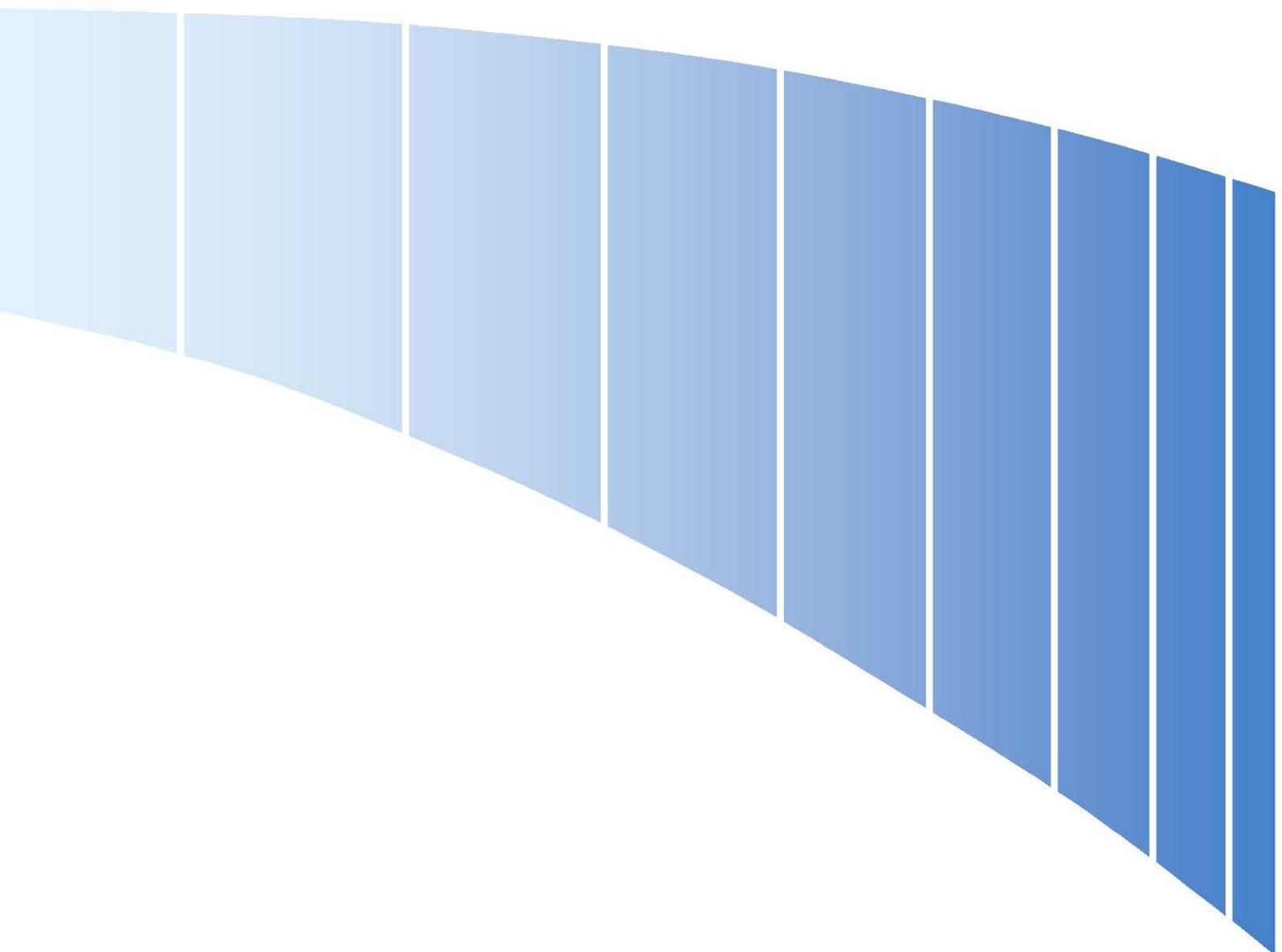


Payment by Results Guidance for 2013-14



DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Action
Gateway Reference	18768
Title	Payment by Results Guidance for 2013-14
Author	Department of Health Payment by Results team
Publication Date	28 February 2013
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Allied Health Professionals, Communications Leads
Circulation List	GPs
Description	This guidance supports planning for the implementation of Payment by Results in 2013-14
Cross Ref	Code of Conduct for Payment by Results in 2013-14
Superseded Docs	Payment by Results Guidance for 2012-13
Action Required	N/A
Timing	
Contact Details	Payment by Results team Department of Health Quarry House Quarry Hill Leeds LS2 7UE pbrcomms@dh.gsi.gov.uk
For Recipient's Use	

Contents

List of tables.....	7
List of figures.....	8
List of abbreviations	9
Section 1: Introduction	11
Purpose.....	11
Main changes in 2013-14	12
Incentivising quality and better outcomes for patients	12
Embedding efficiency and value for money within the tariff	13
Promoting integration and patient responsiveness	13
Expanding the scope of PbR	14
Other changes	14
Tariff information spreadsheet.....	15
Scope of the national mandatory tariff.....	15
Tariff adjustment.....	15
Clinical negligence scheme for trusts	16
Clinical audits	18
Help and advice.....	18
Section 2: Classification, currency and grouping	20
Currency.....	20
Classification	20
Grouping.....	21
Data stages	22
PbR pre-processing stage	23
Grouping stage	24
PbR post-grouping stage	24
PbR adjustments stage.....	24
Section 3: Admitted patient care	25
Structure.....	25
Elective care.....	25
Marginal rate emergency tariff.....	26
Short stay emergency adjustment.....	31
Long stay payment	32
Specialised services.....	33
Zero price	35
No tariff price	35
Emergency readmissions	35
Section 4: Post discharge tariffs.....	40
Introduction.....	40
Implementation of post discharge tariffs.....	40
Cardiac rehabilitation post discharge tariff	41
Pulmonary rehabilitation post discharge tariff.....	42
Hip replacement	42
Knee replacement	43
Recovery, Rehabilitation and Reablement (RRR)	44
Section 5: Outpatient care	45
Structure.....	45
Procedures in outpatients.....	46

Outpatient attendances	47
Introduction	47
Consultant led and non-consultant led.....	48
First and follow-up attendances	48
Multi-professional and multi-disciplinary	49
Diagnostic imaging in outpatients	51
Pre-operative assessments	57
Zero price	57
Section 6: Direct Access	58
Introduction.....	58
Direct access diagnostic imaging	58
Direct access simple echocardiograms	58
Airflow studies	58
Flexible sigmoidoscopies	59
Section 7: Urgent care	60
Accident and emergency services.....	60
Section 8: Best practice tariffs.....	61
Introduction.....	61
General guidance	61
Summary of BPT package	62
Pricing approach for appropriate setting BPTs	64
Acute stroke care	65
Adult renal dialysis	68
Cataracts.....	73
Day case procedures	76
Diabetic ketoacidosis and hypoglycaemia.....	79
Early inflammatory arthritis.....	81
Endoscopy procedures.....	85
Fragility hip fracture.....	87
Interventional radiology	90
Major trauma	92
Outpatient procedures.....	94
Paediatric diabetes.....	97
Paediatric epilepsy	100
Parkinson's disease	102
Pleural effusion.....	104
Primary total hip and knee replacements	106
Same day emergency care	108
Transient ischaemic attack.....	112
Section 9: Exclusions.....	116
Introduction.....	116
Excluded services	117
Cancer multi disciplinary teams	118
Excluded procedures.....	118
Soft tissue sarcoma surgery	118
Pelvic reconstructions.....	119
Head and neck reconstructive surgery	120
Intracranial telemetry	121
Balloon assisted enteroscopy	121
Excluded HRGs.....	121

Excluded TFCs.....	122
Excluded drugs.....	122
Excluded devices	125
Section 10: Pathway payments.....	128
Maternity pathway payment.....	128
Cystic fibrosis	139
Section 11: Chemotherapy and radiotherapy.....	146
Chemotherapy.....	146
Radiotherapy	150
Section 12: Other currencies and non-mandatory prices	154
Introduction.....	154
Specialist rehabilitation	155
Health Assessments for Looked After Children (LAC).....	160
Ambulance services	160
Critical care	165
HIV adult outpatient services.....	167
Renal Transplantation	169
Acute phase of rehabilitation	173
Adult hearing services	175
Neurology and neurosurgery	175
Non face-to-face outpatient attendances.....	176
Direct access plain film x-rays	176
Cochlear implants.....	176
Transcatheter Aortic Valve Implantation (TAVI)	176
Genito-urinary medicine outpatient attendances	176
Any Qualified Provider.....	177
Assistive technology - telehealth and telecare.....	177
Section 13: Flexibilities	178
Introduction.....	178
Section 14: Other operational issues	188
Market forces factor.....	188
Monthly reporting.....	188
Non-contract activity.....	189
Devolved administrations	190
Never events	193
NHS number.....	193
Annex A Figure 1: Admitted patients.....	195
Annex A Figure 1a: Best practice tariffs.....	196
Annex A Figure 1b: Emergency readmissions rule	197
Annex A Figure 1c: Emergency readmissions rule and transfers.....	198
Annex A Figure 1d: Emergency readmissions and exclusions	199
Annex A Figure 1e: Short stay emergency adjustment.....	200
Annex A Figure 1f: Long stay payments	201
Annex A Figure 1g: Specialised services top-ups	202
Annex A Figure 1h: Home births.....	203
Annex A Figure 2: Outpatients.....	204
Annex A Figure 2a: Outpatient attendance HRG	205
Annex A Figure 3: A&E	206
Annex A Figure 4a: Cataracts best practice tariff.....	207
Annex A Figure 4b: Day case best practice tariffs	208

Annex A Figure 4c: Fragility hip fracture best practice tariff	209
Annex A Figure 4d: Stroke best practice tariff	210
Annex A Figure 4e: TIA best practice tariff	211
Annex A Figure 4f: Same day emergency care best practice tariffs.....	212
Annex A Figure 4g: Major trauma best practice tariff	213
Annex A Figure 4h: Interventional radiology best practice tariffs	214
Annex B: Coding guidance to generate BPTs for EVAR and UFE	215
Annex C: Evidence base for interventional radiology and primary total hip and knee replacements BPTs	218
Annex D: Flow of information to enable validation of major trauma best practice	221
Annex E: NHFD reports for the fragility hip fracture best practice tariff.....	222
Annex F: Emergency readmission review proforma.....	224
Annex G: Processing diagnostic imaging data.....	228
Annex H: Health Assessment for Looked after children checklist tool	230

List of tables

Table 1: 2013-14 net price adjustment.....	16
Table 2: Apportioning CNST costs to HRGs	17
Table 3: Applying PbR rules to patient data	22
Table 4: Tariff type and CDS	23
Table 5: Short stay emergency adjustment percentages	31
Table 6: Specialised service top-ups	34
Table 7: Zero price HRGs	35
Table 8: Zero price outpatient TFCs	57
Table 9: Summary of BPT package	63
Table 10: National Renal Dataset fields Renal care.....	70
Table 11: Cataracts pathway	73
Table 12: Day case BPT areas	78
Table 13: Early inflammatory arthritis BPTs.....	82
Table 14: Interventional radiology procedures in BPT programme	90
Table 15: Achievable and estimated outpatient rates for diagnostic hysteroscopy and cystoscopy	96
Table 16: Same day emergency care clinical scenarios	112
Table 17: Definition of soft tissue sarcoma surgery procedure exclusion	119
Table 18: Definition of pelvic reconstruction procedure exclusion.....	120
Table 19: Changes to the 2012-13 device exclusion list.....	126
Table 20: Maternity pathway payments	129
Table 21: Guide prices for activity at other providers	132
Table 22: Proportion of pathway tariff to refund or transfer on change of pathway provider	133
Table 23: Chemotherapy delivery HRGs	147
Table 24: Payment arrangements for chemotherapy HRGs	149
Table 25: Treatment of hormonal therapies and high cost supportive drugs	150
Table 26: Payments for external beam radiotherapy	152
Table 27: Adult critical care benchmark data	166
Table 28: Neonatal critical care benchmark data.....	166
Table 29: High volume activity most likely to be carried out in different sectors and settings	185
Table 30: Monthly reporting dates.....	189
Table 31: Charges for emergency treatment outside of contracts.....	191

List of figures

Figure 1: Model of managing patients suitable for ambulatory emergency care	109
Figure 2: Quality markers from the National Stroke Strategy	114
Figure 3: Chemotherapy payment arrangements.....	148
Figure 4: Levels of specialised and specialist rehabilitation service.....	156
Figure 5: Summary of ambulance PbR patient and payment pathways.....	163
Figure 6: Renal transplantation pathway.....	170

List of abbreviations

A&E	Accident and emergency
AEC	Ambulatory emergency care
AHP	Allied Health Professional
BADS	British Association of Day Surgery
BNF	British National Formulary
BPT	Best practice tariff
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
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised tomography
DH	Department of Health
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
HRG	Healthcare resource group
HTCS	Healthcare travel cost scheme
HSCIC	Health & Social Care Information Centre
ICD	International classification of diseases
ISB	Information Standards Board
ISTC	Independent sector treatment centre
LHB	Local health board
MFF	Market forces factor
MIU	Minor injury unit
MRI	Magnetic resonance imaging
MSC	Main speciality codes
NAO	National Audit Office
NCA	Non contract activity
NHFD	National hip fracture database
NHS	National Health Service
NHS CB	NHS Commissioning Board
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
PETCT	Positron emission tomography computed tomography
PROMs	Patient reported outcome measures
PTS	Patient transport services
QALY	Quality adjusted life year
SCG	Specialist commissioning group
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
UKROC	UK Rehabilitation Outcomes Collaborative
UKRR	UK Renal Registry

Section 1: Introduction

Purpose

1. This guidance provides information to support the operation of Payment by Results (PbR) in 2013-14. It should be used alongside the following¹:
 - a) *2013-14 tariff information spreadsheet*
 - b) *Code of Conduct for PbR 2013-14* – 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 2013-14 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 2013-14* – comprehensive guidance on the application of the MFF in PbR
 - e) *PbR Q&A for 2013-14* – questions and answers to complement the issues covered in this guidance
 - f) *Guidance for the implementation of SUS PbR from April 2013*².
2. Newcomers to PbR might like to begin with *A simple guide to Payment by Results*.³
3. Please note that guidance on mental health PbR in 2013-14 is published separately.⁴
4. Under the terms of the Health and Social Care Act 2012, responsibility for currency and tariff design and price-setting for 2014-15 and beyond rests with the NHS Commissioning Board and Monitor. The Department has worked with both organisations in the production of this PbR guidance for 2013-14, with the aim of providing a sound platform for the future development of the payment system.
5. As part of the work arising from the NHS Chief Executive's *Innovation, Health and Wealth* review, the NHS Institute for Innovation and Improvement has created a range of informative case studies in collaboration with NHS commissioners and providers. A number of the case studies show how local health economies have successfully used tariff flexibilities to support innovation. Additional examples show how commissioners and providers have developed innovative care pathways, introduced new technologies and negotiated local prices. Whilst some of these services are outside the scope of mandatory national tariff, these case studies nonetheless provide useful insights into the change

¹ <http://www.dh.gov.uk/pbr>. *PbR Q&A for 2013-14* document planned for publication in March or April 2013

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/health/2012/11/pbrguide/>

⁴ <http://www.dh.gov.uk/pbr>

processes adopted and the benefits achieved. To see these case studies, along with good practice guidance and other useful links, please visit the NHS Institute for Innovation and Improvement's High Impact Innovations website⁵ and click on the relevant link.

Main changes in 2013-14

6. The main changes to note are covered in this section. There are important changes to note such as the introduction on a mandatory basis of the maternity pathway payment system and the setting of separate tariffs for diagnostic imaging, the costs of which have been previously included in the outpatient attendance tariffs. In addition, there have been changes in the underpinning healthcare resource group (HRG) structure, further information on which can be found on the Health and Social Care Information Centre's (HSCIC) website.⁶
7. PbR arrangements for 2013-14 build on the changes made in recent years 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

8. We are further expanding the **best practice tariff** programme (Section 8: Best practice tariffs). Findings from the evaluation of these tariffs indicate that the policy is delivering real improvements in the quality of care that patients receive. In 2013-14 we will further expand the number of best practice tariffs aimed at:
 - Promoting better management of long term conditions to reduce the risk of avoidable hospital admissions
 - Delivering care in appropriate settings, with further tariffs set to incentivise day case and outpatient treatments where clinically appropriate
 - Improving the quality of endoscopy services by linking payment to accreditation.
9. We are rolling forward existing best practice tariffs, but with revisions to:
 - a) **Cataract surgery** (paragraph 341) – in 2013-14 this best practice tariff will be non-mandatory. We have changed the status from mandatory to alleviate any undue administrative burden on those commissioners for whom the benefits are outweighed by the costs.
 - b) **Hip and knee replacement** (paragraph 527) – under the 2012-13 tariff arrangements we removed the estimated cost of one day's

⁵ <http://innovault.innovation.nhs.uk>

⁶ <http://www.ic.nhs.uk/casemix/payment>

stay in hospital (£240) to incentivise a move from the average six-day to the best practice five-day length of stay. We have amended the price for 2013-14 to reflect the fact that reported costs are now in line with a five-day length of stay, which is what the best practice tariff was designed to promote.

10. We are making **diagnostic imaging in the outpatient setting** subject to separate tariffs, rather than 'bundling' the costs into the attendance tariffs (paragraph 221). The diagnostic imaging tariffs will apply even where the outpatient attendance is outside the scope of the mandatory tariff. We are making this change to support early diagnosis and efficient pathways for patients.
11. We recognise the potential financial risks associated with this change, and the additional administrative effort that may be needed, so we have provided guidance which is designed to assist providers and commissioners (paragraph 233).

Embedding efficiency and value for money within the tariff

12. We are maintaining the approach first 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 115).
13. 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 84)
 - b) further increasing the number of mandatory outpatient procedure HRG tariffs (paragraph 188).

Promoting integration and patient responsiveness

14. After a year in which organisations have been expected to 'shadow' run the **maternity pathway payment system**, its use will be mandatory for contracting from April 2013 (paragraph 630). There are mandatory tariffs for the ante natal, delivery and post natal elements of the pathway. We recognise however that implementation of the new system may present a challenge for some organisations, and so we have set out in guidance a flexible approach to the implementation of the new system in 2013-14.
15. We will continue the policy of non-payment for some **emergency readmissions** (paragraph 136), with the savings being invested to support rehabilitation, reablement and the prevention of readmission. We are not requiring new clinical reviews of readmissions to be undertaken, unless providers or commissioners wish to do so, for example to reflect a change in trend.

Expanding the scope of PbR

16. We will complete the transition to a **year-of-care tariff for cystic fibrosis** (paragraph 704). Following the introduction of mandatory currencies in 2012-13, we are now introducing mandatory tariffs for **chemotherapy delivery** (paragraph 736) and **external beam radiotherapy** (paragraph 755). We recognise that the move from local to national prices may represent a significant change for some organisations, and so we have set out in this guidance document a staged approach to the implementation of these tariffs in 2013-14.
17. We are introducing mandatory currencies for **HIV adult outpatient services, specialist rehabilitation, renal transplants** and some **health assessments for out of area looked-after children** (paragraph 808).

Other changes

18. We are introducing a more 'granular' **A&E tariff** in 2013-14, with separate prices for all 11 HRGs rather than grouping HRGs into five price bands as is the case in 2012-13.
19. We are moving from a single to a two-tiered **specialist top-up payment for children's services** in 2013-14, to recognise different levels of specialisation. The new top-up levels will be 64% and 44%, though we are maintaining the overall value of the current children's top-up. There are also separate chapter-level long stay payments for children-specific HRGs.
20. We have improved the section of the guidance relating to **patient or procedure selection** (also known as 'cherry picking') (paragraph 924). We have provided a list of procedures which may be prone to patient selection, with the intention being to give commissioners and providers a starting point for discussions about ensuring that a fair price is paid for the services being provided.
21. We are setting non-mandatory tariffs in 2013-14 for **cochlear implants** in recognition of possible changes in procurement arrangements for these devices.
22. The Health and Social Care Information Centre will make available an algorithm to enable commissioners and providers to determine whether or not a particular treatment is commissioned by the NHS Commissioning Board. In the meantime, we understand that specialised commissioning colleagues are providing a tool to be used locally before the algorithm is available.

Tariff information spreadsheet

23. This guidance should be used alongside the *2013-14 tariff information spreadsheet* which contains:
- i. 2013-14 national mandatory tariffs – for admitted patient care, outpatient procedures and attendances, accident and emergency (A&E), diagnostic imaging in outpatients, best practice tariffs, unbundled services, maternity pathway tariffs, cystic fibrosis pathway tariffs, direct access tariffs and post discharge tariffs
 - ii. 2013-14 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. 2013-14 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. expected Local Payment Grouper changes and reference cost Grouper changes

Scope of the national mandatory tariff

24. The national mandatory tariff plus an adjustment for MFF is payable by commissioners for day cases, regular attenders, 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.
25. 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.
26. The 2013-14 tariff is based on 2010-11 NHS reference costs⁷. Some activity remains outside the scope of the mandatory tariff and is subject to local price negotiation.

Tariff adjustment

27. Table 1 sets out the efficiency requirement and tariff adjustment for 2013-14. The national efficiency requirement is –4% and pay and price

⁷ <http://www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/nhs-costing/>

inflation is assessed at +2.7%. This gives an adjustment of –1.3% which should be the base assumption for discussions on price for non-tariff services.

Table 1: 2013-14 net price adjustment

	%
Pay and price inflation	+2.7%
Total national efficiency requirement	-4.0%
Net price adjustment	-1.3%

28. In addition, mandatory tariffs will increase on average by an additional 0.2% in recognition of changes in underlying costs faced by providers. Prices within the scope of the mandatory tariff will therefore change by an average of -1.1%. Prices for non-tariff activity may already account for changes in costs and so it is not appropriate to apply this adjustment to this activity. As stated above, the base assumption for discussions should therefore be -1.3%.
29. As in previous years, prices have been adjusted with regard to the Clinical Negligence Scheme for Trusts (CNST)⁸. We have recognised this additional cost pressure of 0.02% (£7 million) through targeted adjustments to tariff prices (paragraph 32).
30. As a consequence of the design of the new suite of best practice tariffs being introduced in 2013-14, it has not been necessary to account for any embedded efficiency in tariff prices when setting the overall adjustment. Where the pricing of best practice tariffs reduces income to providers who do not adopt best practice, 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.
31. We have not made any allowances in the tariff adjustment for CQUIN.

Clinical negligence scheme for trusts

32. Rather than include the cost pressure arising from NHS contributions to the CNST in the overall tariff adjustment, we have made £7 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).
33. The price adjustments made to take account of changes in CNST payments for 2013-14 relate to the national changes by specialty group.

⁸ <http://www.nhsla.com/Pages/Home.aspx>

Any individual hospital's payment will be determined not just by the pattern of services delivered in the hospital but by other factors such as previous claims history.

34. 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 adjustment to each of the HRG subchapters to reflect CNST contributions.

