is intended to give the providers a way of viewing the data to be sent to the commissioners in the same format as the commissioners will receive it. It includes the following fields:

- Hospital number
- Patient name
- NHS number
- PCT
- Surgery within 36 hours (Yes/No)
- Orthopaedic GMC number and geriatrician GMC number (Yes/No)
- Admitted using a jointly agreed assessment protocol (Yes/No)
- Geriatrician grade (consultant, SAS or ST3+) and assessment within 72 hours (Yes/No)
- Multidisciplinary rehabilitation team assessment (Yes/No)
- Specialist falls assessment and bone health assessment (Yes/No)
- BPT additional payment qualification (Yes/No)

BPT-NHFD commissioner report

This report will be sorted by hospital and include the following fields:

- Hospital name
- NHS number
- Date and time of A&E admission
- Date and time of surgery
- Surgery within 36 hours (Yes/No)
- Orthopaedic GMC number and geriatrician GMC number (Yes/No)
- Admitted using a jointly agreed assessment protocol (Yes/No)
- Geriatrician grade (consultant, SAS or ST3+) and assessment within 72 hours (Yes/No)
- Multidisciplinary rehabilitation team assessment (Yes/No)
- Specialist falls assessment and bone health assessment (Yes/No)
- BPT additional payment qualification (Yes/No)

Annex F: Example for cystic fibrosis banding

Step one: define the value for each criteria

The values for Patient A are:

FEV_1% predicted lung function	75%
Maximum number of total days of IV antibiotics	12
Nebulised antibiotics (*Pseudomonas* infection)	Yes
Long-term (>3 months) nebulised antibiotics OR DNase	No
Long-term (>3 months) nebulised antibiotics AND DNase	No
Maximum numbers of days in hospital	7
Nasogastric feeds	Yes
Gastrostomy	No
CF Related Diabetes OR ABPA w/o other complications	Yes
CF Related Diabetes AND ABPA	No
Massive Haemoptysis OR Pneumothorax	No
CF Related Diabetes AND Gastrostomy	No
Non Tuberculous mycobacterium treated or difficult to treat infections (MRSA)	No

Step two: determine the band for each criteria using the CF banding matrix:

Banding definitions		Band						
		1	1A	2	2A	3	4	5
Therapies	Maximum number of total days of IV antibiotics	0	14	28	56	84	112	≥113
	Nebulised antibiotics (*Pseudomonas* infection)		Yes					
	Long-term (>3 months) nebulised antibiotics or DNase			Yes				
	Long-term (>3 months) nebulised antibiotics and DNase				Yes			
Hospitalisations	Maximum numbers of days in hospital	0	7	14	14	57	112	≥113
Supplemental feeding	Nasogastric feeds				Yes			
	Gastrostomy					Yes		
Complications	CF Related Diabetes or ABPA w/o other complications				Yes			
	CF Related Diabetes and ABPA					Yes and (FEV_1 ≥60%)	Yes and (FEV_1 <60%)	
	Massive Haemoptysis or Pneumothorax					Yes and (FEV_1 ≥60%)	Yes and (FEV_1 <60%)	
	CF Related Diabetes and Gastrostomy					Yes and (FEV_1 ≥60%)	Yes and (FEV_1 <60%)	
	Non Tuberculous mycobacterium treated or difficult to treat infections (eg MRSA or Cepacia) requiring other nebulised antibiotics eg Meropenem, Cayston , Vancomycin.					Yes		

It is to be expected that the criteria will fit multiple bands. In our example, patient A is eligible for bands 1, 1A and 2A.

Step three: allocate the patient to their highest band

In our example, patient A is allocated to band 2A. This process is repeated for each patient. The process is automated by extracting data from the Cystic Fibrosis Registry and feeding it into a template that produces the banding.

Annex G: Example of a MOU for managing the introduction of care clusters

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is made on ____ of _____ 2010 **between ……** ("the Commissioners") and……. ("the Providers")

The Providers and Commissioners agree to work together in order to

- Jointly develop and implement the proposed currency model from the Care Pathways and Packages Consortium, to support and inform currency development across the consortium and as part of the national roll out of its implementation.
- Jointly develop a costing approach for the currency in keeping with national costing requirements.
- Utilise the currency for benchmarking and analysis of current service activity and future service developments.
- Explore options for utilisation in contracting and for development of a tariff for mental health services, including assessing the implications of practical implementation of each option to inform developments across the Consortium and the development of PbR for Mental Health.
- Develop shadow pricing to road test the preferred currency option. This will be run in tandem with existing contract data collection for a shadowing period for an agreed number of months and will require the agreement of both parties prior to replacing existing commissioning arrangements ahead of any national timescales.
- Ensure that the implementation of national PbR policy is effectively managed locally across the North East and maximize local influence over the development of national policy including engagement of local authorities and other relevant stakeholders.