Table 2: Apportioning CNST costs to HRGs

HRG chapter or sub-chapter	Specialty	% increase in tariff prices*
AA	Nervous System Procedures and Disorders	0.3%
AB	Pain Management	0.5%
BZ	Eyes and Periorbita Procedures and Disorders	0.2%
CZ	Mouth Head Neck and Ears Procedures and Disorders	0.1%
DZ	Thoracic Procedures and Disorders	0.2%
EA	Cardiac Procedures	0.1%
EB	Cardiac Disorders	0.1%
FZ	Digestive System Procedures and Disorders	0.7%
GA	Hepatobiliary and Pancreatic System Surgery	0.8%
GB	Hepatobiliary and Pancreatic System Endoscopies and Radiological Procedures	0.4%
GC	Hepatobiliary and Pancreatic System Disorders	0.6%
HA	Orthopaedic Trauma Procedures	1.1%
HB	Orthopaedic Non-Trauma Procedures	1.1%
HC	Spinal Surgery and Disorders	0.6%
HD	Musculoskeletal Disorders	0.4%
HR	Orthopaedic Reconstruction Procedures	0.6%
JA	Breast Procedures and Disorders	0.6%
JC	Skin Surgery	0.4%
JD	Skin Disorders	0.3%
KA	Endocrine System Disorders	0.4%
KB	Diabetic Medicine	0.0%
KC	Metabolic Disorders	0.1%
LA	Renal Procedures and Disorders	0.1%
LB	Urological and Male Reproductive System Procedures and Disorders	0.5%
MA	Female Reproductive System Procedures	5.2%
MB	Female Reproductive System Disorders	4.7%
NZ	Obstetric Medicine	-8.9%
PA	Paediatric Medicine	0.0%
PB	Neonatal Disorders	-
QZ	Vascular Procedures and Disorders	0.2%
RC	Interventional Radiology	-
SA	Haematological Procedures and Disorders	0.1%
VA	Multiple Trauma	1.4%
WA	Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare contacts	0.0%

HRG chapter or sub-chapter	Specialty	% increase in tariff prices*
A&E (excl Minor)		1.2%

*Figures rounded to 1 decimal place. Where the percentage increase was less than 0.05% this will appear as 0.0% in the table.

35. For 2013-14 the NHS Litigation Authority has revised its methodology for calculating CNST contributions, which has led to a substantial fall in contributions for maternity services. This is partly due to the creation of a separate contribution for gynaecological services, which were previously combined with maternity. Consequently there has been a large downwards adjustment in the tariff prices for obstetrics, which is partly offset by an increase in the price for gynaecology.

Clinical audits

36. No further adjustments have been made for clinical audits in 2013-14.

Help and advice

37. 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.
38. It is anticipated that the Department's PbR team will continue to provide a query management service in support of the 2013-14 tariff.
39. With the above in mind, NHS foundation trusts, NHS trusts and other organisations that have queries which remain unanswered after referring to this guidance should contact the PbR team via pbrcomms@dh.gsi.gov.uk.
40. Operational queries from commissioners which cannot be resolved through reference to guidance should also be directed to the Department's PbR team, unless alternative arrangements are put in place locally.

Queries that the Health and Social Care Information Centre can help with

41. The Health and Social Care Information Centre's National Casemix Office designs and refines currencies that are used by the NHS to describe healthcare activity. These currencies – known as Healthcare Resource Groups (HRGs) - underpin PbR from costing through to payment, and support local commissioning and performance

management. The National Casemix Office also produces grouper software used for reference cost collection and tariff payment purposes.

42. The Health and Social Care Information Centre (HSCIC), in collaboration with NHS Connecting for Health, deliver the Secondary Uses Service (SUS). SUS is a repository of healthcare data which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services. Within SUS there is a PbR specific service available, called SUS PbR.
43. Information on SUS⁹, SUS PbR guidance¹⁰ and the National Casemix Office¹¹ is available online. The HSCIC can help with queries related to casemix, HRGs, grouping and groupers as well as SUS and SUS PbR. The HSCIC can be contacted on 0845 300 6016 (available 9am - 5pm Mon-Fri). Queries can be submitted by e-mail to enquiries@ic.nhs.uk

Queries that NHS Connecting for Health can help with

44. Consistent data formats and the use of appropriate coding systems is key to effective electronic healthcare in the NHS. NHS Connecting for Health (CfH) provide advice and guidance to support the effective use of data standards across the NHS.
45. A range of information is available on the CfH website, on subjects such as data standards¹², the ICD and OPCS classification systems¹³ and training and accreditation for clinical coders¹⁴.
46. CfH can help with queries related to data standards, data flows, data definitions, the NHS data model and dictionary and clinical coding.
47. Queries relating to data standards or clinical coding should be directed to the NHS Data Standards helpdesk on 0845 13 00 114. Queries can be submitted by e-mail to datastandards@nhs.net.

⁹ <http://www.ic.nhs.uk/sus>

¹⁰ <http://www.ic.nhs.uk/article/1922/sus-payment-by-results>

¹¹ <http://www.ic.nhs.uk/casemix>

¹²

<http://www.connectingforhealth.nhs.uk/systemsandservices/data?url=http://www.connectingforhealth.nhs.uk/systemsandservices/data/standards>

¹³ <http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding>

¹⁴

<http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/trainingaccred>

Section 2: Classification, currency and grouping

Currency

48. 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.
49. HRG4 design remains under constant review for changes in clinical practice and the 2013-14 Local Payment Grouper includes new HRGs that improve differentiation of care as well as removal of HRGs (for example due to low volumes of activity). As the 2013-14 tariff is based on the 2010-11 reference costs, the basis for these HRG design changes is the changes made between the 2009-10 and 2010-11 reference cost groupers. The HSCIC produce a summary of changes document that provides an overview of the main changes between the HRG4 2012-13 Local Payment Grouper and the 2013-14 Local Payment Grouper, as well as between the underlying reference cost groupers. Both of these sets of documentation are available from the HSCIC's website¹⁵.
50. As a part of the *tariff information spreadsheet*, we have also published a brief summary of changes between the reference cost groupers as well as any additional changes for the Payment Grouper.
51. More information about HRGs is available on the HSCIC's website.¹⁶ The HRG4 grouper roots documentation is particularly helpful in understanding changes to the HRG4 design.

Classification

52. 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
 - b) Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions¹⁷. The latest upgrade for OPCS-4, OPCS-4.6, was implemented in April 2011.

¹⁵ Information available at <http://www.ic.nhs.uk/article/2580/HRG4-201314-Local-Payment-Grouper>

¹⁶ www.ic.nhs.uk/casemix

¹⁷ www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4

53. The fourth edition of the ICD-10 diagnosis classification was implemented in April 2012. Further information is available on the NHS Connecting for Health website.¹⁸
54. The Terminology Reference-data Update Distribution (TRUD) service¹⁹ 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.
55. The acute renal dialysis HRGs use data items available from the national renal dataset (NRD)²⁰ and further details are at paragraph 318.
56. The ante natal and post natal elements of the maternity pathway system uses data items available from the maternity services secondary uses data set and further details are in the *Ante and post natal pathways: Data requirements and definitions* spreadsheet, which is published alongside this document.
57. In 2012 the Audit Commission published *By definition: improving data definitions and their use by the NHS*²¹, which reviews guidance and the recording of activity which relates to stays of less than 24 hours. The review was undertaken in conjunction with the DH, HSCIC and NHS CFH and focused on two areas: the differentiation between day cases and procedures in an outpatient setting, and how to classify short stay non-elective observations and minor procedures. Guidance in this area has been updated as a result of this work²², and the briefing provides examples of how providers and commissioners can work together to ensure this activity is recorded accurately.

Grouping

58. 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

¹⁸ http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/icd-10/icd_updates

¹⁹ <http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home>

²⁰ <http://www.ic.nhs.uk/article/2117/National-Renal-Data-Set>

²¹ <http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/Downloads/20120419ByDefinition.pdf>

²² <http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/pbr/guidance-for-pbr>

HSCIC²³. The relevant Grouper is the HRG4 2013-14 Local Payment Grouper. The HSCIC 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.

59. 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.
60. 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.
61. This guidance assumes that where users are locally grouping data, that they are making use of the 2013-14 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 2013-14 SUS PbR algorithm.

Data stages

62. 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 calculating length of stay adjustments 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

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

²³ <http://www.ic.nhs.uk/casemix/payment>

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

64. PbR pre-processing describes the preliminary processing of episode level data before it is fed through the Grouper.
65. 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 136) an initial admission preceding an emergency readmission is not necessarily in the scope of PbR.
66. Certain episodes are excluded because they are outside the scope of PbR, for example 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.
67. Some pre-processing exclusions do not have specific codes listed (for example 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 as part of the SUS PbR suite of guidance.²⁴
68. 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 (with the exception of episodes with SD03). 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.

²⁴ <http://www.ic.nhs.uk/article/1922/SUS-Payment-by-Results>

69. The Grouper has input fields for lengths of stay for rehabilitation and specialist palliative care as well as critical care. CDS 6.2 introduced new data items for length of stay for rehabilitation and specialist palliative care and as such, where the fields are populated, SUS PbR will perform the length of stay adjustment. SUS PbR will continue to adjust the length of stay for data reported in the separate critical care datasets, as in previous years.
70. 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.
71. Once the relevant excluded episodes have been removed and any relevant adjustments have been calculated, and included in the relevant grouper fields, for length of stays, the data is ready to be grouped.
72. SUS PbR performs the pre-processing stage, which it then applies to data submitted by providers in CDS records.

Grouping stage

73. Users should refer to the manuals on the HSCIC website²⁵.

PbR post-grouping stage

74. 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.
75. It should be noted that although a core outpatient attendance activity may be outside the scope of PbR, unbundled diagnostic imaging for the same record may still be within the mandatory scope of PbR. Further details are at paragraph 227.

PbR adjustments stage

76. The final stage is the application of any relevant PbR tariff adjustments (paragraph 81 lists these for admitted patient care). The MFF (paragraph 928) is applied to the tariff after any adjustments.
77. It should be noted that the final tariff should be rounded to the nearest whole pound. This is consistent with SUS PbR processing.

²⁵ <http://www.ic.nhs.uk/casemix/payment>

Section 3: Admitted patient care

Structure

78. 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, which is the period from admission to discharge or death, and 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.
79. The admitted patient care tariffs include the costs of diagnostic imaging carried out in admitted patient care.
80. The relevant year's tariff to apply is determined by date of discharge, regardless of date of admission.
81. 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: Best practice tariffs).
82. The flow diagrams in Annex A illustrate the application of these adjustments.

Elective care

83. 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.
84. 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: Outpatient care). 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.
85. Where there is a difference in the tariff set between outpatient procedures and other settings, this is primarily because we believe there is a difference in the activity taking place in the different settings, and in

some cases this is reflected in a large differential in the tariffs for a given HRG. However, commissioners should be aware that some activity usually carried out as a day case in the hospital setting may also be carried out in a GP clinic. In this case, consideration should be given to the use of the flexibilities set out in Section 13: Flexibilities.

86. 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.
87. In a change to last year, some regular attenders are now no longer excluded from tariff and are now within the scope of PbR. This is to accommodate the expansion of PbR into chemotherapy delivery and external beam radiotherapy where some of the activity is reported as regular attender activity and tariff will apply. The only core HRGs to have mandatory tariffs for regular attenders will be the renal dialysis HRGs, as they are independent of setting, and the zero-priced core HRGs. All other core HRGs will be for local negotiation, as in 2012-13.
88. 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

89. 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 2013-14 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.
90. Paragraphs 100 to 103 cover arrangements for setting the baseline. We recognise that much has changed since 2008-09 and that this is a complicating factor when setting a baseline, and so we fully expect that a pragmatic approach will be taken locally when setting a workable baseline. For example, rather than re-set the baseline, it may be possible to apply a simple uplift to the baseline used in 2012-13.
91. Contracts worth 5% or less of the 2008-09 baseline should not attract the marginal rate, provided that the overall value of emergency admissions is below the 2008-09 baseline. This rule applies in this

circumstance regardless of whether these low volume contracts are above or below the 2008-09 baseline.

Application

92. The marginal rate applies to increases, but not decreases, in the value of emergency activity. Where the actual value of emergency activity in 2013-14 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 2013-14 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 2013-14 is £1.1 million, then the payment is £1.03 million (being 30% of the difference between actual and baseline).
93. 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.
94. 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.

Defining emergency

95. Emergency spells are defined by admission method codes 21-25 and 28 (please note 28 has been replaced by 2A, 2B, 2C and 2D in CDS 6.2)²⁶ for the purposes of the marginal rate.
96. While the marginal rate does apply to emergency transfers (admission method code 2B, but included in admission code 28 in previous CDS versions), 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 103(c)).
97. 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 (admission method code 2C, but included in admission method code 28 in previous CDS versions) but not other births (admission codes 82 or 83), and it applies to admission method codes 21-25, 2A, 2B, 2C, 2D and 28 regardless of TFC.
98. The marginal rate does not apply to:

²⁶

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

- a) activity outside the scope of PbR
 - b) non-contract activity
 - c) activity covered by the best practice tariffs, with the exception of the best practice tariffs which promotes same day emergency care
 - d) A&E attendances
 - e) outpatient appointments
 - f) contracts with commissioners in the devolved administrations.
99. The marginal rate policy will apply to activity covered by the best practice tariffs designed to encourage management of a range of emergency clinical scenarios on a same day basis. This because 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

100. The baseline above which the marginal rate takes effect is determined on the basis of contractual relationships between commissioners and providers. Where there is one provider and several commissioners in the contract, then we would expect arrangements to be agreed locally in line with contractual payment flows (see paragraph 92). There will need to be explicit agreement of the baseline for each contractual relationship, which should be included within the 2013-14 contract and concluded as part of the 2013-14 contract negotiations.
101. 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. Providers and commissioners should take a pragmatic approach to determining the baseline which could involve rolling forward an existing baseline with a suitable uplift.
102. Where a service opened during 2008-09 then the activity data needs to be annualised, or a later year's activity used. Where a service has transferred between providers since 2008-09, or is to be transferred in 2013-14, the baseline will need to be adjusted accordingly.
103. The only other circumstances in which an amendment to the value of the baseline may be made are where:
- a) a commissioner 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.

Managing the savings

104. *Everyone Counts: Planning for Patients 2013/14*, the NHS CB's planning guidance for 2013-14, confirmed that commissioners should budget for all admissions at 100% tariff and suggested that NHS Commissioning Board Area Teams would administer the 70% balance for local investment in relevant demand management schemes, jointly owned by commissioners and providers. Decisions on how to spend the resource were to be undertaken by NHS Commissioning Board Area Teams in partnership with clinical commissioning groups.
105. Following further discussions it is clear that transparency around the use to which these savings are put, and the outcomes which are achieved for patients, are the most important elements for all partners in making this policy work.
106. For 2013-14 commissioners will therefore need to work with providers, including social care, and the NHS Commissioning Board Area Teams, to develop proposals for the use of the savings from the marginal rate. Commissioners will be expected to work together to maximise the benefit to patients, for example where a number of commissioners work with the same acute or social care service provider.
107. There needs to be early engagement in the financial year on how the funds will be distributed. For example, business case proposals from providers may be invited early in the planning process, so that funds can be rapidly redistributed to the providers to pump prime a range of schemes to reduce the incidence of and/or the consequences arising from emergency admissions. The level of information required to support these proposals should be proportionate to the scale of the proposed plans, to support the development of small scale changes that can be rapidly rolled-out to improve patient care and admission avoidance.
108. Final plans should be agreed with Area Teams, shared with all relevant stakeholders and will form part of the Board's oversight of CCGs. These plans should include a description of the process that was undertaken to engage providers in the development of the plans. The outcomes of the investments must be made public in due course.
109. Schemes which are designed to reduce the numbers of avoidable admissions will only succeed if the design of the scheme and decisions around the investment are the product of joint decision making between commissioners and providers. There are good local examples of where this can work well and case studies are provided below.

Case study 1

One acute trust in the South East has collaborated with commissioners to extend acute geriatrician outreach to local nursing homes. This has increased the benefits of specialist input to patient evaluation and pathway management in primary care settings.

This collaborative initiative includes geriatrician consultant ward rounds at nursing homes, expedited telephone access for GPs and care home managers to acute geriatricians, and geriatrician involvement in end of life care discussions and medical advisory meetings. An alert system has also been established in the acute trust to flag when a nursing home resident is admitted. This facilitates early assessment and review by geriatric specialists who can liaise with both the GP and nursing home to support discharge.

This regular structured contact between hospital geriatric consultants, GPs and nursing home managers has led to a 60% reduction in the rate of hospital admissions for local nursing home residents, reductions in acute length of stay and cost savings to the wider health system through the review and modification of medication and fluid management. It is important that initiatives such as this, which focus on partnership working across the primary and secondary care interface, are adopted more widely to improve health outcomes and the experience of older patients.

Case study 2

Providers of community services have developed a range of programmes in collaboration with commissioners to support the whole health economy goal of admission avoidance. For example, in the North East significant investment has been agreed for Care at Home schemes where patients can be continually assessed and diagnosed in their own home rather than in an acute hospital. Technical interventions such as intravenous antibiotics can also now be delivered in the patient's own home.

Crisis Response Teams in the East of England have also been highly successful in preventing avoidable hospital admissions in patients who find themselves at a crisis point. Multi-disciplinary teams including occupational therapists, social workers and physiotherapists provide rapid assessment and treatment in the patient's own home. These teams are particularly effective in avoiding peaks in the number of older patients who present to emergency departments after 7pm at night, when it is hard to discharge patients to home without the support of additional community services. In many areas demand for these services, especially during out of hours and weekend periods, far outstrips supply and further investment in these services would support the goals of preventing unnecessary hospital admission and increasing the number of older patients who are supported to live independently at home.

Case study 3

In the South Central region the Ambulance Service has made demand management a strategic focus from frontline crews to Board level. Closely aligning with commissioner goals the trust has developed a "whole systems care" programme to generate targeted actionable intelligence on demand patterns to support admission avoidance as early as possible in the patient pathway. Schemes included in the programme are the development of a falls referral form which is transmitted to community falls teams, the GP triage system, the In Case of Emergency (ICE) bus to allow local treatment in the night economy and the development of patient-specific ambulance anticipatory care plans which are held on the despatch system. These schemes have helped identify and stratify patients such as elderly fallers, so that community and falls teams can see the most at risk patients as urgently as possible. This has resulted in more patients being treated safely at home rather than being conveyed to emergency departments and admission units.

Short stay emergency adjustment

110. 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 Annex A Figure 1e.
111. The short stay emergency prices are published in the *tariff information spreadsheet*, based on the percentages in Table 5 (which remain unchanged in 2013-14), 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 5: 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%

112. In 2012-13, we introduced a new best practice tariff to promote same day emergency care (see paragraph 539)
113. The short stay emergency adjustment applies when all of the following criteria are met:
- the HRG is not within the scope of a best practice tariff
 - the patient's adjusted length of stay is either zero or one bed day
 - the patient is not a child, defined as aged under 19 years on the date of admission

- d) the admission method code is 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented CDS 6.2)
- e) the average length of non-elective stay for the HRG is two or more days
- f) 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.

114. 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 payment

115. 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 1f: Long stay payments.

116. The HRG costs reported in the published 2010-11 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.

117. In 2013-14 we are continuing with the approach adopted in 2011-12, whereby there is a trim point floor of five days²⁷. For 2013-14, there will be two long stay payment rates per chapter – one for children-specific HRGs and one for all other HRGs.

118. If a patient is medically ready for discharge and delayed discharge payments²⁸ 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.

²⁷ 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.

²⁸ <http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Delayeddischarges/index.htm>

Specialised services

119. 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 1g illustrates their application.
120. Services that were previously commissioned by the National Specialised Commissioning Group (NSCG) continue to be excluded from PbR under the new heading of “highly specialised services”. As these services will be commissioned by the NHS CB, along with other services that are within the scope of PbR, the exclusion can no longer apply to the commissioner code. Instead, organisations will need to process this exclusion in SUS PbR via the use of the equals sign (=) exclusion. Further details can be found on the NHS Specialised Services website.²⁹
121. The top-up policy in 2013-14 will continue in the same form as in 2012-13, with the exception of specialised children’s services for which there will be two top-up values depending on the level of specialisation of the activity.
122. As part of continued efforts to ensure adequate reimbursement for specialised services, the Department commissioned the Centre for Health Economics (CHE) at the University of York to undertake some analysis to examine whether the very broad specialised children’s definition set exhibited varying levels of specialisation. Based on a sub-categorisation of the original trigger list by the number of providers performing each code, CHE found that codes performed by fewer providers were associated with higher costs. Following consultation and further analysis with specialist providers it was decided that there was evidence to support sub-categorisation of codes into High and Low³⁰ specialisation, with differing top-ups to be applied to each.
123. The level of the top-up values has been set to reflect the relative difference in costs found by the CHE analysis, but the top-up levels were adjusted such that the average top-up remains in line with last year’s value of 50%.
124. The reports of the analysis undertaken by CHE that underpin top-up policy and corresponding web links are:
- a) Estimating the costs of specialised care³¹

²⁹ <http://www.specialisedservices.nhs.uk/info/nhs-specialised-services>

³⁰ Codes performed by 15 or fewer providers are categorised as High else the code is categorised as Low

³¹

http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP61_specialised_care_costs.pdf

- b) Estimating the costs of specialised care: Updated analysis using data for 2009-10³²
- c) Specialisation hierarchy within the children's SSNDS³³

125. Top-ups are a percentage of the relevant HRG tariff and are shown in Table 6 together with the relevant specialised service code (SSC) flag and provider eligibility.

Table 6: Specialised service top-ups

	Top-up	SSC flag	Eligible provider list?
Children – High	64%	93	Yes
Children – Low	44%	91	Yes
Neurosciences	28%	8	Yes
Orthopaedic	24%	34	No
Spinal surgery	32%	6	Yes

126. 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 2009³⁴.

127. The Grouper then applies one of the SSC flags in Table 6 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. All HRGs are eligible for top-ups.

128. 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.

129. SUS PbR automates payments by generating the SSC flag for those spells undertaken by eligible providers³⁵ (where applicable) and applying the percentage top-up to the relevant HRG tariff.

130. The Grouper will generate multiple SSC flags per spell, as such organisations will need to select the highest percentage top-up that they are eligible for, where a spell is eligible for multiple top-ups.

131. The specialised services top-up is applied after a short stay emergency adjustment, long stay payment or best practice tariff. However, please note the additional payments for the acute stroke and fragility hip fracture are not eligible for the specialised services top-ups.

³²

http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP71_estimating_the_costs_of_specialised_care.pdf

³³ http://www.eshcru.ac.uk/publications/children_SSNDS.pdf

³⁴ <http://www.specialisedservices.nhs.uk/info/specialised-services-national-definitions>

³⁵ Note that only SUS PbR applies the eligibility criteria and not the Grouper.

132. 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 446).
133. 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).

Zero price

134. Table 7 shows HRGs that have a mandatory tariff of zero pounds (£0). There should be no payment for this activity.

Table 7: 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

135. 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

136. In 2012-13 the emergency readmissions policy was based on a clinical review of readmissions. Providers and commissioners should continue to use clinical reviews to inform setting thresholds for readmissions. However if there is local agreement that the threshold can be based on the 2012-13 review, a review does not need to be undertaken again in 2013-14.
137. Providers should not be reimbursed for the proportion of readmissions judged to have been avoidable. Separate proportions can be set for readmissions following elective admission and readmissions following non-elective admission.
138. Where applicable, 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 and re-ablement 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.

139. If it is not possible to complete the review in time to influence contracts, a planning assumption can be made until 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 2012-13 clinical reviews, and those reviews are not restricted to the actions of the acute trust, then those arrangements can, by agreement, continue in 2013-14.

The review (where one is undertaken for 2013-14)

140. As in 2012-13, the review should be undertaken between the provider and its coordinating commissioner³⁶, 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 larger, tertiary providers additional reviews may be necessary – for example one to establish a threshold for patients covered by local 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.
141. The review team must be clinically led by a person not employed by the provider. Relevant clinical staff from the provider trust and primary care services must be included as must representatives from the commissioning body, local primary care providers and, if at all possible, social services. Appropriate consideration should be given to information governance with regard to protecting the confidentiality of patient medical records.
142. The team should review the readmissions taking place within an agreed period. 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 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.
143. For each readmission the team should complete a proforma - an example is provided at Annex F. This can be adapted if there is a desire

³⁶ The Collaborative Commissioning Agreement produced by the NHS Commissioning Board allows for roles and responsibilities to be allocated to the commissioners in the collaborative, to the extent provided by the Health & Social Care Act 2012

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.

144. The aim is not 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 150) 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.

Reinvesting non payment money for emergency readmissions

145. 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.

146. 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

147. 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 code³⁷ of 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented CDS 6.2)
- (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

³⁷ 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

- (f) irrespective of whether it is non-contract activity (paragraph 936)
 - (g) irrespective of whether the initial admission or readmission occurs in the NHS or independent sector.
148. Where multiple admissions precede a readmission, the admission immediately before the readmission should be considered the initial admission.
149. The amount that will not be paid for the readmission is the total price associated with the continuous inpatient readmission spell,³⁸ including any associated unbundled costs, eg critical care or high cost drugs.
150. 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
 - (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 readmission³⁹
 - (g) cross border activity – where the initial admission or readmission is in the devolved administrations (paragraph 938).
 - (h) patients receiving renal dialysis
 - (i) patients readmitted subsequent to a transplant.
151. Commissioners should continue to reimburse providers for readmitted patients when any of these exclusions apply.

³⁸ 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.

³⁹ Emergency transfers of an admitted patient from another provider are included in admission method code 2B (or 28 for those providers who have not implemented CDS 6.2), which also includes other means of emergency admission. Organisations may wish to adopt additional rules to flag emergency transfers.

152. 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 935.
153. 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).
154. SUS PbR will 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 from April 2012* contains advice on how SUS PbR will support the readmission rule.

Section 4: Post discharge tariffs

Introduction

155. In 2012-13 the post discharge tariffs were introduced to take forward the vision of a shift of responsibility for patient care following discharge, from commissioners to the acute provider who treated the patient. With the help of NHS colleagues, post discharge tariffs for four specific rehabilitation pathways were released:

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

156. The tariffs, which are set out in the *tariff information spreadsheet*, are based on clinical advice and, where available, 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

157. In 2013-14 post discharge tariffs 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 continue to be non-mandatory.

158. 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.

159. Where services are not integrated we encourage the use of these tariffs as part of local negotiations on the commissioning of post discharge pathways of care.

160. In the longer term, we expect the recovery, rehabilitation and reablement workstream (RRR) to provide a broader approach for managing and funding post-discharge care.

161. The tariff 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
- 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.
162. In 2013-14, commissioners will not pay for a proportion of emergency readmissions within 30 days of discharge. 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.
163. 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 reconciliation to the actual numbers of packages completed at year end.

Cardiac rehabilitation post discharge tariff

164. 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 for these patients during the period of rehabilitation outside of a defined cardiac rehabilitation pathway 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 Cardiac Rehabilitation Commissioning Pack.⁴⁰ 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. It is for them to assess what type of rehabilitation is required and how it is provided.
166. Based on clinical guidance, the post discharge tariff will only apply to the 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).
167. 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.

⁴⁰http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_117504

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

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

168. 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.
169. The tariff is based on the pathway of care outlined in the Department's Chronic Obstructive Pulmonary Disease (COPD) Commissioning Pack.⁴¹ 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.
170. 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

171. 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 will remain the funding responsibility of the patient's commissioner and is not covered by this tariff.

⁴¹ <http://www.dh.gov.uk/health/2012/08/copd-toolkit/>

172. 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
173. 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 the tariff 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.
174. 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.
175. The post discharge tariffs for hip and knee replacement cover the defined clinical pathway for post discharge activity only. 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 527), which encourages a shorter length of stay.

Knee replacement

176. 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 will remain the funding responsibility of the patient's commissioner, and is not covered by this tariff.
177. 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
178. 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 the tariff 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.

179. The mandatory tariff payment should 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.
180. 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 527), which encourages a shorter length of stay.

Recovery, Rehabilitation and Reablement (RRR)

181. The DH is currently working with stakeholders to test the proposed concept of the recovery, rehabilitation and reablement approach. The concept is that within certain HRGs that cover the admitted patient stay, there are resources that can be released to support alternative models of service delivery. In 2013-14 the RRR concept will be piloted with the expectation that currencies and guidance will be developed.

Section 5: Outpatient care

Structure

182. The outpatient attendances tariffs are based on treatment function code (TFC)⁴². We also have 91 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 2013-14 national tariff*⁴³. These will be reimbursed using the relevant outpatient attendance tariff, unless commissioners and providers wish to employ the flexibility at paragraph 907.
183. The main change to the tariffs for outpatient care for 2013-14 is that we are making diagnostic imaging associated with outpatient attendances subject to separate tariffs, rather than 'bundling' the costs into the attendance tariffs. This change does not apply where the outpatient activity is paid by mandatory tariff against a procedure-driven HRG. We are making this change to support early diagnosis and efficient pathways for patients. Further information on this change is set out at paragraph 221.
184. Commissioners and providers should have regard for the provisions in the *Code of Conduct for PbR in 2013-14* around standard notice periods and transition arrangements where the introduction of mandatory tariffs for outpatient procedures and attendances results in increased reporting of activity.
185. 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, apart from the tariff for any diagnostic imaging associated with the attendance. This is illustrated in Annex A Figure 2.
186. 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 2.
187. In 2011-12, we introduced a distinction between HRGs that are excluded across all settings, and HRGs that are excluded for admitted patient care

⁴² 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."

⁴³ Published as part of the final PbR package for 2013-14.

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

188. In 2013-14 we have increased the number of mandatory tariffs for procedure-driven HRGs to reflect changes in HRG design, but also to reflect increases in activity levels. We do not expect every procedure that maps to these HRGs can be appropriately carried out in an outpatient setting.
189. 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.
190. 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 issue⁴⁴. 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 has reviewed definitional issues in conjunction with the Department, NHS Connecting for Health and the HSCIC.⁴⁵
191. In cases where activity is carried out in a GP clinic, please see the flexibilities set out in Section 13: Flexibilities.
192. There are best practice tariffs for diagnostic cystoscopy, diagnostic hysteroscopy and hysteroscopic sterilisation performed in an outpatient setting (paragraph 464).
193. In 2013-14 we have added a mandatory outpatient tariff for DZ50Z Respiratory Sleep Study. This is a combined outpatient and daycase tariff which applies where the sleep study is undertaken at the patient's home. The tariff has been set assuming that patients will have an outpatient attendance both before and after they carry out the sleep study.

⁴⁴http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/cds/admitpat/day_case

⁴⁵<http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/Downloads/20120419ByDefinition.pdf>

Outpatient attendances

Introduction

194. The mandatory outpatient attendance tariff remains applicable only to pre-booked, consultant led attendances. The pre-booked requirement is not limited to Choose and Book⁴⁶, and may include local systems accepting patients based on GP letters or phone calls. 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.
195. 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.
196. 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.
197. 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.
198. 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.
199. For the avoidance of doubt, if a patient goes on to have separate attendances with an Allied Health Professional (AHP) (eg a physiotherapist) following an outpatient attendance, the costs of the attendances with the AHP are not included in the tariff for the original attendance.

⁴⁶ 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.

200. With commissioning responsibility for GUM outpatient attendances transferring to local authorities, we are no longer publishing a mandatory tariff for this activity. We are however making a non-mandatory tariff available for organisations to use if they wish. We understand that there may be circumstances where local authorities are 'cosignatories' to NHS standard contracts, and in these case it may be appropriate for this non-mandatory tariff to be adopted.
201. We are publishing a mandatory tariff for the new TFC for Spinal Surgery.

Consultant led and non-consultant led

202. 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 all [consultant led activity](#) but the consultant takes clinical responsibility for each patient's care."⁴⁷ A consultant led service does not apply to nurse consultants or physiotherapist consultants.
203. 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.
204. The exception to this approach is for maternity services in an outpatient setting. All maternity activity, for both consultant led care (TFC 501 obstetrics), and midwife led (TFC 560 midwife episode) care, is included in the maternity pathway tariff (paragraph 630).

First and follow-up attendances

205. 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 planned or expected future 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.
206. 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

⁴⁷http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_led_service_de.asp?shownav=1

six months apart, or where the patient attends having been given a further appointment at their last attendance, the follow-up tariff applies.

207. 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).
208. 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.
209. 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.
210. We are again publishing a non-mandatory price for non face-to-face outpatient activity (paragraph 893), which commissioners and providers may wish to use to facilitate changes to outpatient pathways.

Multi-professional and multi-disciplinary

211. 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.
212. 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.
213. 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.

214. 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.
215. They do not apply if one professional is supporting another, clinically or otherwise, eg 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 such in line with existing NHS Data Model and Dictionary guidance on joint consultant clinics⁴⁸.
216. 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.
217. 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.
218. 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.
219. 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, eg systemic lupus erythematosus
 - c) a patient sees a paediatrician to discuss their disease and a clinical geneticist to discuss familial risk factors.

⁴⁸<http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/cds/outpatient/sharedcare>

220. 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.

Diagnostic imaging in outpatients

Introduction

221. In a change from 2012-13 and previous years, we have unbundled diagnostic imaging from outpatient attendance tariffs.
222. This is in response to concerns that including the costs of diagnostic imaging in outpatient attendance tariffs was hindering delivery of appropriate imaging activity, including direct access diagnostic imaging and integration of care, and not appropriately reimbursing providers with a different from average casemix in outpatients. Separate tariffs for diagnostic imaging in outpatients will also help to promote greater clinical integration and development of clinical pathways between primary and secondary care and within clinical networks. In addition, patients are increasingly referred to an outpatient attendance having already had a range of diagnostic tests organised in primary care to agreed joint protocols.

Scope of the change

223. The diagnostic imaging that has been unbundled from outpatient attendance tariffs is that which has an unbundled HRG in subchapter RA, ie:
- a) Magnetic resonance imaging scans
 - b) Computerised tomography scans
 - c) Dexa scans
 - d) Contrast fluoroscopy procedures
 - e) Non-obstetric ultrasounds
 - f) Nuclear medicine
 - g) Simple echocardiograms
224. This excludes plain film x-rays, obstetric ultrasounds, pathology, biochemistry and any other diagnostics that generate an HRG outside subchapter RA. For further information on the treatment of diagnostic

tests other than diagnostic imaging, please refer to the introductory sections on outpatient tariffs, and in particular to paragraph 185.

225. Diagnostic imaging remains bundled (ie does not attract a separate payment) where the patient data groups to a procedure-driven HRG (ie not from HRG4 sub-chapter WF) with a mandatory tariff. This is to maintain consistency with admitted patient care across any given HRG, where diagnostic imaging costs are bundled into core tariffs.
226. This includes cases where the mandatory tariff is zero, eg LA08E, SB97Z and SC97Z, which relate only to the delivery of renal dialysis, chemotherapy or external beam radiotherapy. In these cases, any diagnostic imaging is assumed to be connected to an outpatient attendance other than for just the delivery of renal dialysis, chemotherapy or external beam radiotherapy. Therefore a separate outpatient attendance should also be recorded and associated with diagnostic imaging.
227. Where patient data groups to a procedure-driven HRG without a mandatory procedure tariff, the unbundled diagnostic imaging tariffs apply.
228. Diagnostic imaging also remains bundled where it is part of a currency and/or tariff for a pathway or period of time other than an attendance (eg the best practice tariff for early inflammatory arthritis). The use of the diagnostic imaging tariffs is not mandated where imaging is part of a wholly excluded service (eg cleft lip and palate).
229. Each diagnostic imaging HRG has the same price across the outpatient setting and direct access, reflecting the costs reported for both settings. The tariffs for outpatient diagnostic imaging are mandatory, regardless of whether or not the core outpatient attendance activity has a mandatory tariff. Any local tariffs for outpatient attendances that do not have a mandatory tariff should be adjusted to reflect separate payments for diagnostic imaging. Please note that not all local tariffs for outpatient attendances will need to be renegotiated, but rather just where there is significant diagnostic imaging involved.
230. The admitted patient care tariffs continue to include the costs of diagnostic imaging carried out when a patient is admitted, as do the A&E tariffs.
231. However, where diagnostic imaging is requested as part of an admitted patient care episode but carried out post-discharge, this should be recorded as outpatient activity and attract a separate payment.
232. Please note that the tariff for PET CT (RA42Z) is based on services being delivered through a fixed site facility with the provision of a local isotope supply. Differential costs may be attributed to mobile services

through local commissioning. Providers may need to identify the additional costs using an open book approach.

Managing financial risk

233. There are three areas of financial risk in moving from the current “bundled” model to separate tariffs for diagnostic imaging in outpatients in 2013-14:
1. The risk to either commissioners or providers of moving from reimbursement at an average level of diagnostic imaging activity to reimbursement for actual diagnostic imaging activity.
 2. The risk to commissioners from providers increasing their diagnostic imaging activity.
 3. The risk to commissioners from providers increasing the reporting of diagnostic imaging, where this is currently under reported.

234. The guidance for managing these three areas of risk is set out below.

Risk area 1: The risk to either commissioners or providers of moving from reimbursement at an average level of diagnostic imaging activity to reimbursement for actual diagnostic imaging activity.

235. Moving from the “bundled” model in use in 2012-13 to separate tariffs for diagnostic imaging in outpatients in 2013-14 means that providers will be paid for the diagnostic imaging that they carry out rather than being paid at a national average basis.
236. As a result and in the event that a provider’s overall level of outpatient income varies significantly from that in 2012-13, providers and commissioners should agree risk sharing arrangements to transition to the new level of provider income. For this purpose, the level of diagnostic imaging activity should be adjusted for growth in line with current trends for diagnostic imaging. It should be noted that the marginal rate outlined below for risk area 2 is not intended for this purpose.
237. These risk sharing arrangements may be particularly relevant where a provider is dependent on income from a small number of TFCs, for example ophthalmology.
238. If providers and commissioners are unable to agree on an appropriate growth rate to use, they should use the growth calculated by comparing diagnostic imaging activity to date in 2012-13 to the same period in 2011-12 from the monthly diagnostic return made to the DH for waiting times and activity (DM01).

Risk area 2: The risk to commissioners from providers increasing their diagnostic imaging activity.

239. The new payment structure should facilitate access to diagnostic imaging and could lead to an increase in the number of scans for legitimate clinical reasons. In order to manage the potential financial impact of an increase in scanning, providers and commissioners should agree a baseline for activity currently undertaken (but adjusted for growth in line with current trends for diagnostic imaging), and put in place arrangements to pay a marginal rate of 50% in 2013-14 for activity over and above that baseline.
240. The baseline exercise and marginal rate should not be seen as an opportunity for commissioners to reduce costs by diverting services. If there is a significant change in which providers will provide scanning activity, this should be taken into account in the baseline and therefore not subject to the marginal rate.
241. As set out in paragraph 238, if providers and commissioners are unable to agree on an appropriate growth rate to use, they should use the growth calculated by comparing diagnostic imaging activity to date in 2012-13 to the same period in 2011-12 from the monthly diagnostic return made to the DH for waiting times and activity (DM01).
242. The marginal rate of 50% represents risk sharing between providers and commissioners, and should not be seen as a penalty to providers or an incentive to cap activity.
243. Providers' clinical policies and protocols in relation to imaging should be based on appropriate national clinical guidance, and any changes to policies or protocols by providers should be after consultation with commissioners, allowing for good financial planning and governance.
244. The Royal College of Radiologists' evidence-based referral guidelines (iRefer), play an important role in improving the quality of care for patients and should be used to ensure all imaging requests are appropriate. iRefer is now available to all NHS commissioners and providers via the e-Learning for Health (eLfh) portal.⁴⁹ It will also be available to the NHS via the N3 network in due course.
245. *Direct Access to Diagnostic Tests for Cancer - Best Practice Referral Pathways for GPs* have been designed to support GPs with direct referral to specific diagnostic tests for the assessment of particular symptoms where cancer may be suspected but urgent GP referral (two week wait) is not applicable⁵⁰. These are supported by the evidence described in i-Refer.
246. In addition, the Diagnostics Improvement Team at NHS Improvement has published *Supporting direct access to diagnostic imaging for cancer diagnostics: best practice pathways for diagnostic imaging teams*. This

⁴⁹ To obtain access please register by visiting <http://portal.e-lfh.org.uk/>

⁵⁰ <http://www.dh.gov.uk/health/2012/04/access-cancer-tests>

has been written to support diagnostic imaging teams and to help them understand the best practice pathways for GP direct access to diagnostic imaging tests for suspected cancer.⁵¹

247. Providers should also consider the internal controls in place in relation to levels of diagnostic imaging by condition, speciality, and consultant. The resulting data should be regularly shared with commissioners. This should include targeted clinical audit where outliers are identified to confirm that good clinical practice is being adhered to.
248. Providers and commissioners should regularly review their own imaging data as collected via the monthly Diagnostic Imaging Data (DID) collection and compare it to others with similar populations. This data includes monthly activity and report turnaround times, Access to DID information is available to colleagues in the NHS through the Health and Social Care Information Centre's web-based reporting tool, i-View. Registered users will be able to access anonymised data at aggregate level in a consistent and flexible format. For more information please visit the i-View website⁵².
249. Providers and commissioners should also put in place systems to ensure that scans are not repeated unnecessarily following direct access, and that direct access and cross-provider scans are available for all subsequent referrals. The use of iRefer will support this.
250. The Royal College of Radiologists has produced *Standards for the provision of teleradiology within the United Kingdom*.⁵³ Under Standard 1, *Ensure patient safety when sharing images and reports*, it states:
- Patient data, imaging and all relevant clinical data should be available for review in any hospital the patient attends irrespective of its type. This will reduce the need to repeat studies.
 - It is essential that all organisations are able to display images and view reports obtained from other organisations alongside their own images irrespective of the vendor origin of the images.

Risk area 3: The risk to commissioners from providers increasing the reporting of diagnostic imaging, where this is currently under-reported

251. There may also be an increase in the reporting of diagnostic imaging, where existing activity is currently under-reported. Providers must comply with the PbR Code of Conduct and NHS Standard Contract in relation to changes in the counting and coding of activity.⁵⁴

⁵¹ http://www.improvement.nhs.uk/documents/Diagnostic_Imaging_Cancer.pdf

⁵² <https://iview.ic.nhs.uk/?aspxerrorpath=/>

⁵³ Further information is available at

[http://www.rcr.ac.uk/docs/radiology/pdf/BFCR\(10\)7_Stand_telerad.pdf](http://www.rcr.ac.uk/docs/radiology/pdf/BFCR(10)7_Stand_telerad.pdf)

⁵⁴ See section 7 (information sharing) of the 2013-14 PbR Code of Conduct.

Summary

252. Providers and commissioners are expected to follow these steps:

- Establish and agree estimated activity baseline of outpatient diagnostic imaging activity for 2013-14, adjusted for growth in line with trends for diagnostic imaging activity.
- Use the estimated activity baseline to calculate the estimated 2013-14 provider income for outpatients, based on the published outpatient and diagnostic imaging tariffs for 2013-14.
- Compare the estimate 2013-14 provider income for outpatients to that for 2012-13, and agree risk sharing arrangements if there is a significant difference.
- Agree in-year monitoring arrangements for outpatient diagnostic imaging, and apply the marginal rate of 50% for any outpatient diagnostic imaging activity above the estimated 2013-14 baseline.
- Comply with the PbR Code of Conduct and NHS Standard Contract in relation to changes in the counting and coding of activity.

Operational issues

253. It is expected that providers will use SUS submissions as the basis for payment. Where for technical reasons this is not possible from April 2013, providers should agree with commissioners the date in 2013-14 by which this will be achieved. Where providers and commissioners have reached agreement on a date for SUS to be used for payment, providers should be paid based on patient level activity datasets provided to commissioners, in an agreed minimum dataset format, up until that date. This data should include (separately identified) direct access scans so that double charging can be avoided.

254. Where there is no existing link between the radiology system and the provider's Patient Administration System (PAS), imaging records should be matched via other means, for example the NHS number or other unique identifier and scan request date to outpatient records. This will enable identification of which radiology activity should and should not be charged for separately. Where the scan relates to outpatient activity that generates a procedure-driven HRG with a mandatory tariff, the scan should be excluded from charging.

255. Further details on the processing of diagnostic imaging data are set out in Annex G.

Sub-contracted imaging activity

256. Sub-contracted imaging activity should be dealt with as for any other sub-contracted activity, ie if Provider A provides scans on behalf of Provider B, Provider B should pay Provider A and Provider B should charge their commissioner for the activity.

Pre-operative assessments

257. 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 2013-14.
258. 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

259. Outpatient attendance TFCs that have a mandatory tariff of zero pounds (£0) are shown in Table 8. No payment should be agreed or made for this activity.

Table 8: 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

260. There are a number of mandatory tariffs for activity accessed directly, eg commissioned directly from primary care.
261. CDS 6.2 contains an optional field to identify services that have been accessed directly. SUS PbR will not use this field for 2013-14, but the field can be used by commissioners and providers to identify services accessed directly. As SUS PbR will assign a tariff to unbundled outpatient diagnostic imaging, it will also assign a tariff to direct access unbundled diagnostic imaging that flows on the outpatient CDS, as it will not distinguish between the two. The exception to this is where the core activity attracts a mandatory tariff for a procedure-driven HRG, in which case SUS PbR will correctly not assign a tariff for the unbundled diagnostic imaging. If providers do use the outpatient CDS to report direct access diagnostic imaging, they need to ensure that it is reported against TFC 812 Diagnostic Imaging so that an attendance tariff is not paid in addition.
262. 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

263. The tariffs for direct access diagnostic imaging are mandatory. Please note that there are also now tariffs for outpatient diagnostic imaging, with full details at paragraph 221.
264. 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.
265. For 2013-14, following requests from the NHS, we are publishing a non-mandatory tariff for direct access plain film x-rays.

Direct access simple echocardiograms

266. As in 2012-13, there is a mandatory tariff for direct access simple echocardiograms (HRG RA60Z).

Airflow studies

267. As in 2012-13, there are mandatory tariffs for direct access simple airflow studies (HRG DZ44Z) and simple bronchodilator studies (HRG DZ35Z).

Flexible sigmoidoscopies

268. As in 2012-13, there are mandatory tariffs for direct access diagnostic flexible sigmoidoscopy 19 years and over, with and without biopsy (HRGs FZ54Z and FZ55Z).
269. The tariffs are to support the cancer strategy, as set out in *Improving Outcomes: A Strategy for Cancer*, published on 12 January 2011⁵⁵.
270. 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.