Within this group it is agreed that:

- Information pertaining to currency development within the N.E. will be shared openly between all parties on a confidential basis and for the sole use of currency development unless agreed by all parties.
- Nothing will be implemented on the basis of information shared unless the underpinning data quality has been assured by all parties or nationally mandated.

- Any mechanisms for the implementation and management of contracting for the new currency will be jointly agreed prior to implementation.
- There will be no change to existing contracting arrangements unless agreed by all parties or directed by national policy.
- Any strategic commissioning intentions based on the currency model will be shared openly between all parties on a confidential basis and for the sole use of currency development unless agreed by all parties.
- Partners to this agreement will work to make transparent any approaches or agreements to mitigate against inappropriate or unnecessary financial pressures upon mental health services.

Annex H: Summary of actions to be taken

By April 2012

Commissioners and providers should work together to:

- Confirm what is within and what is outside the clusters;
- Develop and use a Memorandum of Understanding to support joint working and risk sharing;
- Agree a risk share mechanism for 2012/13, which will have a cost neutral impact in 2012/13;
- Share initial cluster data, understanding that there may be quality issues around the data;
- Agree the process for costing clusters and assessments based on the current version of the national PbR guidance;
- Agree indicative costs per cluster per day, and how these are used to set prices;
- Agree an activity plan that specifies the level of activity expected on a cluster basis;
- Agree quality and outcome metrics for 2012/13;
- Agree a set of data to flow locally, and use of the Mental Health Minimum Dataset (MHMDS) v4.0, that enables monitoring of:
    - Initial assessments completed and outcome
    - Numbers in cluster
    - Duration in cluster
    - Numbers in cluster 0, characteristics, and outcomes
    - Numbers detained under the Mental Health Act with cluster allocation
    - Treatment episode and review duration
    - Discharges
    - Percentage of reviews undertaken in accordance with cluster protocols
    - Quality and outcomes metrics
- Agree whether any Commissioning for Quality and Innovation (CQUIN) will be linked into the currency model
- Agree a work programme for 2012/13 to include developing and testing more comprehensive currency models

Providers should:

- Ensure all clinical staff are trained and cluster all new and current service users
- Ensure all clinical staff apply the care transition protocols for all new referrals and reviews
- Ensure staff record Mental Health Clustering Tool (MHCT) scores at discharge – but do not cluster
- Ensure that financial staff can cost the clusters, apply the principles of the mental health costing standards and NHS costing handbook;
- Put in place internal processes to quality assure the clustering data

- Ensure that local IT systems and staff are prepared for the introduction of the new currencies;
- Start to develop packages of care associated with each cluster

Commissioners should:

- Review and map service specifications to clusters and redraft if required, redefine quality standards and information flows
- Clarify the models of commissioning
- Confirm access and use of MHMDSv4.0 and familiarise themselves with the dataset
- Engage with Clinical Commissioning Groups

SHAs should:

Facilitate or deliver to each PCT cluster a package of support to ensure preparedness for April 2012 and plan and implement further development during 2012-13.

Actions to be taken in 2012-13 and beyond

Commissioners and providers together should:

- Jointly review the quality and outcome metrics collected, as recommended in the quality and outcomes reports and agree how these will be used locally as a measure of quality
- Agree joint plans for the use of PROMS and the choice of questionnaire
- Develop joint plans for how users and carers are involved in all the developing processes
- Develop joint communication plans on care packages outcomes and for users and carers
- Agree a data improvement plan for 2012/13 and onwards
- Assess current delivery against ideal delivery models
- Develop a programme to deliver NICE guidance
- Review the opportunities for innovation and creative plans in current services
- Look at how risks should be shared in 2013/14

Providers should:

- Ensure all service users are clustered accurately at the appropriate times
- Ensure all new clinical staff are trained in use of the metal health clustering tool, and there is in-going training for existing staff
- Embed re-assessment and the transition protocols within routine practice