⁵⁵http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Section 7: Urgent care

Accident and emergency services

271. In 2012-13 there were 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.
272. In 2013-14 we will be basing the A&E tariff on the full 11 HRGs for A&E rather than grouping tariffs into five price bands. This will ensure that the tariff is more granular, and improves consistency between the costs and the tariff.
273. We will also be making Type 2 A&E departments eligible for the full range of A&E tariffs to bring them more into line with the definition in the data dictionary. Type 3 A&E departments remain eligible for the lowest tariff only.
274. Patients who are dead on arrival (DOA) should always attract the tariff VB09Z.
275. Where a patient is admitted following an A&E attendance, both the relevant A&E and non-elective tariffs are payable.

Major trauma

276. Information on the major trauma best practice tariff can be found at paragraph 446.

Section 8: Best practice tariffs

Introduction

277. A best practice tariff (BPT) is a national tariff that has been structured and priced to adequately reimburse and incentivise care that is high quality and cost effective. The aim is to reduce unexplained variation in clinical quality and universalise best practice. A specific approach has been developed for each BPT, tailored to the clinical characteristics of best practice and the availability and quality of data.
278. The service areas covered by 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

279. This guidance covers all new and existing BPTs introduced since 2010-11. For each BPT, operational level guidance is provided first with separate sub-sections on policy related information and an explanation of the underpinning pricing approach. For BPTs that promote care in an appropriate setting, in order to avoid repetition the pricing approach is explained immediately after the section summarising the BPT package (paragraph 289).
280. The *tariff information spreadsheet* lists the BPT prices, HRGs and associated technical detail.
281. Some of the BPTs apply at the sub-HRG level with the use of a BPT flag. An explanation of BPT flags is provided in the *tariff information spreadsheet* in the BPT flag sheet.
282. There are several changes to the operation of BPT flags in 2013-14. These are:
- a) the Grouper will only generate a BPT flag for the HRGs relevant to the BPT;
 - b) the Grouper and SUS PbR will generate a BPT flag for all of the same day emergency care BPTs, irrespective of whether the tariff applies at the sub-HRG level, in order to facilitate the automation of payment within SUS PbR;
 - c) the format of the BPT flag sheet has been amended to reflect the HRG Code to Group spreadsheet issued by the Health and Social Care Information Centre (HSCIC).

283. Where a BPT applies at the sub-HRG level, 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.

284. Unless otherwise stated in the guidance below, each of the BPTs 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: Flexibilities where the principles of application apply.

Summary of BPT package

285. The table below summarises the package in 2013-14 and how existing BPTs have been revised, where relevant.

Table 9: Summary of BPT package

BPT	2010-11	2011-12	2012-13	2013-14
Acute Stroke (paragraph 294)	Introduced	Increased price differential	Further increase in price differential	Split of some HRGs to differentiate between patients with and without complications
Cataracts (paragraph 341)	Introduced and maintained			Status changed to non-mandatory
Fragility hip fracture (paragraph 418)	Introduced	Increased price differential	Further increase in price differential and expansion of best practice characteristics	Maintained
Day case procedures (paragraph 354)	Gall bladder removal	12 further procedures added	Two further procedures added; breast surgery procedures amended and revision to some day case rates	One further procedure added; hernia and breast surgery procedures amended
Adult Renal Dialysis (paragraph 309)		Vascular access for haemodialysis	Home therapies incentivised	Maintained
Paediatric Diabetes (paragraph 482)		Activity based structure (non-mandatory)	Year of outpatient care structure (mandatory)	Maintained
Transient ischaemic attack (paragraph 561)		Introduced and maintained		MRI payment removed in line with guidance on unbundling
Primary total hip and knee replacements (paragraph 527)		Introduced and maintained		Tariff at HRG level and change to calculation
Interventional radiology (paragraph 432)		Two procedures introduced	Five further procedures added	Maintained
Outpatient procedures (paragraph 464)			Three procedures introduced	Flexibility to encourage see and treat hysteroscopy
Same day emergency care (paragraph 538)			12 clinical scenarios introduced	Seven new clinical scenarios introduced
Major trauma care (paragraph 446)			Introduced	Maintained
Diabetic Ketoacidosis and hypoglycaemia (paragraph 364)				Introduced
Early inflammatory arthritis (paragraph 381)				Introduced
Endoscopy procedures (paragraph 403)				Introduced
Paediatric Epilepsy (paragraph 490)				introduced
Parkinson's disease (paragraph 501)				Introduced
Pleural Effusions (paragraph 517)				Introduced

286. The BPTs are presented in this Guidance in alphabetical order.
287. Where a BPT is based on reference costs, the price has been updated to reflect the 2010-11 reference costs.
288. Specialist top-ups and long stay payments apply to all of the relevant BPTs. The short stay adjustment applies to all relevant BPTs except for acute stroke care, fragility hip fracture and same day emergency care.

Pricing approach for appropriate setting BPTs

289. This pricing approach applies to the following BPTs, each of which are designed to encourage a shift from the traditional setting to a more appropriate setting:

Best practice tariff	Shift in setting (from/to)
Same day emergency care	Traditional wards to same day setting
Day case procedures	Overnight to day case setting
Outpatient procedures	Day case to outpatient setting
Pleural effusion	Emergency to elective setting

290. The structure and tariff calculation methodology provides a clear incentive for providers to change practice but penalises those that do not whilst ensuring that overall best practice does not cost commissioners more. This has been achieved by:
- departing from the conventional tariff structure with the price for the appropriate setting *relatively* higher than that for traditional setting;
 - decreasing the *absolute* level of tariffs for both settings to reflect the lower cost of providing a greater proportion of care in the appropriate setting.
291. With separate tariff prices per setting, unlike with the conventional tariff structure there is a revenue/expenditure consequence to changing the setting in which the procedure is performed. This offers a financial incentive to providers to change practice but the way in which the level of the tariffs are set ensures the commissioner will not pay more overall.
292. For a provider, the decision to change practice will depend on, amongst other factors, revenue and costs. The tariffs for both settings are set so that the average provider will only break even if it performs in line with best practice. The tariff for the appropriate setting over-reimburses the national average of costs of that setting, providing a clear incentive to change practice. Whereas the tariff for the traditional setting under-reimburses costs for that setting and acts as a penalty to those that do not change practice. The extent to which the tariff over/under reimburses

the relevant settings is based on the current and achievable rates of best practice.

293. Expenditure for commissioners under the BPT structure will not be greater than that under a conventional tariff structure. Although every procedure that shifts into the appropriate setting will attract a higher payment, this payment is lower than or equal to a tariff set in the conventional way ie based on the national average of reported costs across both settings. As a result, even if a provider performs all procedures in the appropriate setting, the commissioner will not pay more. For BPTs that apply at the HRG level this cannot be verified by organisations as there is no conventional tariff issued but it can be for those that apply at the sub-HRG level.

Acute stroke care

Tariff arrangements

294. The acute stroke care BPT (illustrated in Annex A Figure 4d) will continue in the same form in 2013-14 with the following revision:

- HRGs AA22Z and AA23Z have been split to differentiate between patients with and without complications and co-morbidities

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

- (a) patients are admitted directly⁵⁶ to an acute stroke unit⁵⁷ 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 majority⁵⁸ 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*⁵⁹. The scan should not only be done in the

⁵⁶ 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.

⁵⁷ Or similar facility where the patient can expect to receive the service set out in quality marker 9 of the National Stroke Strategy.

⁵⁸ Defined as greater than or equal to 90% of the patient's stay within the spell that groups to HRGs: AA22A; AA22B; AA23A; AA22B. For a definition on measuring the 90% stay, we recommend that used for the Sentinel Stroke National Audit Programme. IPMR Guidance is available to download from here: <http://transparency.dh.gov.uk/2012/07/20/integrated-performance-measures-monitoring/>

⁵⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085146

stated timescales⁶⁰ but immediately interpreted and acted upon by a suitably experienced physician or radiologist.

- (c) Patients are assessed for thrombolysis, receiving alteplase if clinically indicated in accordance with the NICE technology appraisal guidance⁶¹ on this drug⁶².

296. Acute stroke units should meet all the markers of a quality service set out in the National Stroke Strategy quality marker 9 as follows:

- (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 the monitoring of patients
- (e) appropriately qualified clinicians are available to address respiratory, swallowing, dietary and communication issues.

297. The base tariff and the additional payments apply at the sub-HRG level with the use of a BPT flag to capture the relevant activity within the associated HRGs. The BPT flag is generated by the Grouper and SUS PbR, where the spell meets the following criteria:

- (a) patient aged 19 or over (on admission)
- (b) emergency, or transfer admission method (admission method codes 21-25, 2A, 2B, 2C, 2D (or 28 if the provider has not implemented CDS 6.2) and 81)
- (c) a primary diagnosis code from the list in the *tariff information spreadsheet*
- (d) HRG from the list in the *tariff information spreadsheet*

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

299. 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 AA22A or AA22B, as Annex A Figure 4d illustrates.

⁶⁰ In short, these are: in next scan slot (or within 60 minutes for out of hours) where urgent imaging is required, otherwise within 24 hours for those not requiring urgent imaging. For full guidelines please refer to the Imaging Guide.

⁶¹ www.nice.org.uk/TA122

⁶² The additional payment covers the cost of the drugs, the additional cost of nurse input and the cost of the follow-on brain scan.

300. For the other two characteristics, organisations will need to agree local reporting and payment processes. The Stroke Improvement National Audit Program (SINAP)⁶³ will be a useful source of information and support to organisations in establishing these processes.

Background and supporting information

301. The acute stroke care BPT is designed to generate improvements in clinical quality in the acute part of the patient pathway. It does this by incentivising key components of clinical practice set out in the National Stroke Strategy⁶⁴, NICE clinical guideline CG68⁶⁵ and the NICE quality standard for stroke QS2⁶⁶.
302. 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.
303. Commissioners will be aware that there are a number of different models for delivering high quality stroke care. While 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 but which do not qualify for the element of the BPT in relation to 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 in place to qualify for the incentive payment for direct admission to a stroke unit.
304. 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. SINAP is one of the audits in the National Clinical Audit and Patient Outcomes Programme (NCAPOP)

Pricing approach

305. The pricing approach is designed to provide both additional funding per patient to adequately fund the costs of best practice and the cost of not changing practice.
306. For a provider, there is a real additional resource cost of delivering care on a high-quality stroke unit. The national average of reported costs would not cover the full costs of delivering best practice so an additional

⁶³ <http://www.rcplondon.ac.uk/projects/stroke-improvement-national-audit-programme-sinap>

⁶⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

⁶⁵ <http://www.nice.org.uk/CG68>

⁶⁶ <http://www.nice.org.uk/guidance/qualitystandards/stroke/strokequalitystandard.jsp>

payment of £342 is payable to remove that barrier within the conventional tariff. It would be financially imprudent to set a zero tariff for care that does not meet best practice so over time the base tariff has been lowered in a sustainable way, leading to a further cost for not changing practice.

307. For the urgent brain imaging element, the structure of the conventional tariff was changed so that reimbursement of the scan costs are conditional on meeting best practice. Under the conventional tariff structure, the costs of scans are reimbursed by the core spell tariff irrespective of whether and when the scan is performed.

308. In 2013-14 the differential between best practice and standard care will remain the same as that in 2012-13 at £1,425. The differential has been achieved by lowering the base tariff by the increased additional payments, 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
2013-14	£1,425

Adult renal dialysis

Tariff arrangements

309. This section includes information relating to the best practice tariffs for haemodialysis and also details of the conventional mandatory tariffs for home therapies.

310. The scope of the tariffs for adult renal dialysis is:

Dialysis modality and setting	Basis of payment
Haemodialysis	per session
Home haemodialysis	per week
Peritoneal dialysis and assisted Automated Peritoneal Dialysis (aAPD)	per day
Dialysis away from base	per session ⁶⁷

311. The tariffs apply to adult patients with chronic kidney disease⁶⁸ and not those with acute kidney injury⁶⁹.

⁶⁷ Including local flexibility where applicable.

312. If a patient with acute kidney disease requires dialysis whilst in hospital during an unrelated spell then the dialysis tariff is payable in addition to the tariff for the core spell.
313. The national tariff is 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% of a provider's total activity.
314. 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 2013-14:
- (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
315. 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.
316. 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).

⁶⁸ 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).

⁶⁹ Principally this is because acute renal failure is excluded from the scope of the NRD for detailed data collection.

317. The tariffs apply at HRG level. The HRGs and prices are contained in the *tariff information spreadsheet*.
318. The HRGs are generated by data items from the National Renal Dataset (NRD). Commissioners should include, as a minimum, the data items listed in Table 10 in information schedules of NHS contracts where these services are provided.

Table 10: National Renal Dataset fields Renal care

<p>Renal Care</p> <p>[1] renal treatment modality, eg haemodialysis, peritoneal dialysis</p> <p>[6] renal treatment supervision code, eg home, hospital</p> <p>Person observation</p> <p>[75] blood test HBV surface antigen</p> <p>[77] blood test HCV antibody</p> <p>[79] blood test HIV</p> <p>Demographics</p> <p>[19] PCT organisation code</p> <p>Dialysis</p> <p>[182] type of dialysis access, eg fistula</p> <p>[23] dialysis times per week</p> <p>Organisations will also need to derive:</p> <ul style="list-style-type: none"> • a unique patient identifier • patient age (in years derived from date of session – date of birth)
--

319. 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 2013-14 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.
320. The HRGs in sub-chapter LD are core HRGs. 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 because the activity data is recorded in the NRD and reported locally. 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* - will be generated, with a tariff set to zero.
321. Reporting and reimbursement for acute kidney injury will need to be agreed locally. The Grouper will only produce HRGs for dialysis sessions associated with acute kidney injury where activity is captured by the seven NRD data items used for chronic kidney disease. Organisations

will need to clearly identify the activity as being for acute kidney injury as the tariff arrangements for this activity is for local agreement.

Background and supporting information

Haemodialysis

322. 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.
323. 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.
324. As a result of feedback from the service relating to the challenges associated with achieving the rates in the first two years of the transition, we have taken a decision to freeze the rate at 80% for 2013-14.
325. Providers should continue to work towards the recommended rate in the renal guidance. It is anticipated that the transition to 85% will be completed in future years.
326. 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.
327. 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.
328. 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.
329. Renal units will need to collaborate with surgical services to establish processes that facilitate timely referral for formation of vascular access.

330. 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

331. The aim of the mandatory tariffs for home haemodialysis is to provide a real choice of home haemodialysis for patients.

332. 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.

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

334. 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.

335. 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

336. The tariffs for peritoneal dialysis are based on reference costs and are set to adequately reimburse providers for the associated costs. Whilst this is not a BPT area it is included here and in the *Tariff Information Spreadsheet* for completeness.

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 there are two local flexibilities (described in paragraph 313).

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 continue to work with Kidney Alliance and other stakeholders to understand the costs of dialysis away from base. The evidence from the latest reference costs collection exercise does not support a need to introduce separate costs for these patients, but we will continue to review this area.

Cataracts

Tariff arrangements

341. In 2013-14 the BPT for cataract surgery will be non-mandatory. Those commissioners that wish to reimburse on the basis of the BPT will not require the approval of the provider organisation but must, within reason, share the administrative effort in operating the tariff.
342. The BPT 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.
343. The tariff corresponds to the elements of the best practice pathway (Table 11). 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 11: 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 (2 nd 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

Level	Description	Events
		optometrist (pathway price does not include cost of this as it is incurred in primary care).

344. 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 field⁷⁰, returning records in chronological order per patient. More information is available in the SUS PbR documentation via the NHS Connecting for Health website⁷¹. If providers and commissioners agree, they can implement local solutions for paying for cataract pathways.

345. As cataracts can be a bilateral procedure, the pathway tariff has been split into two sub-pathways: first eye and second eye. Clinical guidelines recommend that where a patient requires cataract extraction on their second eye this should be discussed and agreed at the post-operative appointment for the first eye surgery such that the patient can leave the appointment with a firm date for surgery. If cataract surgery is not considered beneficial on the second eye then the patient should be discharged.

346. Occasionally it may be important to carry out cataract procedures on both eyes within a short space of time of each other (for example a high myope or hypermetrope who is made emmetropic) and the patient would be expected to have the second eye operation soon after the first in line with clinical best practice.

347. The best practice tariff for cataracts is intended to apply only to secondary care. Where elements of the pathway are carried out in a primary care setting then the tariff prices should be reduced accordingly.

348. Only a small proportion of patients are likely to require multiple follow-up attendances on the cataract pathway, including where patients have other ophthalmic conditions, eg glaucoma, or where there have been surgical complications. Follow-up attendances for these patients should not be considered as part of the best practice pathway and they should no longer be coded as on the same Patient Pathway ID. Commissioners and providers may wish to agree through contracts the notification and approval processes for patients moving onto an additional pathway as a safeguard against any incorrect coding.

349. The pathway for some patients will span multiple providers, for example due to configuration of services in the health economy or through patient choice. The national pathway tariff can be implemented across multiple

⁷⁰ This is one of the 18 weeks (referral to treatment) fields mandated for compliance since January 2010.

⁷¹ <http://www.ic.nhs.uk/sus/pbrguidance>

providers only where there is robust reporting of information between providers using the inter-provider minimum dataset (IPMDS) locally. Where this data is sufficiently robust, we recommend that it is used in local implementation across multiple providers. To facilitate this pathway and similar pathway approaches in the future, we encourage organisations to capture and flow information in the IPMDS. Where robust reporting is not in place, commissioners will need to make arrangements locally to monitor compliance in order to make the financial adjustments.

350. While the best practice tariff is intended to cover all elective cataract patients grouped to BZ02Z and BZ03Z, in a minority of cases high risk patients may require an additional pre-operative assessment the day prior to surgery to ensure it is safe to proceed. Commissioners will need to satisfy themselves that robust protocols are in place for determining these cases and agree locally a suitable level of reimbursement, ie a follow-up attendance price paid either in full or at a percentage.

Background and supporting information

351. The aim of the BPT is to encourage the provision of a streamlined pathway to the benefit of patient experience and value for money. The pathway is in line with the Royal College of Ophthalmologist's⁷² guidelines. Please refer to the PbR Guidance for 2010-11⁷³ for background information to the cataract BPT.
352. We have changed the status from mandatory to alleviate any undue administrative burden on those commissioners for which the benefits of operating the BPT are outweighed by the cost. For example, where commissioners already make use of contractual mechanisms to reduce the number of follow-up attendances the additional effort in operating the BPT may meet the same objective. This change has been prompted by the findings of the BPT evaluation⁷⁴ as well as other feedback.

Pricing approach

353. The pricing approach is designed to adequately reimburse the cost of best practice and also to introduce a cost of not changing practice. It is achieved by a single price per pathway, set on the costs of a streamlined pathway and is fixed even if best practice is not achieved.

⁷² <http://www.rcophth.ac.uk/page.asp?section=451§ionTitle=Clinical+Guidelines>

⁷³

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112284

⁷⁴ Commissioned by the Department and conducted by researchers at the universities of Manchester and Nottingham

Day case procedures

Tariff arrangements

354. The BPTs will continue in the same form with the following revisions:
- a) Tympanoplasty⁷⁵ (all ages) added to the list of procedures
 - b) FZ18A is no longer part of the hernia repair BPT, based on clinical concern over the suitability of patients 'with major complications and co-morbidities' for day surgery
 - c) Breast surgery BPTs have been simplified by removing the differentiation between with and without axillary surgery for excision of breast and mastectomy
355. The BPT (illustrated in Annex A Figure 4b) is made up of a pair of prices for each procedure: one applied to day case admissions the other to ordinary elective admissions.
356. For around one third of the procedures, the BPT will apply to the HRG. For the remaining, 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 and SUS PbR, where the spell meets the following criteria:
- patient classification is either 1 for ordinary admissions or 2 for day case admissions
 - elective admission method (admission method is 11, 12 or 13)
 - relevant procedure codes from the list in the *tariff information spreadsheet*
 - HRG from the list in the *tariff information spreadsheet*

The *tariff information spreadsheet* details the prices, whether they apply at HRG or BPT flag level and the relevant OPCS codes⁷⁶.

357. SUS PbR will automate payment by generating the relevant flag, where required and applying relevant prices either to the BPT flag within relevant HRGs or at the HRG as appropriate.

Background and supporting information

358. A day case is defined in the NHS Data Dictionary as⁷⁷:

⁷⁵ Tympanoplasty includes: myringoplasty; mastoidectomy; ossiculoplasty; and stapedectomy.

⁷⁶ OPCS codes for procedures for which the BPT applies at HRG level are detailed in the BADS Directory available to purchase from here: <http://daysurgeryuk.net/bads/joomla/> . or available to download in the Definition document on the NHS Better Care, Better Value indicators website:

<http://www.productivity.nhs.uk/Indicator/609/For/National/And/25th/Percentile>

⁷⁷http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_classification_de.asp?shownav=1

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.

359. 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. The procedures selected for BPTs come from the third edition of this directory, with some revisions following the update to fourth edition in 2012. They are high volume, and have day case rates that vary significantly between providers and are nationally below the BADs rates.
360. 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.
361. Table 12 lists the procedures introduced in previous years. The table also contains a range of different rates: those used in tariff calculation; the rates from the BADs Directory of procedures (4th edition) and estimates of the current rates using 2010-11 HES.
362. In a number of areas the tariff calculation rate differs from BADs. Our assumption is that the rates will continue to move towards the BADs rates in future, however this will be a decision for Monitor and the NHS Commissioning Board.

Table 12: Day case BPT areas

Procedure	BADS rate (4th edition)	Tariff calculation rate	Current rates (2010-11 HES)	Comments
Breast surgery				
Excision of breast – Excision/biopsy of breast tissue including wire guided – Wide local excision	95% 75%	75% (weighted average)	53% (weighted average)	
Simple mastectomy	30%	15%	3%	Differs from BADS rate given the very low current day case rate.
Sentinel lymph node biopsy	80%	80%	39%	
Axillary clearance	80%	40%	8%	Differs from BADS rate given the very low current day case rate.
Gynaecology				
Operations to manage female incontinence	60%	45%	35%	Differs from BADS rate based on clinical advice
Urology				
Endoscopic resection of prostate (TUR)	15%	15%	2%	
Resection of prostate by laser	75 %	60%	16%	Differs from BADS rate based on clinical advice
General surgery				
Cholecystectomy	60%	60%	34%	
Repair of range of hernia (umbilical, inguinal, recurrent inguinal and femoral)	90%	90%	65%	Rates are a weighted average of the individual hernia repair procedures
Orthopaedic surgery				
Arthroscopic subacromial decompression	80% (75%)	n/a	54%	The figures in parentheses in the BADS rate column are the 75 th percentile day case rates from HES 2009-10.
Bunion operations with or without internal fixation and soft tissue correction	85% (72%)	n/a	58%	
Dupuytren's fasciectomy	95% (90%)	n/a	80%	
Ear, nose and throat				
Tympanoplasty (including myringoplasty; mastoidectomy; ossiculoplasty; and stapedectomy)	80%	50%	30%	
Tonsillectomy – Children – Adults	70% 80%	70% 80%	34% 34%	
Septoplasty	60%	60%	43%	

Pricing approach

363. The pricing approach is the same as for all BPTs where the aim is to promote the appropriate setting (paragraph 289).

Diabetic ketoacidosis and hypoglycaemia

Tariff arrangements

364. The BPT applies to adults only, admitted as an emergency with diabetic ketoacidosis (DKA) or hypoglycaemia.

365. The BPT is made up of two components: a base tariff and a conditional payment. The base tariff is payable for all activity irrespective of whether best practice was met. The conditional payment is payable if all of the following characteristics are achieved:

- a. referred to the Diabetes Specialist Team (DST) on admission, and seen within 24 hours by a member of the DST
- b. have an education review by a member of the DST prior to discharge⁷⁸
- c. be seen by a Diabetologist or DSN prior to discharge
- d. be discharged with a written care plan, a process that allows the person with diabetes to have active involvement in deciding, agreeing and owning how their diabetes is managed. This should be copied to the GP
- e. patients to be offered access to structured education, with the first appointment scheduled to take place within 3 months of discharge⁷⁹

366. The base tariff and conditional payment apply at the sub-HRG level, with the use of a BPT flag to capture the relevant activity within the associated HRGs. The BPT flag is generated by the Grouper and SUS PbR, where the spell meets the following criteria:

- patient aged 19 or over (on admission)
- emergency admission method (codes 21 – 25, 2A, 2B, 2C, 2D (or 28 if the provider has not implemented CDS 6.2))

⁷⁸ In some circumstances not all elements of the review are applicable (eg injection issues that would not be relevant to people who are not taking insulin (for example those taking oral medication) and ketone monitoring that is only required for individuals with type 1 diabetes). **Review to include:** usual glycaemic control; injection technique/blood glucose; monitoring/equipment/sites; discussion of sick day rules; assessment of the need for home ketone testing (blood or urinary) with education to enable this; and contact telephone numbers for the DST including OOH

⁷⁹ It is accepted that in some circumstances structured education may not be appropriate for patients (ie elderly people with dementia or living in care homes). Where this is the case then structured education can be excluded from the criteria.

- a diagnosis from the list in the *tariff information spreadsheet*
- one of the HRGs from the list in the *tariff information spreadsheet*

367. The *tariff information spreadsheet* details the prices, the BPT flag detail and the relevant ICD codes. Please note that as the HRGs are specific to adults there should be no overlap with paediatric diabetes.

368. SUS PbR will apply the base tariff to spells with a BPT flag.

369. SUS PbR will not apply the conditional payment. Compliance with the characteristics of best practice will need to be measured and monitored locally with the conditional payment paid accordingly.

370. The BPT excludes reimbursement for the structured education so arrangements for this will need to be agreed locally. There is a new TFC for diabetic education services (TFC 920) against which organisations should record and cost activity.

Background and supporting information

371. We are introducing a mandatory BPT for the emergency admission of adult patients with diabetic ketoacidosis (DKA) and hypoglycaemia.

372. The aims of the BPT are to ensure the involvement of a diabetes specialist team and access to a structured education programme. The involvement of a diabetes specialist team shortens patient stay and improves safety and the involvement should occur as soon as possible during the acute phase. The benefit of a structured education programme is predominantly a reduction in admission rates.

373. DKA remains a frequent and life threatening complication of type 1 diabetes. Errors in its management are not uncommon and are associated with significant morbidity and mortality.

374. The practice of admitting, treating and discharging patients with DKA or hypoglycaemia without the involvement of the diabetes specialist team could compromise safe patient care.

375. Specialists must also be involved in the assessment of the precipitating cause of DKA or hypoglycaemia, management, discharge, and follow up. This will include assessment of the patient's understanding of diabetes plus their attitudes and beliefs.

376. A significant percentage of organisations with a specialist team should be able to formalise their current arrangement in line with best practice. Other organisations should be able to establish a specialist team as the majority will already have a diabetologist, diabetes specialist nurse and dietitian on site.

377. There is variation across the country in the provision of structured education in terms of access and waiting lists.
378. Structured education should be delivered in line with the criteria laid out in the Diabetes UK Care Recommendation Education of People with Diabetes.
379. The evidence base and characteristics of best practice have been informed by and are in line with:
- NICE Quality Standard for Diabetes in Adults (2011)⁸⁰
 - NICE Type 1 diabetes guidance⁸¹
 - NHS Institute for Innovation and Improvement Think Glucose Project
 - NHS Diabetes and Joint British Diabetes Societies guidance on the management of Diabetic Ketoacidosis, and on the prevention and management of hypoglycaemia in hospital
 - Joint British Diabetes Society (JBDS), Diabetes UK. The Hospital Management of Hypoglycaemia in Adults with Diabetes⁸²

Pricing approach

380. The pricing approach is designed to provide a cost of not achieving best practice. Only spells that meet best practice will attract the full conventional tariff otherwise only 85% of the tariff is payable. Best practice will not cost commissioners more and expenditure will reduce where best practice is not met but it is expected that commissioners will engage with providers to improve services.

Early inflammatory arthritis

Tariff arrangements

381. The BPT applies to adults only, who are referred to an outpatient clinic with suspected early inflammatory arthritis and who receive care in line with best practice.
382. There are three separate tariffs applicable to all newly referred patients from 1 April 2013, seen in adult rheumatology clinics. Patients already diagnosed with early inflammatory arthritis prior to April 2013 are excluded from the BPT. Treatment for these patients should continue to be paid for using the existing rheumatology TFC 410. Each of the tariffs is an annual payment. Patients are only eligible for one of the tariff

⁸⁰ <http://guidance.nice.org.uk/QS6>

⁸¹ <http://www.nice.org.uk/CG15>

⁸² <http://www.nelm.nhs.uk/en/NeLM-Area/News/2010---April/07/Joint-British-Diabetes-Societies-Inpatient-Care-Group-guidance-on-the-management-of-diabetic-ketoacidosis/>

payments in year, subject to meeting all criteria.

383. The BPTs are as follows:

Table 13: Early inflammatory arthritis BPTs

Diagnosis and discharge BPT	<p>For those patients with suspected EIA who are:</p> <ul style="list-style-type: none"> – seen within three weeks of referral; – diagnosed as not having EIA and discharged within 6 weeks of referral⁸³. <p>The tariff includes the costs of plain radiology, ultrasounds, all blood tests, clinical consultations with doctors / nurses.</p>
DMARD Therapy BPT	<p>For those patients with suspected EIA who:</p> <ul style="list-style-type: none"> – are seen within three weeks of referral; – have DMARD treatment initiated within 6 weeks of referral⁸⁴; – receive regular follow up⁸⁵ and monitoring over first year of treatment with evidence of appropriate titration of therapy. <p>The tariff includes the annual costs of all blood tests, non-biologic prescriptions, clinical consultations with doctors/nurses, annual review.</p> <p>The tariff excludes physiotherapy, psychology, podiatry, occupational therapy, telephone emergency advice line, inpatient admissions, biologics and associated drug costs.</p>
Biological therapy BPT	<p>For patients with suspected EIA who:</p> <ul style="list-style-type: none"> – are seen within three weeks of referral; – are diagnosed with DMARD treatment initiated within 6 weeks of referral; – receive regular follow up and monitoring over first year of treatment; – meet NICE eligibility criteria for biological therapy and biologics are prescribed and initiated in year 1. <p>The tariff includes the annual costs of all blood tests, non-biologic prescriptions, clinical consultations with doctors/nurses, annual review.</p> <p>The tariff excludes physiotherapy, psychology, podiatry, occupational therapy, telephone emergency advice line, inpatient admissions, biologics, drug infusion and associated costs</p>

⁸³ In exceptional circumstances where a patient is referred twice in-year then only the initial referral is eligible for the BPT. The second referral should be paid at the first and follow up price for TFC 410. Patients with palindromic rheumatism can be paid the BPT on second referral at the discretion of the commissioner

⁸⁴ In some circumstances patients are known to decline DMARDs therapy. If the patient still receives the requisite regular follow-ups and monitoring then the BPT is still applicable.

⁸⁵ The requirement for follow up will vary depending on the disease-specific activity measures. It is anticipated that there would usually be a minimum of four consultant led follow-ups and an annual review as part of the pathway, in addition to further nurse-led reviews.

384. Please note that for the purposes of this BPT, diagnostic imaging remains bundled. This is consistent with the imaging guidance which states that “diagnostic imaging remains bundled where it is part of a currency and/or tariff for a pathway or period of time other than an attendance”.
385. To ensure that the tariff does not limit innovation and reflects differing local circumstances, there will be two flexibilities in relation to the BPT in 2013-14, as follows:
- Where a provider and commissioner agree that the existing service exceeds the criteria set out above, then additional payments can be made. This should be agreed locally.
 - Where the best practice tariff criteria is met through shared care arrangements, commissioners and providers should negotiate the level of payment to a provider
386. SUS PbR will not apply any of the three BPTs and there is no discrete TFC for early inflammatory arthritis activity. Organisations will therefore need to identify activity and administer the BPTs locally.
387. Activity meeting best practice will need to be excluded from the CDS in order to avoid double payment. Providers achieve this by including an equals sign ('=') as the last significant character of the 6-character CDS data item Commissioning Serial Number. The equals sign will exclude the episode and a PbR tariff will not be applied.
388. If a provider is not meeting the best practice specification they will continue to be paid the outpatient first and follow up attendance tariffs for the rheumatology TFC 410. There are two scenarios where this TFC may be applicable:
- a) If a provider does not think that it is meeting best practice criteria then it should continue to code to the TFC 410 Rheumatology.
 - b) Where a provider chooses to exclude activity from the TFC (in line with paragraph 387) and indicates that this meets best practice but is unable to demonstrate this locally.

Background and supporting information

389. We are introducing mandatory BPTs for adult patients referred to an outpatient clinic with suspected early inflammatory arthritis who receive care in line with best practice.
390. The aim of the BPT is to ensure timely diagnosis and initiation of therapy where appropriate.

391. The proposed tariffs have been developed in association with the British Society for Rheumatology and Arthritis Research UK, and reflect NICE clinical guideline 79⁸⁶.
392. For patients with inflammatory arthritis, it should almost always be possible to make the decision to start DMARD therapy within six weeks of GP referral where inflammatory synovitis is sustained at specialist review.
393. Current classification criteria for rheumatoid arthritis do not specify a minimum duration of disease, but do assign a single point (out of ten possible) for duration of six weeks or more. The hypothetical case of a patient presenting to their GP on their first day of symptoms and being referred the same day would be quite exceptional given the insidious onset of symptoms. Even in that situation, there would be six weeks' joint inflammation by the time DMARD initiation is suggested.
394. There is substantial proven benefit of DMARD initiation within 12 weeks of symptom onset. To enable this, general practitioners should continue to develop and follow local guidance for referral to ensure that patients with suspected early inflammatory arthritis are referred within a maximum of 6 weeks of the onset of symptoms.
395. Given the potential of urgent, intensive DMARD treatment to transform outcomes for people with inflammatory arthritis by inducing remission and preventing disability, as well as reducing the need for subsequent biologic therapies, Arthritis Research UK and the British Society for Rheumatology support this suggested six-week timeframe for specialist review and initiation of DMARD therapy.
396. The National Audit Office report on rheumatoid arthritis also noted "The likelihood of people with rheumatoid arthritis being diagnosed and treated within the clinically recommended period of three months from the onset of symptoms has not improved in recent years".
397. Given the current variances in practice, it is important that providers and commissioners work together to improve services in order to meet the expectation that providers are delivering best practice care in 2014-15.

Pricing approach

398. The pricing approach is designed to adequately reimburse the costs of best practice. At present, providers are paid on a first and follow up attendance basis as part of a generic TFC for rheumatology. This approach does not in all circumstances adequately reflect the actual costs of a best practice service.

⁸⁶ <http://www.nice.org.uk/CG79>

399. The structure of the BPT aims to remove any first and follow up ratios in operation locally that may prevent providers from receiving full payment for delivering a best practice service.
400. The pricing of the DMARD therapy BPT is reflected of the anticipated average number of follow-ups. We appreciate that there will be patients with more complex needs requiring additional follow-ups, but we would anticipate that the tariff should adequately fund, on average, providers with a regular mix of patients.
401. As set out in paragraph 385, we have introduced two local flexibilities for 2013. These flexibilities are to ensure that the BPT does not impact on those already delivering a best practice service and reflects shared care arrangements.
402. Please note that the introduction of the BPT has not impacted on the price of the TFC for rheumatology.

Endoscopy procedures

Tariff arrangements

403. The BPT applies to adults only for elective endoscopic procedures in all NHS providers (including community organisations) and independent sector providers.
404. The BPT comprises a single tariff per HRG with provision for commissioners to withhold 5% of the tariff from providers that either:
- are not engaged in the accreditation scheme; or
 - have been assessed by JAG and, following a six month review, accreditation has not been awarded.
405. The status of providers are defined by JAG, available on the JAG website^{87,88} and updated on a monthly basis as:

Engaged – full tariff applies	Not engaged – 5% to be withheld
<i>Assessed: accreditation awarded</i>	<i>Assessed: accreditation not awarded</i>
<i>Engaged: improvements required</i>	Not engaged

406. Commissioners should ensure that they reflect changes to status of providers in-year.

⁸⁷ <http://www.thejag.org.uk/>

⁸⁸ If a provider does not appear in the lists contained on the website then commissioners should contact the JAG helpdesk for further information regarding the relevant status to be applied.

407. SUS PbR will automate payment by applying the full tariff price to the HRG. Commissioners will need to reclaim any overpayments from providers not engaged in the accreditation scheme.
408. Information on the JAG website is at site-level rather than organisation level. Where a provider has sites of mixed status, commissioners should apply the tariff at this level if they are able to do so, otherwise organisations will need to agree the appropriate reduction that reflects the service provision across the provider. If agreement cannot be reached then we suggest that payments are reduced in proportion to the number of sites not engaged.

Background and supporting information

409. We are introducing mandatory BPTs in 2013-14 for a number of endoscopic procedures.
410. The aim is to encourage providers to achieve and maintain the required quality standards in line with the JAG accreditation scheme for endoscopy services.
411. JAG Accreditation provides formal recognition that an endoscopy service meets the competence to deliver against the measures in the endoscopy Global Rating Scheme (GRS).
412. Further information relating to the accreditation process and the associated benefits is available via the JAG website.⁸⁹
413. The idea behind linking the accreditation to a financial lever is that those providers who are not currently accredited will be motivated to engage in the process, ensuring improved and consistent standards.
414. Although there has been no decision about the structure of the BPT in future years, we would encourage all providers to aim to achieve JAG accreditation at the earliest opportunity. This will ensure that any possible future changes will not adversely impact on income.
415. The decision to include all those providers who have been subject to a six month improvement plan and subsequent review aims to create an incentive to address the issues outlined above and ensure best practice.
416. The introduction of the BPT has not impacted on the tariff prices for the HRGs, which continue to reflect conventional tariff calculation methods.

Pricing approach

417. The pricing approach is designed to provide a cost of not achieving best practice. Only spells that meet best practice will attract the full

⁸⁹ <http://www.thejag.org.uk/>

conventional tariff otherwise 95% of the tariff is payable. Best practice will not cost commissioners more and expenditure will reduce where best practice is not met but it is expected that commissioners will engage with providers to improve services.

Fragility hip fracture

Tariff arrangements

418. The fragility hip fracture BPT (illustrated in Annex A Figure 4c) will continue in the same form in 2013-14.
419. The BPT is made up of two components: a base tariff and a conditional payment. The base tariff is payable to all activity irrespective of whether the characteristics of best practice are met. The conditional 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 surgeon⁹⁰
 - (c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia⁹¹
 - (d) assessed by a geriatrician⁹² 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.
420. 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 appropriate discharge and follow-up arrangements.
421. The base tariff and the additional payment apply at the sub-HRG level with the use of a BPT flag to capture the relevant activity within the associated HRGs. The BPT flag is generated by the Grouper and SUS PbR, where the spell meets the following criteria:

⁹⁰ 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.

⁹¹ We recommend that providers issue their commissioners with a copy of the agreed joint assessment protocol. Examples are available at www.nhfd.co.uk

⁹² Geriatrician defined as consultant, non-consultant career grade (NCCG), or specialist trainee ST3+.

- (a) patient aged 60 or over (on admission)
 - (b) emergency, or transfer admission method (admission codes 21-25, 2A, 2B, 2C, 2D(or 28 if the provider has not implemented CDS 6.2) and 81)
 - (c) a diagnosis and procedure code (in any position) from the list in the *tariff information spreadsheet*
 - (d) HRG from the list in the *tariff information spreadsheet*
422. 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.
423. SUS PbR will apply the base tariff to spells with the BPT flag in HRGs from the list in the *tariff information spreadsheet*.
424. 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 timetable⁹³ (paragraph 935), ie the report for the April to June quarter will be available at the final reconciliation date. 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.
425. 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.
426. 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 BP01 to additionally validate matching. All records, including those for patients aged 60 or over who fail to meet the criteria, are sent to relevant commissioners when available.

⁹³ 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.

427. 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.

Background and supporting information

428. The aim of the BPT is to promote best practice in the care and secondary prevention of fragility hip fracture in line with the clinical guidelines and quality standards from NICE (CG124 and QS16). For background information to the BPT please refer to the 2010-11 PbR Guidance⁹⁴.

Pricing approach

429. The pricing approach is designed to provide both additional funding per patient to adequately fund the costs of best practice and a cost of not changing practice.

430. For a provider, there is a real additional resource cost of delivering best practice. The national average of reported costs would not cover the full costs of delivering best practice so an additional payment of £445 is payable to remove that barrier within the conventional tariff. It would be financially imprudent to set a zero tariff for care that does not meet best practice so over time the base tariff has been lowered in a sustainable way, acting as an opportunity cost for not changing practice.

431. In 2013-14 the differential between best practice and standard care will remain the same as that in 2012-13 at £1,335. The differential 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
2013-14	£1,335

94

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112284

Interventional radiology

Tariff arrangements

432. The BPTs for interventional radiology (IR) (illustrated at Annex A Figure 4h) are set out in the table below:

Table 14: Interventional radiology procedures in BPT programme

Condition	Procedure
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
Abdominal aortic aneurysms	Abdominal endovascular aortic repair (EVAR)
Uterine fibroids (benign tumours of the uterus)	Uterine Fibroid Embolisation (UFE)

433. There is one change for 2013-14 which is that angioplasty and stenting procedures also apply to the new HRG: RC41Z *Major Vascular Interventional Radiology Procedures*

434. 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.

435. 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 B.

436. 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.

437. SUS PbR will automate payment by generating the relevant flag, where required, and applying relevant prices either to the BPT flag within relevant HRGs or to the HRG as appropriate.

438. 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*.

Background and supporting information

439. 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*⁹⁵, provides a 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.

440. The clinical evidence base for the IR procedures is summarised in Annex C: Evidence base for interventional radiology and primary total hip and knee replacements BPTs.
441. 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.

Pricing approach

442. 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, provision of IR services will improve.
443. The price level of the BPTs is broadly in line with that for 2012-13 which was based on a dedicated costing exercise conducted with a number of providers as well as information from other sources. The BPTs mean that the IR procedures are reimbursed at a higher rate than they would have been otherwise, though we recognise that they may not fully reimburse the costs. It was not possible to fulfil the intention to conduct a more comprehensive costing exercise and PLICS data on the IR procedures was not of robust quality to inform and refine the BPTs in 2013-14 as intended.
444. 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.

⁹⁵ Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121904

445. The level of the BPTs for abdominal EVAR and UFE BPT is now based on Reference Costs as the specific HRGs were included for the first time in the 2010-11 Reference Cost Grouper.

Major trauma

Tariff arrangements

446. The best practice tariff for major trauma patients (illustrated at Annex A Figure 4g) was introduced in 2012-13. The aim of the tariff is to encourage best practice treatment and management of trauma patients within a regional trauma network. The BPT is paid on activity at major trauma centres (MTCs) for the most seriously injured patients. During 2012-13 the BPT was applied in most of the MTCs in England and data demonstrates that compliance with BPT is improving month on month, and that this is having an impact on the quality of care.
447. Although funding is attached to individual patients, the aim of the tariff is to move funding into MTCs. This tariff was designed to drive improved standards of care whilst moving funds into the newly formed MTCs which went live in April 2012.
448. 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)⁹⁶ of the patient and conditional on achieving the criteria. The BPTs for levels 1 and 2 are available in the *tariff information spreadsheet*. The BPT applies to adults and children.
449. The recommendation from the Major Trauma Clinical Reference Group (CRG) is that we should continue to make best practice stretching and two additional criteria have been suggested to reflect this.
450. Firstly, there is evidence that a cheap and simple intervention (tranexamic acid) significantly reduces mortality, and it is proposed its use be adopted into BPT criteria. There is the highest level of scientific evidence that this has significant impact on patient survival in injured patients with severe bleeding.
451. Secondly, there are disparities in the level of implementation of the BPT, and in the funding arrangements for MTCs across the country. There are some MTCs that started implementation earlier and who are further ahead in achieving the performance/quality standards recommended to the NHS by the Clinical Advisory Groups. There needs to be recognition of these higher standards within the design of the BPT to eliminate a perverse incentive to reduce service quality to a lower level.

⁹⁶ <http://www.trauma.org/archive/scores/iss.html>

452. Therefore 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
 - e) Tranexamic acid should be administered for those patients receiving blood products within 3 hours of injury.
453. 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 5 minutes for those who have full MTC implementation, or 30 minutes where implementation is still in progress.
- 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.
454. The BPT will not be applied through 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.
455. The new trauma networks will result in 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.
456. One aspect of 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 must be recorded as part of the TARN minimum data set return.

Background and supporting information

457. 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 periods of

rehabilitation, and fewer treatment complications, and most importantly deliver better quality care.

458. 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 through reductions in death and disability alone, and did not factor in the additional benefits from the reduction in LoS that is expected across the NHS in England.
459. The enhanced specifications for the BPT include immediate consultant input, immediate access to imaging and surgery, combined multispecialty input, and planned complex rehabilitation.
460. 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.
461. A patient cannot attract additional payments for both 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.
462. The major trauma BPT will attract any relevant specialised services top-up provided the spell and provider are eligible.
463. Commissioners will want to monitor emergency admissions in trauma units.

Outpatient procedures

Tariff arrangements

464. The BPTs for three procedures to be performed in an outpatient setting will continue in the same form in 2013-14 but for diagnostic hysteroscopy we are also introducing a flexibility to encourage a 'see and treat' service. The procedures are:
 - a) Diagnostic cystoscopy
 - b) Diagnostic hysteroscopy
 - c) Hysteroscopic sterilisation
465. 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.
466. 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.

- 467. The BPT for all three procedures apply at the HRG level.
- 468. SUS PbR will automate payment by applying the relevant prices to the HRG.
- 469. The *tariff information spreadsheet* details the prices, relevant HRGs, and the relevant OPCS codes.

Flexibility for ‘see and treat’ service

- 470. With the advent of new technologies both the diagnostic and operative interventions can now be safely and effectively carried out in out-patient treatment suites as a combined ‘See & Treat’ service without any need for anaesthesia
- 471. We are therefore introducing a flexibility to allow commissioners to locally agree the payment to providers where the diagnostic and therapeutic procedures for hysteroscopy are carried out during the same theatre visit.
- 472. We recommend a tariff of £1,000 to cover the costs of the procedures as well as an outpatient attendance. This is expected to adequately reimburse the associated costs and represent a saving to commissioners.
- 473. For comparison, the tariffs for a ‘see then treat’ pathway would be £1,498:

1 X Outpatient attendance (TFC 502)	£133
1 X Outpatient procedure for diagnostic hysteroscopy (MA21Z)	£472
1 X Day case procedure for therapeutic hysteroscopy (MA12Z)	£893
Total	£1,498

- 474. Current coding rules do not allow for this activity to be captured in the same visit, therefore providers and commissioners would need to put plans in place locally to capture and pay for this combined activity.

Background and supporting information

- 475. 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.