- Develop and implement systems to review the robustness of cluster allocation which can be shared with commissioners
- Consider the opportunities presented by PbR for service innovation
- Complete development of care packages for each cluster which reflect best practice, building on NICE guidance
- Ensure that data is submitted to MHMDS in a timely manner
- Develop systems to record what is delivered for each user
- Use data collected to provide feedback to users, clinicians, and to commissioners, and to monitor service delivery
- Monitor and report against agreed outcome measures and quality indicators, including PROMS
- Improve the accuracy of costing clusters (models for costing are already available) and running data
- Ensure buy-in for the costing approach from commissioners
- Develop costing information for assessments

Commissioners, care cluster groups and local authorities should:

- Look at risk sharing up to 2014/15 through pooling resources and managing risks
- Share data, building costing confidence from 2012 onwards
- Review potential perverse incentives, developing and taking action to mitigate these
- Begin an analysis of population needs by cluster, building on the joint strategic needs assessment (JSNA), working with the Health and Wellbeing Boards.
- Develop and agree service specifications for clusters
- Review quality standards and information flows.
- Use MHMDS
- Collect and analyse information, data and collaboration including
    - the 2011/12 pattern of service use
    - the number of people in each cluster
    - developing current outcomes data
    - user flows within services, and step up and down rates achievement of quality indicators and outcome measures, and test funding system based on outcomes
    - ensuring data supplied by providers is reviewed and analysed and used within the overall commissioning process
- developing benchmarking plans that enable the commencement of comparisons of cluster price, care package content, and achievement of quality indicators and outcome measures.

DH will:

- Monitor and review progress in implementing mental health PbR currencies to inform moving towards a future national tariff
- Ensure SHAs continue to support PCT clusters and clinical commissioning groups to support further development of the system

- Work to try and bring NHS and social care assessment structures together, supporting both PbR and personalisation
- Work with the NHS to look at costs for each pathway in more detail and identify particular cost pressures and any perverse incentives

Annex I: Emergency readmission review proforma

Section 1 - Demography

1. NHS number……..

2. Age at readmission (years)…….

3. Gender: M F

Section 2 - Initial admission

4. Date of original admission…….

5. Date of original discharge….....

6. Initial admission Elective □ Non Elective □

7. Discharged from which specialty:

……

8. Primary diagnosis

……

and Comorbidities:

Acute myocardial infarction		□
Cerebral vascular accident		□
Congestive heart failure		□
Connective tissue disorder		□
Dementia	□	
Diabetes		□
Liver disease	□	
Peptic ulcer	□	
Peripheral vascular disease		□
Pulmonary disease	□	
Cancer		□
Diabetes complications		□
Paraplegia	□	
Renal disease		□
Metastatic cancer		□
Severe liver disease		□
HIV	□	

Other – please specify……

9. Did patient self discharge No □ Yes □

10. Where did the patient get discharged to:

Own home □ Residential care □ Comm hospital □
Respite care □ Intermediate care □ Tertiary specialist hospital □
Nursing home □

11. Was there any planned follow-up:

Primary □ Secondary □
Community □

Section 3 - Readmission details

12. Date of readmission……..

13. How was the patient readmitted:

Readmission route: A&E □ GP □ Out Of Hours GP □
Clinic □ Clinical Decision Unit (or similar) □

14. Where from:

Own home □ Residential care □ Comm hospital □
Respite care □ Intermediate care □ Tertiary specialist hospital □
Nursing home □ Clinic □

15. Reason for readmission – what happened? – tick any that apply

Same diagnosis □

New episode □

Deterioration of condition □

No change but carer concern □

Complications from original admission □

Surgical site infection □

Other infection □

Medication adverse reaction □

Other □

Unrelated illness/different diagnosis □

Poor discharge plan □

Failure of communication □

Relapse of long term condition □

End of life care □

Not a readmission (coding error) □

Non compliance with medication □

Risky discharge (hospital choice) □

Other – please specify

……
……

If new unrelated illness/different diagnosis please specify

……
……

16. Any social factors in readmission – tick any that apply:

Failure of planned community health services at home (DN/CRT etc) □

Failure of planned social care services at home (package of care) □

Lack of response/capacity in intermediate care □

Lack of response/capacity in social care □

Failure to adhere to agreed care plan □

Failure in communication □

Other…… □

Risky discharge (patient choice) □

17. How many times has this patient been admitted in the last 6 months

……

18. Was there an intervention that could have prevented readmission?

……

……

19. What do the review team consider caused this readmission?

……

……

20. In the opinion of the review team, was this readmission avoidable by the actions of any health or social care organisation?

Yes □ No □