476. 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 15: Achievable and estimated outpatient rates for diagnostic hysteroscopy and cystoscopy

Procedure	Rate for 2013-14 tariff calculation	Achievable outpatient rate⁹⁷	Estimated outpatient rate⁹⁸
Diagnostic hysteroscopy	60% ⁹⁹	80%	39%
Diagnostic cystoscopy	50%	50%	11%

477. 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.

478. 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.

479. 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.

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

⁹⁷ 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.

⁹⁸ Estimates based on 2010-11 Reference cost activity data and HES 2010-11 spell level data.

⁹⁹ Based on clinical opinion staged move starting with 60% moving to 80% over time in order to allow providers transition time.

Pricing approach

481. For the two diagnostic procedures the pricing approach is the same as for all BPTs where the aim is to promote the appropriate setting (paragraph 289). For hysteroscopic sterilisation, the pricing approach is neutral, providing a tariff that adequately reimburses the costs.

Paediatric diabetes

Tariff arrangements

482. In 2012, we introduced a mandatory BPT for paediatric diabetes. It applies to all providers who provide services in accordance with the best practice specification set out below. The aim of the tariff is to enable access to consistent high quality management of diabetes.

483. The 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. The cost of insulin pumps and associated consumables are also excluded. Patient education associated with the use of insulin pumps is, however, included in the tariff whether provided in outpatients or as a day case. Insulin and blood glucose testing strips prescribed as an emergency by the Specialist Team are 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: Exclusions.

484. 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.¹⁰⁰ 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, which should be integral to the team, 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 contribution to the funding of the network administrator will be required. 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

¹⁰⁰ 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>

hour expert 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. A provider of expert advice should be fully trained and experienced in managing paediatric diabetes emergencies.

- (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.

485. Commissioners will monitor compliance with these criteria via terms set out in the 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.

486. 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.

487. Providers not meeting the specification in 2013-14 will be paid on the basis of the outpatient attendance tariff (first and follow-up) for TFC 263. During 2012-13 we carried out a costing exercise, and as a result the level of the best practice tariff has been reduced. To continue to provide an incentive to trusts to meet the standards, we have also reduced the level of TFC 263 by 10%. Where providers find it difficult to meet the standards on their own, they should consider working in partnership with other local providers.

Background and supporting information

488. These criteria are underpinned by:

- (a) DH guidance: *Making every young person with diabetes matter*¹⁰¹;
- (a) NICE guidance: *CG15: Diagnosis and management of type 1 diabetes in children, young people and adults*¹⁰² and *TA151 Diabetes – insulin pump therapy*,¹⁰³ and
- (b) NHS Diabetes guidance: *Commissioning services for children and young people with diabetes*¹⁰⁴.

¹⁰¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073674

¹⁰² <http://www.nice.org.uk/CG15>

¹⁰³ <http://www.nice.org.uk/TA151>

489. As the BPT does not include admitted patient care, except any associated with patient education in the use of insulin pumps, commissioners may wish to consult the Child and Maternal Health website¹⁰⁵ or the National Paediatric Diabetes Audit¹⁰⁶ to obtain information regarding paediatric admission rates after the BPT is fully operational.

Paediatric epilepsy

Tariff arrangements

490. The BPT is a per attendance payment for follow up appointments and covers outpatient care after first acute or outpatient assessment, for patients with a diagnosis of probable epilepsy until they transfer to adult services.

491. The BPT is payable to providers of a service that meets the following criteria:

- (a) paediatric consultants¹⁰⁷ with expertise in epilepsies lead the service with epilepsy specialist nurses (ESNs) performing an integral role.
- (b) patients should have a comprehensive care plan that is agreed between the patient, family and/or carers and both the paediatric consultant with expertise in epilepsies and the epilepsy specialist nurse. This should cover lifestyle issues as well as medical issues.
- (c) the follow-up appointments provide sufficient time with both the paediatric consultant (or associate specialist) with expertise in epilepsies and the epilepsy specialist nurse to manage the patient against the agreed care plan. As a guide, it is expected that the patient spends at least 20 minutes with each professional (either at the same time or in successive slots). All children with epilepsy should be able to be reviewed when clinically required. Outpatient booking systems should be able to guarantee these follow up appointments.

¹⁰⁴ http://www.diabetes.nhs.uk/commissioning_resource/

¹⁰⁵ <http://www.chimat.org.uk/>

¹⁰⁶ <http://www.rcpch.ac.uk/child-health/standards-care/clinical-audit-and-quality-improvement/national-paediatric-diabetes-audit>

¹⁰⁷ Paediatric consultants (or associate specialists) with expertise in epilepsies are defined as having (a) job plans and appraisals that evidence appropriate training and ongoing education in paediatric epilepsies, for example Paediatric Epilepsy Training (PET2); (b) epilepsy as a significant part of their clinical workload (equivalent to at least one session a week); (c) undertake regular peer review of practice

- (d) the service has evidence of: shared care and referral pathways to tertiary paediatric neurology services; transition and referral pathways to adult services; and continuing full participation in Epilepsy12 national audit
492. Activity meeting the best practice criteria should be coded against the new TFC 223 Paediatric Epilepsy.
493. SUS PbR will automate payment by applying the BPT to the TFC.
494. Commissioners and providers should monitor compliance with the criteria locally to determine the relevant payment against the TFC 223. Where a provider codes to the new TFC but is unable to demonstrate eligibility for the BPT, then the tariff for TFC 420 Paediatrics applies.
495. The BPT does not include costs related to
- acute inpatient care
 - new patient assessment
 - epilepsy investigation and treatment costs (eg EEG, MRI, drugs, surgery, vagal nerve stimulation, ketogenic diet etc) with the exception of the costs of blood tests
 - the costs of the more complex epilepsy patients who, in line with NICE guidelines have shared care with a paediatric neurologist and coded to the paediatric neurology TFC. It is anticipated that approximately 1/3 of epilepsy patients fall into the category
 - costs of CAMHS, other therapists etc
 - costs of assessment and treatment for other health problems.

Background and supporting information

496. We are introducing a mandatory BPT for the outpatient follow-up management of paediatric epilepsy. The aim is to enable access to consistent high quality management of children's epilepsy services.
497. There are continuing concerns regarding quality of and variance in care for patients with epilepsy in the UK compared to that recommended by NICE. This includes misdiagnosis, misclassification, inappropriate drug choices, under referral of epilepsy surgery candidates, inadequate communication, inadequate comorbidity management and school support.
498. One of the key issues in the variation in practice is the lack of Epilepsy Specialist Nurses (ESN). Services should develop care pathways that include appropriate access to ESNs and also paediatricians with expertise in epilepsies. The ESNs form a fundamental bridge between primary, secondary and tertiary care and ensure that epilepsy management is delivered in the community and school when needed rather than just in the hospital ward or clinic.

499. The criteria for the BPT are structured to reflect the recommendations in NICE CG137 2012¹⁰⁸.

Pricing approach

500. The pricing approach is designed to adequately reimburse the costs of best practice. At present, the activity covered by the BPT is currently captured within the general paediatric TFC, which does not reflect the costs of a best practice.

Parkinson's disease

501. We are introducing a mandatory BPT for the management of Parkinson's disease at diagnosis and during the first year of the patients care.

502. The aim of the new tariff is to enable access to consistent high quality management of Parkinson's, in line with NICE clinical guidelines, to reduce unscheduled care and length of stay in hospital.

Tariff arrangements

503. The BPT applies to adults with a probable diagnosis of Parkinson's disease where care during the first year is delivered in line with the criteria detailed below. This is an annual payment to reflect the costs from the initial referral date for the first year of care.

504. The criteria for best practice is as follows:

- (a) Referrals from primary care with suspected Parkinson's disease should be seen by a movement disorder specialist (neurology/elderly care) within 6 weeks. These timescales are applicable to all patients for the purposes of the BPT, but the expectation is that new referrals in later stages of disease with more complex problems should continue to be seen within two weeks.
- (b) Each patient should receive regular follow-up and diagnostic review with a specialist nurse at least every six months with a process in place to identify the appropriate period of follow-up. Each patient should have a nominated person identified to continue with follow-up and diagnostic review.
- (c) All patients should be referred to a Parkinson's Disease Nurse Specialist (PDNS) (local names may include Neurology Nurse Specialist or Movement Disorder Specialist) who will be responsible for co-ordinating care

¹⁰⁸ <http://guidance.nice.org.uk/CG137>

- (d) Evidence to demonstrate that the provider is using recognised tools, for example patient feedback, NMS screening tool and cognitive assessment tools
 - (e) Patients should be offered therapy assessment within one year (including physiotherapist, speech and language therapist and occupational therapist). The costs of the therapy assessment are not included in the BPT, however payment is dependent on therapy assessment being offered (irrespective of whether patient takes this up)¹⁰⁹.
505. 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 locally.
506. The BPT excludes the costs of admitted patient care and the cost of any items specifically excluded from PbR (see exclusions list for further information).
507. SUS PbR will not apply the BPT and there is no discrete TFC for Parkinson's disease activity. Organisations will therefore need to identify activity and administer the BPTs locally.
508. Commissioners should monitor compliance with the criteria through evidence provided by providers which may include local records of clinic attendances, local education programmes etc. Where a provider does not meet all of the criteria, activity should continue to be paid at locally agreed rates.
509. One way to identify the activity applicable for consideration against the BPT is to use the non-mandatory diagnosis codes in outpatients (G20X).
510. Activity meeting best practice will need to be excluded from the CDS in order to avoid double payment. Providers achieve this by including an equals sign ('=') as the last significant character of the 6-character CDS data item Commissioning Serial Number. The equals sign will exclude the episode and a PbR tariff will not be applied.

Background and supporting information

511. We are introducing a mandatory BPT for the management of Parkinson's disease at diagnosis and during the first year of the patients care.

¹⁰⁹ There are a small number of circumstances where therapy assessment is not relevant and where providers are able to evidence this, the BPT should still apply.

512. The aim of the BPT is to enable access to consistent high quality management of Parkinson's, in line with NICE clinical guidelines, to reduce unscheduled care and length of stay in hospital.
513. Parkinson's therapy in secondary care settings ranges from basic (a care of elderly or neurology review) to comprehensive (multidisciplinary review with full access to therapy services).
514. Given the current variations in practice, it is not anticipated that all providers will be delivering services at the best practice level from April 2013. However, it is important that providers and commissioners work together to improve services.
515. The criteria for the BPT are underpinned by:
- Parkinson's disease: diagnosis and management in primary and secondary care. Clinical guidelines, CG35¹¹⁰. National Institute for Health and Clinical Excellence, June 2006
 - National Service Framework (NSF) for long-term neurological conditions. Department of Health, 2005¹¹¹
 - Recommendation 12 and 13. Local adult neurology services for the next decade. Report of a working party. Association of British Neurologists and the Royal College of Physicians, June 2011¹¹²
 - The European Parkinson's disease Standards of Care Consensus Statement. European Parkinson's Disease Association, Volume I, 2011

Pricing approach

516. The pricing approach is designed to adequately reimburse the costs of best practice. At present, the activity covered by the BPT is captured within a non-mandatory neurology TFC, which does not reflect the costs of best practice.

Pleural effusion

Tariff arrangements

517. The BPT applies to adults only, with undiagnosed unilateral pleural effusions.
518. The BPT is made up of a pair of prices: one applied to emergency admissions, the other to elective admissions.

¹¹⁰ www.nice.org.uk/CG035.

¹¹¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105361

¹¹² <http://bookshop.rcplondon.ac.uk/contents/pub354-2b209ee8-f1f9-4259-9075-bdfa1accdb3e.pdf>

519. The price for emergency admissions applies at the HRG level whereas the price for the elective admissions applies at the sub-HRG level with the use of a BPT flag to capture the activity within the associated HRG. The BPT flag is generated by the Grouper and SUS PbR, where the spell meets the following criteria:
- Patient aged 19 or over
 - Elective admission method (11, 12 or 13)
 - A procedure and approach code from the list in the *tariff information spreadsheet*
 - An HRG code from the list in the *tariff information spreadsheet*
520. SUS PbR will automate payment by generating the relevant flag, where required and applying relevant prices either to the BPT flag within the relevant HRGs or at the HRG as appropriate.

Background and supporting information

521. We are introducing a mandatory BPT for the treatment of patients with undiagnosed unilateral pleural effusions. The aim of the tariff is to encourage drainage of pleural effusions to be performed on a planned elective basis under ultrasound control.
522. At present, many patients present at A&E with a pleural effusion and they are often admitted unnecessarily. These patients often receive imaging related pleural management, introducing a delay in the patient's journey and potentially leading to an unnecessary increase in length of stay. The BPT aims to incentivise a shift in activity from non-elective admissions to the booked elective management of patients.
523. We would anticipate that some patients will need to be admitted immediately to Acute Medical Unit to relieve breathlessness before being discharged with a booked daycase appointment. These patients will remain eligible for the best practice payment alongside the short stay emergency adjustment. This approach will ensure that we do not disqualify providers from receiving the proposed BPT where they deliver care in line with the best practice criteria.
524. British Thoracic Society guidelines¹¹³ and National Patient Safety Agency stipulate that pleural effusion should be performed using bedside ultra-sound guidance when determining the best site for aspiration and or biopsy.
525. In setting the BPT, we have assumed that 50% of current admissions to DZ16B and 80% to DZ16C are suitable to be managed on an elective basis. These figures are based on assessment using expert clinical opinion. The remaining admissions comprise those unsuitable either because of complications and co-morbidities or bi-lateral pleural

¹¹³ <http://www.brit-thoracic.org.uk/guidelines.aspx>

effusions. DZ16A has been specifically excluded because patients grouped to this HRG have major complications and co-morbidities.

Pricing approach

526. The pricing approach is the same as for all BPTs where the aim is to shift activity into the appropriate setting, described at paragraph 289.

Primary total hip and knee replacements

Tariff arrangements

527. The BPT for elective primary total hip and knee replacements will continue in 2013-14 but with the following revisions:

- (a) the tariff applies at the HRG level
- (b) there is no subtraction of the cost of one excess bed day to derive the BPT

528. Please note that a post discharge tariff applies to these procedures (see paragraph 155).

529. SUS PbR will automate payment and apply the BPT to spells within the relevant HRGs from the list in the *tariff information spreadsheet*.

530. 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 PROMs¹¹⁴ form part of any range of indicators agreed.

531. Commissioners are encouraged to promote participation of providers in the National Joint Registry (NJR)¹¹⁵ 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.

Background and supporting information

532. 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 NHS Improvement website.¹¹⁶

¹¹⁴ 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.

¹¹⁵ 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>

¹¹⁶ <http://www.improvement.nhs.uk/enhancedrecovery/>

533. 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.

534. 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.

Pricing approach

535. The BPT is designed to adequately reimburse the costs of best practice.

536. Since the introduction of the BPT in 2011-12, the tariff has been set as the conventional tariff less the cost of one excess bed day. The rationale for this was 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. The average length of stay in 2010-11, the year on which the 2013-14 tariff is set, is now broadly in line with that expected from following enhanced recovery. It is therefore no longer appropriate to adjust the conventional tariff in setting the BPT.

537. The NHS Institute report (April 2012) *Fulfilling the potential: A better patient journey for patients and a better deal for the NHS*¹¹⁷ sets out reduced length of stay and shows that in 2010-11 the average was just over 5 days with the downward trend continuing into 2011-12 where the average falls to 5 days.

538. The reduction in length of stay is at the expected level but variation remains and length of stay is only a proxy for adoption of enhanced recovery. As set out in paragraph 530 above, commissioners and providers should continue to agree in the contract the enhanced recovery improvements that will be made as well as indicators and mechanisms for monitoring quality and outcomes.

¹¹⁷ http://www.improvement.nhs.uk/documents/er_better_journey.pdf

Same day emergency care

Tariff arrangements

539. The BPT applies to adults only, admitted as an emergency across a range of clinical scenarios. The clinical scenarios are:

New clinical scenarios in 2013-14	Retained clinical scenarios from 2012-13
Abdominal pain	Acute headache
Anaemia	Appendicular fractures not requiring immediate fixation
Bladder outflow obstruction	Asthma
Community acquired pneumonia	Cellulitis
Low risk pubic rami	Chest pain
Minor head injury	Deep vein thrombosis (DVT)
Supraventricular tachycardias (SVT) including atrial fibrillation (AF)	Deliberate self harm
	Epileptic seizure ¹¹⁸
	Falls including syncope and collapse
	Lower respiratory tract infections without chronic obstructive pulmonary disease
	Pulmonary embolism
	Renal/ureteric stones

540. 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 one or more days.

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

541. The implementation of the BPT will differ by scenario. For around three quarters of the scenarios, the BPT will apply to the HRG. For the remaining scenarios, the BPT will apply at the sub-HRG level. In both cases the Grouper and SUS PbR will generate a BPT flag in order to facilitate the automation of payment by SUS PbR¹¹⁹. The BPT flags are generated by the Grouper and SUS PbR, where the spell meets the following criteria:

- patient aged 19 or over
- emergency, or transfer admission method (admission method codes 21-25, 2A, 2B, 2C, 2D (or 28 if the provider has not implemented CDS 6.2) and 81)
- a primary diagnosis from the list in the *tariff information spreadsheet*

¹¹⁸ Includes first seizure and seizure in known epileptic

¹¹⁹ This will only happen for Same Day Emergency Care BPTs because SUS PbR requires a flag to differentiate between tariffs on the basis of zero day length of stay and greater than zero days length of stay.

- an HRG from the list in the *tariff information spreadsheet*

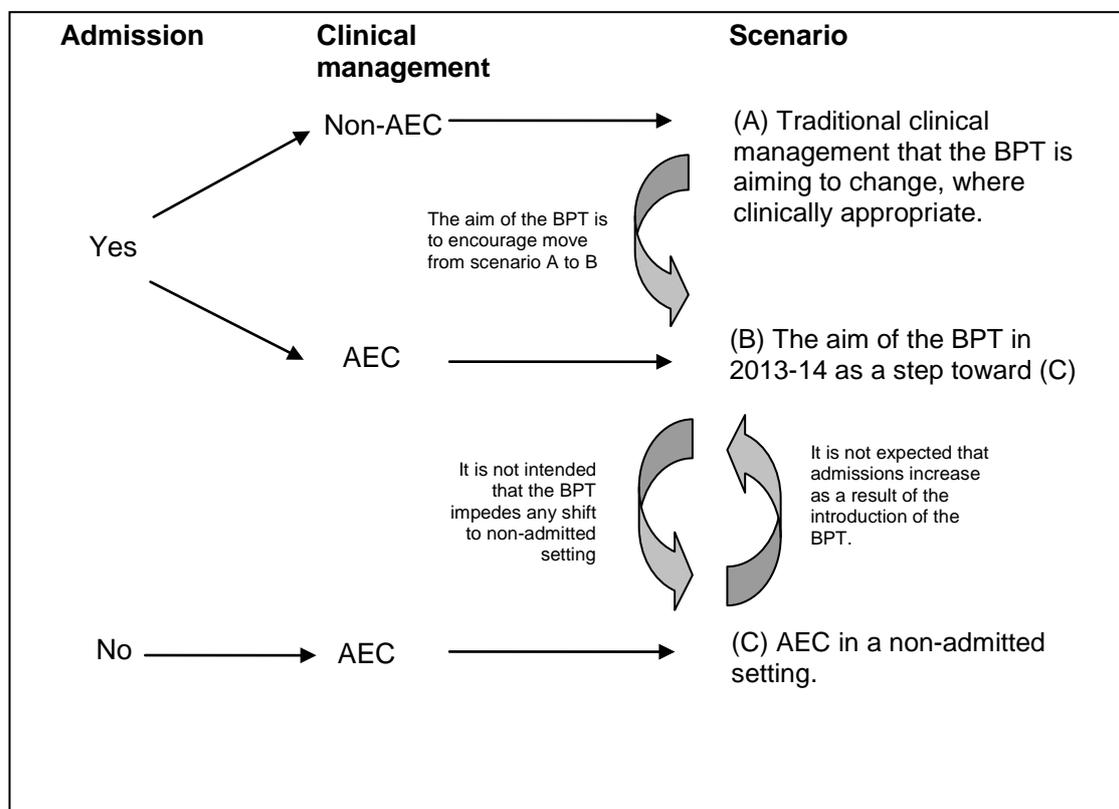
542. The *tariff information spreadsheet* details the prices, whether they apply at HRG or sub-HRG level and the relevant ICD-10 codes.

543. SUS PbR will automate payment by generating the relevant flag, where required and applying relevant prices either to the BPT flag within relevant HRGs or at the HRG as appropriate.

544. Some providers have already implemented best practice in ambulatory emergency care. The BPT is specifically designed for those providers that are not so well 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: Flexibilities of the 2012-13 PbR Guidance, 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.

545. 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



546. In relation to scenario B, with the focus on the admitted setting, it is not intended that the BPT discourage 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.
547. 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.
548. If local arrangements are in place to reimburse AEC pathways then these may remain, subject to agreement with commissioners.
549. 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, providers should only admit patients where clinically appropriate.
550. 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.

Background and supporting information

551. We are expanding the list of clinical scenarios covered by the same day emergency care BPTs. As in 2012-13, the aim of the BPT is to promote management of these scenarios on a same day basis in an ambulatory emergency care manner.
552. The Royal College of Physicians' Acute Medicine Task Force and the College of Emergency Medicine have agreed a working definition of Ambulatory Care¹²⁰:

¹²⁰ 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>

“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.”

553. 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.
554. As a first step towards realising the potential of ambulatory emergency care, the initial aim of the same day emergency care BPT 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.
555. The 19 scenarios have been selected from the NHS Institute’s Directory of AEC in Adults¹²¹. 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 19 scenarios either are in the top 25, or are related to them.
556. 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.
557. The BPTs for 2013-14 are based on the 75th percentile same day rate¹²² by provider for each clinical scenario. It is believed that these rates represent a sufficiently stretching, but achievable rate for most providers. 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.

¹²¹http://www.institute.nhs.uk/quality_and_value/high_volume_care/ambulatory_emergency_care.html

¹²² Calculated as: (zero day emergency admissions) / (total emergency admissions)

558. Table 16 shows for each of the new clinical scenario the 75th percentile same day rate and the current national average same day rate based on data from 2010-11 Hospital Episode Statistics.

Table 16: Same day emergency care clinical scenarios

Clinical scenario	75th percentile rate	Current national average rate
Abdominal pain	40%	35%
Anaemia	16%	12%
Bladder outflow obstruction	30%	23%
Community acquired pneumonia	12%	10%
Low risk pubic rami	13%	10%
Minor head injury	64%	56%
Supraventricular tachycardias (SVT) including atrial fibrillation (AF)	34%	29%
Epileptic seizure	35%	29%
Acute headache	43%	36%
Pulmonary embolism	18%	13%
Asthma	30%	24%
Lower respiratory tract infections without chronic obstructive pulmonary disease	49%	41%
Chest pain	50%	45%
Falls including syncope and collapse	41%	35%
Appendicular fractures not requiring immediate fixation	39%	31%
Cellulitis	35%	26%
Renal/ureteric stones	45%	34%
Deep vein thrombosis	75%	55%
Deliberate self harm	56%	49%

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

Pricing approach

560. The pricing approach is the same as for all BPTs where the aim is to shift activity into the appropriate setting, described at paragraph 289.

Transient ischaemic attack

Tariff arrangements

561. The BPT for TIA (as illustrated in Annex A Figure 4e) will continue in the same form in 2013-14, with the exception of the additional payment for use of MRI, which has been removed. The removal of the additional payment reflects the wider policy decision to unbundle diagnostic imaging from outpatient attendance tariffs.

562. The BPT is made up of two components: a base tariff and a conditional payments. Both 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 alternative TFC 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 Training¹²³
 - 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-imburement locally.
- (b) additional payment for investigation and treatment of high risk patients¹²⁴ 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 presentation¹²⁵ 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 investigations¹²⁶ and treatments¹²⁷ should be completed.

¹²³ <http://www.ukstrokeforum.org/>

¹²⁴ 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.

¹²⁵ Re-classification of patient risk does not later clock start time.

¹²⁶ 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).

¹²⁷ Aspirin, statin and control of blood pressure all where needed or alternative if contraindicated.

563. 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.

564. SUS PbR will:

- (a) apply the base tariff price to activity coded under the appropriate TFC
- (b) prevent generation of an outpatient procedure eg where 24 hour ECGs are performed, when reported against the TIA TFC.

565. 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.

Background and supporting information

566. 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

<p>QM5. Assessment – referral to specialist</p> <ul style="list-style-type: none">• 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 <p>QM6. Treatment</p> <ul style="list-style-type: none">• All patients with TIA or minor stroke are followed up one month after the event, either in primary or secondary care
--

Pricing approach

567. The pricing approach is primarily designed to adequately reimburse the costs of best practice.

568. 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. The introduction of a separate TFC reflecting the costs of best practice removes that barrier of the conventional tariff.

569. 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 Strategy¹²⁸, and has been set as a further 20% of the base tariff.

¹²⁸http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

Section 9: Exclusions

Introduction

570. 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. For 2013-14 we have introduced a new work sheet in the *tariff information spreadsheet*, which explains where exclusions have been removed.
571. 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.
572. For all excluded activity, commissioners and providers should agree local prices, and local arrangements for monitoring activity. Non-mandatory prices are provided in Section 12: Other currencies and non-mandatory prices 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
573. 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.
574. 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.

575. Providers should strive to procure drugs and devices at the minimum cost while ensuring optimum patient outcomes. Commissioners and providers should consider gain/risk sharing arrangements in the situation where the cost of drugs and devices changes.
576. For 2013-14 we have identified three innovative approaches which have been proposed as exclusions but have not met our exclusion criteria due to low volumes, but which have been assessed by NICE. These three approaches should be considered for innovation payments (paragraph 911), alongside other innovative approaches:
- (a) Bronchial thermoplasty for severe asthma (NICE IPG419).
 - (b) Renal denervation for resistant hypertension (NICE IPG418).
 - (c) Stapled transanal rectal resection for obstructed defaecation syndrome (STARR) (NICE IPG351)
577. 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.
578. 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.

Excluded services

579. Patient transport services (PTS)¹²⁹ and healthcare travel costs scheme (HTCS)¹³⁰ costs remain excluded from the tariff.
580. In a change to 2012-13, some regular attenders are now in the scope of PbR. This is to accommodate the expansion of PbR into chemotherapy delivery and external beam radiotherapy where some of the activity is reported as regular attender activity and is therefore subject to tariff prices. The only core HRGs to have mandatory tariffs for regular attenders will be the renal dialysis HRGs, as they are independent of

¹²⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373

¹³⁰ http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/DH_075759

setting, and the zero-priced core HRGs. All other core HRGs for regular attenders will be for local negotiation, as in 2012-13.

Cancer multi disciplinary teams

581. 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

582. 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 which case local agreements regarding funding for other CMDT activity should be negotiated. In an attempt to clarify this area, the 2011-12 collection of reference costs separately identified all CMDT activity, not just the five categories listed above.

Excluded procedures

583. We are continuing to exclude the following five procedures:

- a) soft tissue sarcoma surgery
- b) pelvic reconstructions
- c) head and neck reconstructive surgery
- d) intracranial telemetry
- e) balloon assisted enteroscopy

584. Following the unbundling of diagnostic imaging in outpatients, we have removed the exclusions for positron emission tomography with computed tomography (PETCT) and single photon emission computed tomography with computed tomography (SPECTCT) in outpatients.

585. The previous procedure exclusions for cardiovascular/cardiac MRIs and CTs are now covered by the HRG specific exclusions for cardiac MRIs and CTs. Cardiovascular MRIs and CTs are now included in the scope of tariff.

Soft tissue sarcoma surgery

586. This surgery is only delivered in a very small number of units and is defined in Table 17 (conditions in both columns to be satisfied).

Table 17: 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 (ie a surgical procedure has actually been carried out), and it is not a chapter X code (chemotherapy or amputation)

Pelvic reconstructions

587. 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 18. Only pelvic reconstruction activity that meets this definition should be excluded from PbR. All other pelvic reconstruction activity should be included within PbR.

Table 18: Definition of pelvic reconstruction procedure exclusion

ICD-10 (primary diagnosis)	OPCS-4 (in any position)
<p>S324 - Fracture of acetabulum OR S328 - Fracture of oth and unspec parts of lumbar spine and pelvis</p>	<p>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)</p>

Head and neck reconstructive surgery

588. 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

589. 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.

Balloon assisted enteroscopy

590. Balloon assisted enteroscopy was 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

591. 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.

592. In addition, for 2013-14 we have excluded the following HRGs:

- (a) All regular attender core HRGs except for LA08E, SB97Z, SC97Z, PB03Z and UZ01Z
- (b) CZ25N – Cochlear Implants with CC
- (c) CZ25Q – Cochlear Implants without CC
- (d) CZ28Z - Fitting of Bone Anchored Hearing Aids
- (e) DZ38Z - Oxygen Assessment and Monitoring
- (f) DZ39Z - Complex Gas Exchange Studies
- (g) DZ40Z - Simple Gas Exchange Studies
- (h) DZ44Z - Simple Airflow Studies
- (i) EA43Z - Implantation of Prosthetic Heart or Ventricular Assist Device
- (j) EA53Z – Transcatheter Aortic Valve Implantation (TAVI)
- (k) MC15Z - Oocyte Recovery with Pre-Implantation Genetic Diagnosis
- (l) SA34Z - Peripheral Blood Stem Cell Harvest

593. The HRGs relating to cochlear implants have been excluded because the NHS Commissioning Board (NHSCB) is carrying out a national procurement exercise which will reduce the cost of the implants part way through 2013-14. We are publishing non-mandatory tariffs for this activity

which the NHSCB will use until such time as the reduced costs are realised.

594. We have excluded HRG EA53Z (Transcatheter Aortic Valve Implantation - TAVI) because, as with cochlear implants, the NHSCB plan to carry out a national procurement exercise which may reduce the cost of this activity part way through 2013-14.
595. Providers should ensure that the activity for TAVI continues to be coded in accordance with coding guidance from Connecting for Health. This coding guidance is also set out in the NICE Interventional Procedure Guidance 421¹³¹.
596. Bone Anchored Hearing Aids were a device exclusion in 2012-13. With the introduction of a new HRG design in 2013-14 which recognises the split between the procedure to implant the fixtures, and the fitting of the device, we have excluded the HRG CZ28Z (Fitting of Bone Anchored Hearing Aids) due to problems with coding this activity currently.
597. We have excluded the HRGs listed above in HRG chapter DZ (respiratory) because they are for activity that should occur in outpatients, but is minor compared to the average respiratory outpatient attendance. However, this activity can still attract an outpatient attendance tariff.
598. We have excluded HRG EA43Z (Implantation of Prosthetic Heart or Ventricular Assist Device) due to difficulties setting a national tariff for this activity.

Excluded TFCs

599. 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

600. 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.

¹³¹ <http://www.nice.org.uk/IPG421>

601. 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)¹³² categories and use generic names of medicines. The general principle is that the exclusion applies to both mandatory and non-mandatory tariffs.
602. 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, eg 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.
603. 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.
604. 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.
605. 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 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.
606. 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 911).

¹³² <http://bnf.org/bnf/index.htm>

607. Usually, if a medicine does not appear on the high cost drug exclusion list, then it is within the scope of PbR, unless it is part of an excluded service. Occasionally, a rarely used medicine, which has not been formally excluded on the basis of this criteria, may be of a cost that is disproportionately high relative to the expected costs within the HRG. In this circumstance, commissioners and providers can make use of the flexibilities in Section 13: Flexibilities of the PbR guidance to reach local agreement. These flexibilities may also apply with new drugs or technologies introduced into the market, particularly after tariff and its exclusions have been published for a given year
608. Home care medicines (as defined in the Hackett Report) continue to be excluded from PbR. This includes the actual drug, delivery and any other associated costs. Please note however that there are mandatory tariffs for some home dialysis and that pathway/year of care tariffs include all home care medicines, apart from those drugs that are explicitly listed as excluded.
609. 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.
610. The following drugs have been added to the exclusions list:
- (a) Alisporivir
 - (b) Axitinib
 - (c) Cobicistat
 - (d) Conestat Alfa
 - (e) Collagenase (only when used in outpatients)
 - (f) Crizotinib
 - (g) Dimethyl fumarate
 - (h) Dolutegravir
 - (i) Elvitegravir
 - (j) Elvitegravir with Cobicistat, Emtricitabine and Tenofovir
 - (k) Factor VIII Fc Fusion Protein
 - (l) Faldaprevir
 - (m) Ivacaftor
 - (n) Laquinimod
 - (o) Mannitol (when delivered via nebulisation/inhalation)
 - (p) Pazopanib
 - (q) Ruxolitinib
 - (r) Simeprevir
 - (s) Teriflunomide
 - (t) Treprostinil sodium
 - (u) Turoctocog alfa

Excluded devices

611. 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.
612. All three of the listed criteria need to be met in order for a device to be considered an exclusion from PbR.
613. Note that a device, for the purposes of PbR, is:
- a) used as part of patient care and generally cannot be transferred or re-used¹³³; and
 - b) not considered capital equipment.
614. 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.
615. 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 911).
616. Excluded devices are reviewed on an annual basis, and will be removed from the exclusion list if they no longer meet the criteria (paragraph 611).
617. 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.

¹³³ There are a few exceptions to devices not being transferable, for example insulin pumps can be reconditioned and reused for a different patient.

618. Commissioners and providers should agree a local price for the programming and maintenance of cochlear implants and bone anchored hearing aids because the tariffs do not cover this activity. For bilateral procedures, the additional cost of the procedure and implant should be subject to local negotiation.

619. 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).

620. 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. Two 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) any additional payment agreed for biological mesh should take account of the amount of mesh used, and the tariff received for the underlying procedure.

621. Table 19 summarises changes to the device exclusion list between 2012-13 and 2013-14.

Table 19: Changes to the 2012-13 device exclusion list

Name of device in 2012-13	Change in 2013-14
Aneurysm coils	Added 'and flow diverters for intracranial aneurysms
Laser sheaths	Amended to Pacemaker extraction sheaths
Penile Protheseses	Device exclusion removed
Percutaneous valve replacement and repair devices	Amended to Percutaneous valve repair and replacement devices for mitral and pulmonary valve only.
Occluder, Vascular and Septal devices	Amended to Occluder, Vascular, Appendage and Septal devices
VADS and Prosthetic Hearts	Device exclusion removed

622. We have amended the existing exclusion for aneurysm coils to aneurysm coils and flow diverters for intracranial aneurysms.

623. The HRGs relating to cochlear implants have been newly excluded (see paragraph 593). However, we have not listed cochlear implants as an

excluded device as we will publish a non-mandatory tariff for the HRGs relating to cochlear implants (including the cost of the device), which the NHSCB will use until such time as the reduced costs are realised.

624. We are excluding the HRG for TAVI (see paragraph 594), but will not list the devices as separately excluded. We have amended the exclusion for percutaneous valve replacement and repair devices to 'Percutaneous valve repair and replacement devices for mitral and pulmonary valve only'.
625. The exclusions for Occluder, Vascular and Septal devices have been extended to also cover appendage occlusion devices.
626. The exclusion for Laser sheaths has been made broader to encompass all pacemaker extraction sheaths in order to remove the perverse financial incentive to providers of using the more expensive laser sheaths in place of other extraction sheaths, when not appropriate.
627. Penile prosthesis has been removed due to the introduction of new HRG LB74Z whereby the use of the device can be specifically identified, and an appropriate tariff set.
628. We have removed the device exclusion for VADs and Prosthetic Hearts as we have now excluded the HRG for the implantation of VADs and Prosthetic Hearts due to difficulties setting a national tariff for this activity. We are therefore not separately listing the devices as an exclusion.

Section 10: Pathway payments

Introduction

629. A number of pathway payment models are described in other sections of this guidance:

- a) post discharge tariffs (paragraph 155)
- b) cataracts (paragraph 341)
- c) Parkinson's disease (paragraph 501)
- d) paediatric diabetes (paragraph 482)

Maternity pathway payment

630. In April 2012 we introduced a maternity pathway payment system in shadow form. Information about the pathway payment was provided on the DH website.¹³⁴ From April 2013-14, we are mandating the maternity pathway system. This includes both the currencies and the tariffs for all three pathways: antenatal, delivery and postnatal.

631. We expect to publish questions and answers about the new system in March or April 2013.

Implementing the pathways and managing risk

632. From April 2013, clinical commissioning groups (CCGs) should use the maternity currencies and tariffs when commissioning maternity care. We recognise however, that this is a significant change and may have a major impact on commissioner or provider finances.

633. Since we are mandating the pathways and tariffs, the tariffs previously used for all the treatment and care covered by the pathways no longer be the basis for reimbursement. We have however provided non-mandatory prices for these HRGs and TFCs based on 2010-11 reference costs and adjusted for reductions in CNST costs. They are for guidance only but may help providers when subcontracting with other providers. We will continue to collect reference costs for these HRGs and TFCs in the 2012-13 collection.

634. Organisations should assess the impact of implementing the system on the overall level of payments they will receive. These may be significantly different from the level of payment they would have received under the old system, either because their casemix is different from the average, or because their information systems are not sufficiently developed to capture all the necessary data items.

134

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132685

635. In either case, organisations should attempt to estimate the impact by comparing what they would have received under the old system (using the published non mandatory prices for 2013-14) and what they would receive with the new system. Any potential gain or loss should be shared between the provider and commissioner.

636. If organisations do not have the necessary information systems to determine pathways they should use the published non-mandatory prices to help inform risk sharing arrangements.

What the pathway payments include

637. Details of what is included and excluded from the pathway payments are set out in the table below:

Table 20: Maternity pathway payments

Area	Included	Excluded
Admitted patient care	All activity against NZ* HRGs (regardless of TFC)	All activity against non-NZ* HRGs (regardless of TFC)
Outpatient care	All activity against NZ* HRGs (regardless of TFC) All attendance activity against TFC 501 (obstetrics) and 560 (midwife episode)	All activity against non-NZ* HRGs (regardless of TFC) or against any attendance TFC other than 501 (obstetrics) or 560 (midwife episode)
Antenatal education	Antenatal education.	
Critical care		All critical care activity
Community/primary care	All maternity community-based antenatal and postnatal care	All primary care activity applicable to payment under the GP contract. A woman may choose some of her maternity pathway to be delivered by her GP or for the practice to be the lead pathway provider, but any care delivered by the GP will be paid under the GP contract.
Scans, screening & tests	All maternity ultrasound scans, and all relevant maternal and newborn screening which is part of National Screening Programmes ¹³⁵ .	The analysis elements of the screening process undertaken by specialist diagnostic laboratories under a separate commissioner contract
Immunisation	All immunisation of the newborn which occurs before handover to primary care ²	
Birth	The birth, irrespective of type and setting	
Post-birth care	Well/healthy babies, both during the delivery module and pathway checks/screening during the postnatal module	Pathways for unwell/unhealthy babies. Babies requiring admitted patient care treatment will have their own admission record

¹³⁵ For further advice, for example on payments for confirmatory screening, please refer to the Public Health Lead at your local NHS CB Area Team

Area	Included	Excluded
Pre-pregnancy care		All pre-pregnancy/pre-conception care and reproductive services.
Non-maternity care	Advice on risks in the context of pregnancy and referral to other relevant professionals where necessary for resolution if possible.	All activity that is the named responsibility of other professionals or providers who receive payment to deliver that care for the population (eg drug and alcohol services, mental health services, stopping smoking services, weight management services etc.)
Specialised services		All activity that is commissioned through the NHS Commissioning Board
Ambulance transfers		All ambulance transfer costs
Accident and emergency		All unscheduled A&E activity
CNST	All CNST costs are included	
High cost drugs & devices		All PbR excluded high cost drugs and devices

638. The payment system is split into three modules, each of which is paid separately. These are: antenatal care; the delivery; and postnatal care.

639. The pathway payments for antenatal and postnatal are new, and based on information in a new data set. We recognise that, once the system is up and running, it may be necessary to review how the system is working and make adaptations.

The antenatal pathway

640. The antenatal pathway commences when the pregnant woman has her first antenatal appointment or attendance with her maternity provider. The pathway payment is based on information collected at the antenatal assessment appointment (usually undertaken around 10 weeks gestation) when the health and social care risk assessment is carried out. The maternity information system (see paragraph 695) will regard the organisation that first submits this information as the lead provider, and therefore that organisation will receive the payment.

641. For the antenatal pathway, there are three casemix levels – standard, intermediate and intensive – with higher payments for intermediate and intensive. The characteristics which determine the level of payment to be made are set out in the *Ante and postnatal pathways: Data requirements and definitions* spreadsheet, published alongside this guidance.

642. If a woman has one or more of the “intensive resource” characteristics, she is allocated to the intensive pathway, irrespective of any other factors.

643. If a woman has none of the “intensive resource” characteristics but has any one (or more) of the “intermediate resource” characteristics, she is allocated to the intermediate pathway.
644. If a woman does not have any of the listed characteristics, she is allocated to the “standard resource” pathway.
645. The antenatal pathway is derived by using data items from the new Maternity Minimum Data Set as well as some other local information.
646. Some items which determine pathway selection are derived from a specific field within the Maternity Data Set – data item 17200350 (mother’s medical history at booking). These relate to a current diagnosis that may present a risk or complication factor to a maternity episode. To promote consistency, we suggest that these items should **only** be used when the mother is currently under the care of a specialist secondary care provider for the relevant condition.
647. Payment is based on the commissioner receiving information about the woman’s health and social care needs reported at the antenatal assessment appointment, together with results from tests organised at this visit (see also paragraph 695). The information will be used to assign each woman to the correct pathway.
648. Commissioners should make one payment per pregnancy for all antenatal care included in the scope (although payments for the delivery or postnatal modules of the pathway may be paid to different providers). The provider receiving this payment will be known as the lead provider.
649. The standard pathway price has been developed taking into account the proportion of women likely to develop complications during pregnancy that will require higher levels of care, or that some of the characteristics may develop or be disclosed later in pregnancy.

Arrangements between providers

650. Where a woman chooses to use a provider other than the lead provider for part of her care (eg a scan, an investigation or appointment etc) or where the woman is referred to a different pathway provider for any reason, it is the responsibility of the lead provider to pay the other organisation. They remain accountable for the care however, and should have contracts in place for this activity.
651. In some cases, one organisation undertakes the initial antenatal assessment, but is not chosen as the lead pathway provider. Again, this organisation needs to be paid for its activity by the provider who receives the antenatal pathway payment (but see 620 and 669).

652. The non-mandatory prices (excluding MFF) or sources in Table 21 are included as a guide for determining the amount to be invoiced and paid for parts of the antenatal pathway.

Table 21: Guide prices for activity at other providers

Type of activity	Standard	Intermediate	Intensive
Antenatal Assessment Visit	£ 187	£ 288	£ 288
Pathway Antenatal Check	Use PbR non-mandatory community prices		
Pathway Postnatal Check	Use PbR non-mandatory community prices		
Pathway ultrasound scans	Use PbR non-mandatory outpatient procedure prices		
Outpatient attendances	Use PbR non-mandatory outpatient attendance prices		
Outpatient procedures	Use PbR non-mandatory outpatient procedure prices		
Admitted patient spells	Use PbR non-mandatory admitted patient care HRG prices		
Drug and device costs excluded from PbR	Excluded from PbR - payable separately		
Critical Care	Excluded from PbR - payable separately		

653. Prices for activities that are not covered by published prices for any maternity care should be agreed between the two organisations.

654. This payment mechanism will also be applicable if care is required while the woman is on holiday or unable to access her pathway provider and needs to access care from another NHS provider.

655. Providers should not attempt to invoice local commissioners for NZ HRGs or TFC 501/560 activity or elements of maternity care costs. If they are not the lead provider for the activity they should invoice the lead provider.

656. A change in lead provider could lead to a transfer of funding between organisations. The proportion of the pathway payment remaining unspent at the time of transfer depends on the stage of pregnancy the woman has reached and has been set out in Table 22. This information was developed through analysis of the pathway costing data provided by NHS trusts and foundation trusts during spring and summer 2011. Any local change of lead provider arrangements will not alter the maternity information system and organisations may need to agree supplementary information flows where this happens.

Table 22: Proportion of pathway tariff to refund or transfer on change of pathway provider

Transfer time (gestational age)	Refund by Lead Provider A to Commissioner A / Payment to Lead Provider B by Commissioner B / Payment by Lead Provider A to Lead Provider B
Prior to 20 weeks 0 days	63%
Between 20 weeks 0 days & 24 weeks 6 days	48%
Between 25 weeks 0 days & 30 weeks 6 days	33%
Between 31 weeks 0 days & 35 weeks 6 days	20%
After 36 weeks 0 days	10%

657. The second provider may choose to reassess the woman's pathway at the time of transfer. If the new information suggests that a higher resource pathway would be applicable, the pro-rata payment should be based on the value of the higher resources pathway.

658. Refunds to commissioners are on the basis of the original categorisation at the antenatal assessment appointment, ie if the original pathway was "standard", the proportion of refund is based on the standard payment tariff.

659. When a woman changes both commissioner and provider (eg if she moves house) any refunds to the original commissioner are on the basis of the original categorisation at the antenatal assessment appointment, ie if the original pathway was "standard", the proportion of refund is based on the standard payment tariff. The payment by the new commissioner to the new lead provider however, will be based on the latest information and may be a proportion of the higher resource pathway.

660. Examples are provided below to aid understanding of this issue.

Example 1 (see also paragraph 649)

Woman categorised as Standard based on antenatal assessment appointment information	Payment of eg £1,200 ¹³⁶ for standard antenatal care by commissioner A to provider A after antenatal assessment appointment
Woman develops gestational diabetes week 23	Onset of gestational diabetes (one of the "intensive" factors)
Woman moves lead provider in week 29, no change in commissioner	Change in provider
Payment transfer	Lead provider A pays 33% of Intensive tariff (eg £3,000 * 33% = £1000) to Lead Provider B

Example 2

Woman categorised as standard based on antenatal assessment visit information	Payment of eg £1,200 for standard antenatal care by commissioner A to provider A after antenatal assessment appointment
Woman develops gestational diabetes week 23	Onset of gestational diabetes (diabetes is one of the "Intensive" factors)
Woman moves house in week 29, new provider and new commissioner	Change in commissioner and provider
Refund	Provider A refunds 33% of standard payment of £1,200 to commissioner A - £400
New payment	Payment of 33% of Intensive payment (eg £3,000 * 33% = £1000) from commissioner B to provider B

Pregnancies that end early

661. The antenatal payment is payable for all pregnancies where an antenatal assessment is undertaken regardless of when they end.
662. Contracts should contain local outcomes and quality measures to incentivise reducing the number of avoidable pregnancy losses.
663. The cost of obstetric/maternity-related healthcare activities (with an NZ HRG or coded to TFC 501 or 560) for pregnant women whose

¹³⁶ Not actual price

pregnancy ends prior to the antenatal assessment visit should not be separately reimbursed. Activity which is currently coded to TFC 502 (Gynaecology) should be separately reimbursed.

664. The antenatal pathway ends at the commencement of the birth spell, which signals the start of the second module within the maternity pathway, or at the termination or miscarriage. In some cases of termination or miscarriage, and depending on the healthcare requirements of the woman, a birth payment and/or a postnatal pathway payment may still be warranted.

Antenatal care spanning more than one financial year

665. Care delivered under the pathway payment system may span more than one financial year. In April 2013 some women will receive care who started their pathway in the 2012-13 financial year.
666. Providers and commissioners may wish to continue to pay for the remaining antenatal care for these women using the published non-mandatory prices.
667. In future, a simple solution may be for trusts to receive payment for all women who commence their pathway within a financial year (although all the care may not be delivered in that year).

The delivery pathway

668. There are two delivery pathway prices, split by whether there were complications and co-morbidities (CC) or not. The price includes all postpartum care of mother and well/healthy baby/babies until transfer to community postnatal care.
669. The prices set already take into account the higher-cost types of births, such as caesarian sections.
670. The complications and co-morbidities are based on ICD diagnosis codes and are listed in the HSCIC's Grouper documentation.¹³⁷
671. Providers will continue to code their delivery spells as now and payment will continue to be via SUS PbR to the organisation that reports the birth.
672. Home births continue to be collected in the admitted patient care other delivery event CDS and are reimbursed at the same rate as a normal delivery without complications. This is illustrated in Annex A Figure 1h.
673. A requisite of the licence to deliver maternity care is that all pathway providers must be able to provide all care, either themselves or with their partner organisations/within their network.

¹³⁷ <http://www.ic.nhs.uk/article/2580/HRG4-201314-Local-Payment-Grouper>

674. A provider must not decline pathway responsibility on the basis that the care or delivery may be expensive.
675. Commissioners will only pay once per intrapartum episode, to the organisation that delivers the baby/babies. This organisation is the lead provider financially responsible for the whole post-partum care period up to transfer of responsibility to domiciliary postnatal care.
676. Where more than one provider shares the care (eg the woman delivers at one provider while another provides postpartum in-hospital care), it is the responsibility of the providers to agree a fair split of the income.

The postnatal pathway

677. The postnatal pathway usually commences after the woman and baby/babies have been transferred to community postnatal care and concludes once the woman has been transferred to primary care.
678. Commissioners should be aware that they should pay for all three modules of the pathway for each pregnancy that leads to a birth. If the care normally delivered under the postnatal pathway happens to be provided while the woman remains in the hospital, the postnatal care provider would still remain entitled to payment for that element of the pathway
679. There are three casemix levels – standard resource, intermediate resource and intensive resource – with higher payments for higher resource usage. The characteristics which determine that levels are set out in *Ante and postnatal pathways: Data requirements and definitions* published alongside this document
680. The postnatal pathway follows similar principles as the antenatal pathway and is derived by using data items from the new Maternity Minimum Data Set as well as some other local information.
681. A commissioner will make one payment for all postnatal pathway care included in the scope. In general this is after transfer from the intrapartum episode, but in some cases the specific care may be provided to a woman who remains in hospital because of other circumstances.
682. Quality postnatal care is dependent on the postnatal provider having immediate access to information that stems from both the antenatal and intrapartum periods. It is the responsibility of providers to ensure this full information is available for every woman, irrespective who provides the postnatal care.
683. Payment is based on the postnatal lead pathway provider flowing information to the commissioner about the relevant characteristics and

factors that assign each woman to their relevant pathway after discharge from postnatal care.

684. For the new maternity system, the lead provider for postnatal care will be a new field that must be submitted as a part of the 'labour and delivery' section of the data set following the birth.
685. Once a pathway level has been assigned to a patient (ie usually when being discharged following the intrapartum episode), then the pathway level stays at the original level determined.
686. Where a woman chooses to use a different provider for an element of her postnatal care (an investigation, spell or appointment, etc), or where the woman is referred to a different provider for any reason, it is the responsibility of the lead pathway provider to pay the other organisation (see Table 21 above)
687. There are some specific exceptions. NICE guidance identifies some potential postnatal complications that require immediate urgent acute care. These are listed below should be claimed from local commissioners.
 - i. Intervention for postpartum haemorrhage
 - ii. Intervention for genital tract sepsis
 - iii. Intervention for venous thromboembolism
 - iv. Intervention for breast mastitis, abscess
 - v. Postnatal wound infection requiring surgery
 - vi. Pulmonary embolism.
688. Payment for the above will be based on PbR HRGs from underlying coding.
689. Where these interventions are undertaken prior to discharge from hospital after the birth, their costs are already included within the birth payment. In these circumstances, providers are not able to claim payment for these interventions instead of, or in addition to, the birth payment
690. Commissioners and providers should determine whether there are any activities during the maternity pathway that could help to reduce the incidence of such complications arising, or whether any local policies contribute to the incidence of complications. CQUIN or QIPP indicators could be developed locally.
691. There is no defined time period during which community postnatal care is provided by the maternity team.
692. The pathway continues until responsibility for ongoing maternity health care is transferred to primary care / the health visitor.

693. All pathway care, as defined in NICE Guidance, including the 6-week postnatal care review if undertaken by the maternity team, is included in pathway payments even if maternity health care has already been transferred to primary care / the health visitor.
694. Commissioners should introduce local outcome and patient experience indicators to ensure the highest quality care and the timing for handover of responsibility is safe.

Information flows for the antenatal and postnatal pathways

695. Although the Maternity Minimum Data set is mandated for data from April 2013, information is not likely to flow until later in 2013. Commissioners and providers will need to agree local information flows in the interim, as well as for the supplementary data flows required for the antenatal and postnatal pathway modules. For further information on data definitions and requirements see *Maternity Pathway Data definitions and requirements* available alongside this guidance.
696. Arrangements for information flows for the new system are not yet finalised. The expected arrangements are set out below but are subject to final confirmation.
697. Unlike in SUS, the new system will not have a refresh submission option. Instead, organisations will be able to make 'pre-deadline' submissions (once an expected date of delivery is known). Organisations will be able to refresh the submissions as many times as they like within the pre-deadline period. This means there will be a window in which information that is not available at the assessment appointment, such as scan or blood test results can be added. Once the deadline for the reporting period is reached, the data will be frozen. The woman's pathway will be determined from this data.
698. The window between the reporting period for the activity and the deadline is expected to be about four weeks.
699. Once the data is frozen, commissioners and providers will be able to access full reports enabling them to extract information on both activity and lead provider. Organisations will be able to identify from the reports where a second provider has submitted information for a woman whose pathway has already been established by a first provider, for example when a woman 'double-books'. This will enable providers to discuss any potential cross-provider charging, outside the system.
700. Furthermore, it is intended that providers will be able to access reports on any data submitted before the deadline. These pre-deadline reports will make some initial, high level, information available, including activity by provider and the initial pathway level (standard, intermediate, intensive). Organisations will be able to access information submitted by other providers where they are a woman's lead provider, and conversely

where they have submitted information for women who have a different lead provider.

701. It is the responsibility of commissioners and public health organisations to ensure that women access maternity care as soon as they realise they are pregnant. Evidence shows that outcomes are worse for late entrants to the maternity pathway. Providers and commissioners should agree locally appropriate thresholds in their contract for the proportion of known first pregnant women who have a late assessment visit.
702. As the Maternity Minimum Data Set is new, for the first few years of operation, details of previous obstetric history will not be available via the national data set. Some of these are needed for determining the correct level of payment for the current pregnancy, for example 'early pre-term birth <34 weeks'. Commissioners and providers will need to agree temporary local information flows for these additional data items to ensure that appropriate payments are made.
703. HIV positive status also impacts on the level of payment providers receive. At the moment, HIV data items are held anonymously in the national data set and, as such, cannot be linked to the maternal NHS number. Local information will need to flow so that commissioners can adjust contract payments where HIV status would move a woman from the standard or intermediate pathway to the intensive.

Cystic fibrosis

704. We are introducing a year-of-care tariff for patients with cystic fibrosis (CF) by transitioning from non-mandatory to mandatory prices.

Currency

705. The CF currency is a complexity-adjusted yearly banding system with seven bands of increasing complexity. There is no distinction between adults and children.

Banding

706. 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).
707. The CF 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.

708. Patients are allocated to a band by the Cystic Fibrosis Trust using data from its national database, the UK CF Registry, and feeding it into a template that produces the banding.
709. 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. Access to the banding data from the registry and information on the number of patients being cared for must be made by the lead clinician in each trust.
710. The bands issued in February 2013 by the CF Registry will be the final bands for all patients for 2013-14 and will be used for contracting purposes. There will be no movement of patients between bands during any one financial year as a full year of data is required for a patient to be appropriately banded.
711. Each provider will be responsible for ensuring that there is sufficient quality data for a patient to be banded through the CF Registry.

Patient numbers

712. Each year 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 may 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 move to the band derived from the matrix process described above when the bandings are revised for the following year.
 - (b) Transition to adult services or another specialist CF centre.
Clinical transition or transfer to another centre may take place at any time during the year. **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 where young people are away at university or patients need 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 when someone is away from the centre responsible for their care, the hospital should submit reasonable costs to the responsible centre for the cost of the treatment provided and 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 other transplants have a separate commissioning mechanism. Payment of the CF tariff for patients receiving a transplant will cease at the end of the month in which they receive their transplant. Commissioning of any continuing care from a CF specialist centre following a transplant will be part of the transplant commissioning arrangements.

Information on patient number variations

713. Each provider will be responsible for informing commissioners of changes in patient numbers due to new births, newly diagnosed patients, transition and transfers, deaths and transplants to enable commissioners to reconcile payments on a regular basis. The UK CF Registry will be used to verify the changes reported by providers and ongoing validation of patient numbers will be undertaken through the CF Trust.

714. 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.

715. Some patients may express a desire not to be registered with the CF Trust. If this is the case the provider will need to work with the CF Trust to discuss how the appropriate band can be established.

What is included in the tariffs?

716. The tariffs 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.
717. 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.
718. For any patient admission or outpatient contact that is for the purpose of cystic fibrosis, the HRG is included in the Year of Care tariff regardless of whether it is one of the CF specific diagnosis driven HRGs or not. We would expect all outpatient CF activity is recorded against TFC 264 and TFC 343.
719. Some elements of services, included in the CF tariffs, may be provided by community services and not the specialist CF centre, such as home care support, including home intravenous antibiotics supervised by the cystic fibrosis service, home visits by the multidisciplinary team to monitor a patient's condition (eg management of totally implantable venous access devices (TIVADs)) and collection of mid-course aminoglycoside blood levels. In such cases there will need to be agreement between the relevant parties on reimbursement from the tariffs paid to the specialist CF centre.

What is excluded from the tariffs?

720. The following are excluded from the mandatory CF tariff:
- (a) High cost CF specific **inhaled/nebulised** drugs: Colistimethate sodium, Tobramycin, Dornase alfa, Aztreonam Lysine, Ivacaftor and Mannitol.
 - (b) Insertion of gastrostomy devices (PEG) and insertion of totally implantable venous access devices (TIVADs) are not included in the annual banded tariff. These 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 surgical procedure should be reimbursed via the relevant HRG tariff. Once discharged after their initial surgical procedure subsequent CF treatment will be covered by the CF

tariff. Annual banding should not include the period they spent as an admitted patient receiving their initial surgical management.

721. 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, activity associated with CF related diabetes, ENT outpatient review for nasal polyps and ENT surgery for removal of nasal polyps.

Drugs

722. Prescription of the high cost drugs Colistimethate sodium, Tobramycin, Dornase alfa, Ivacaftor 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.

723. Funding of Colistimethate sodium, Tobramycin, Dornase alfa, Ivacaftor and Aztreonam Lysine will be governed by the national commissioning policy. 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.

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

725. 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.

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

727. Costs associated with long-term nutritional supplementation via gastrostomy or nasogastric tube feeding are not included in the CF tariff.

728. Commissioning of nutritional supplements will continue to be the responsibility of CCGs. However there must be close liaison between the specialist CF centre and Primary Care to ensure the continued prescription of the most appropriate supplement.

Tariff principles

729. CF care is provided on the basis of the following principles:

- (a) All patients will be registered with a CF specialist centre which will be responsible for all care directly related to the patient's CF.

- (b) CF centres will be responsible for ensuring that the data for all the patients for whom they are responsible are entered on the national CF database, the UK CF Registry. If patients/carers do not wish to have their data to be entered on the UK CF Registry, they must express this wish in writing to their clinician at the specialist centre and the centre will need to work with the CF Trust to establish an appropriate band.
- (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 within the framework of network care. Inter-trust service level agreements will be in place to support these arrangements.
- (f) The providers of CF services – centres and network 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 all current CF specialist drugs.

730. Using these principles, payment of CF tariffs will only be made to specialised CF centres from whom the NHS Commissioning Board is commissioning CF services. The formal process of designating treatment centres will take some time and further guidance will be issued through the NHS Commissioning Board.

Network/Outreach care

731. Network care is a recognised model for paediatric care. 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 must provide care that is of equal quality and access as full specialist centre care.

732. Discussions regarding network care arrangements have identified the need to clearly define the responsibilities of specialist centres and their relationship with shared care providers. A full description of responsibilities of the CF specialist centre in the paediatric network model of care is included in the national service specification.

733. Outreach care is defined as care provided by a specialist centre care team who travel to a local district general hospital. In all cases, CF tariffs will only be paid to designated specialist CF centres.

Payment for Network care

734. Payment of tariffs will only be made to specialist centres which may then elect to undertake network care with shared care providers. There will need to be an agreement of the appropriate reimbursement between the specialist provider and each appropriate network provider based on delivered inputs and compliance with the relevant service specification and service standards.

Details of the tariffs

735. The tariffs for 2013-14 are included in the *tariff information spreadsheet*. The tariffs for bands 1A and 2 remain the same, reflecting the similar costs of service provision. As cystic fibrosis is in itself a specialised service the tariffs are not eligible for any top-up.

Section 11: Chemotherapy and radiotherapy

Chemotherapy

736. Chemotherapy is split into three parts, a core HRG (covering the primary diagnosis or procedure) which is already included within tariff and the unbundled HRGs (for the chemotherapy drug procurement and delivery).
737. For 2013-14, we are introducing mandatory national tariffs for the delivery element of the unbundled chemotherapy in a staged way, with the requirement to move at least half way from local to national prices. This mirrors the approach taken to the introduction of a mandatory tariff for renal dialysis.
738. In an additional change for 2013-14, the regular attender service exclusion will be removed as set out at paragraph 87.
739. The procurement element of chemotherapy remains excluded from the scope of tariff; therefore, procurement HRGs remain subject to local prices.

Structure

740. 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.
741. 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).
742. The chemotherapy delivery HRGs are assigned for each attendance for treatment to reflect the complexity of treatment and resource usage.
743. Table 23 summarises the design of the delivery HRGs (not including oral administration).

Table 23: 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, ie day 8 of a day 1 and 8 regimen or days 8 and 15 of a day 1, 8 and 15 regimen.

744. The delivery HRGs can be generated for day cases, outpatients and regular attenders. For ordinary admissions, the costs of chemotherapy delivery are included in the costs of the core HRG and a delivery HRG should not be generated.

Payment arrangements

745. We have published mandatory tariff prices for chemotherapy delivery for 2013-14. As noted above these prices are being introduced in a staged way, with the requirement to move at least half way from local to national prices in 2013-14.

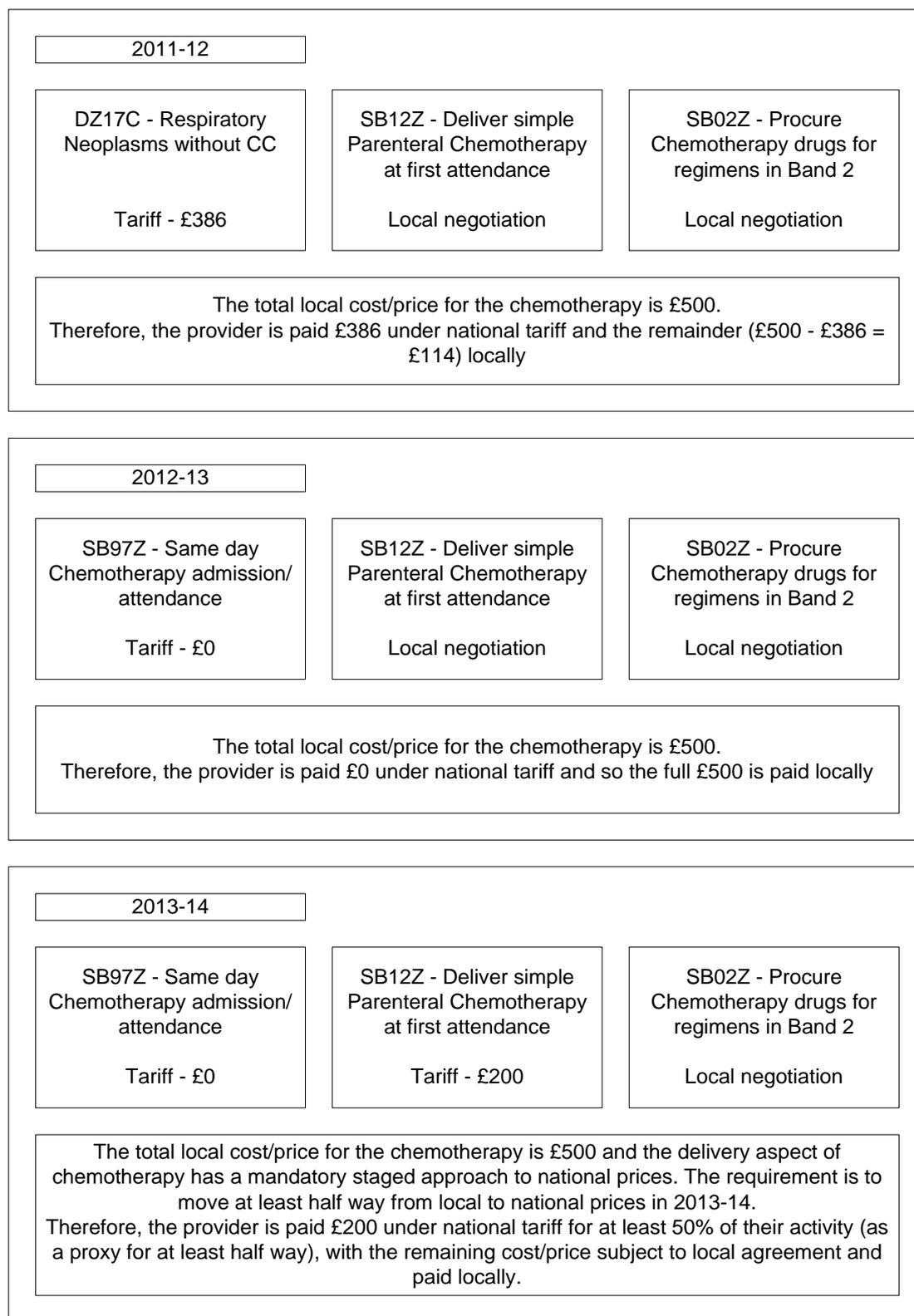
746. There is nothing precluding the use of the full value of these prices in 2013-14 and commissioners and providers will need to work together to manage the impact and transition to full national pricing for chemotherapy delivery.

747. As in 2012-13, SB97Z attracts a zero (£0) price to reflect appropriate reimbursement where a patient has attended solely for chemotherapy delivery and removes the need for organisations to adjust local reimbursement arrangements for chemotherapy to take into account the core HRG for the chemotherapy diagnosis, SB97Z occurs 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).

748. Figure 3 illustrates how SB97Z works, comparing 2011-12, 2012-13 and 2013-14 payment arrangements.

Figure 3: Chemotherapy payment arrangements



749. Table 24 details the full payment arrangements for chemotherapy HRGs.

Table 24: Payment arrangements for chemotherapy HRGs

	Core HRG	Unbundled Chemotherapy Procurement HRG	Unbundled Chemotherapy Delivery HRG
Ordinary admission	eg LB35B Within tariff – includes cost of delivery	eg SB03Z HRG generated – excluded from tariff. Local prices agreed	No HRG generated
Day case and outpatient	SB97Z (generated if no other activity occurs)	eg SB03Z HRG generated – excluded from tariff. Local prices agreed	eg SB14Z Within scope tariff, move at least half way from local to national prices in 2013-14
Day case and outpatient	If other activity occurs eg LB35B	eg SB03Z HRG generated – excluded from tariff. Local prices agreed	eg SB14Z Within scope tariff, move at least half way from local to national prices in 2013-14
Regular day and regular night admissions	As per day case & outpatient	eg SB03Z HRG generated – excluded from tariff. Local prices agreed	eg SB14Z Within scope tariff, move at least half way from local to national prices in 2013-14

750. Delivery codes do not include the consultation at which the patient consents to chemotherapy, nor does it cover any outpatient attendance or diagnostic imaging test for ongoing medical review or as required by any change in status of the patient. These activities would generate an appropriate outpatient HRG on top of the delivery codes if a separate appointment/episode was recorded.

751. 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

752. 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.

753. Work is ongoing to resolve and clarify issues regarding the treatment of hormonal therapies and high cost supportive drugs. Table 25 shows the current treatment of such drugs.

Table 25: 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

754. 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 British National Formulary (BNF) section or sub-section that is wholly excluded from PbR.

Radiotherapy

755. Radiotherapy can be split into two broad areas:

- a) external beam radiotherapy
- b) brachytherapy and liquid radionuclide administration.

756. In 2013-14, we are introducing mandatory national tariffs for external beam radiotherapy in a staged way, with the requirement to move at least half way from local to national prices.

757. 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.

758. 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.

759. In a change for 2013-14, the regular attender service exclusion will be removed as set out at paragraph 87.

Structure

760. It is expected that in line with the RTDS and clinical guidance, 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

761. We have published mandatory tariff prices for external beam radiotherapy for 2013-14. As noted above these prices are being introduced in a staged way, with the requirement to move at least half way from local to national prices in 2013-14.
762. There is nothing precluding the use of the full value of these prices in 2013-14 and commissioners and providers will want to work together to manage the impact and transition to full national pricing for external beam radiotherapy.
763. As in 2012-13, SC97Z attracts a zero (£0) price to reflect appropriate reimbursement where a patient has attended solely for external beam radiotherapy and removes the need for organisations to adjust local reimbursement arrangements for radiotherapy to take into account the core HRG for the diagnosis, SC97Z occurs 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).
764. Table 26 summarises the payments for external beam radiotherapy.

Table 26: Payments for external beam radiotherapy

	Core HRG	Unbundled Radiotherapy Planning HRG (one coded per course of treatment)	Unbundled Radiotherapy Delivery HRG
Ordinary admission	eg 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)	eg SC45Z HRG generated – within scope tariff. Mandated price for 2013/14 for at least 50% contract	eg SC22Z HRG generated – within scope of tariff, move at least half way from local to national prices in 2013-14
Regular day and regular night admissions	As per day case & outpatient	eg SC45Z HRG generated – within scope tariff. Mandated price for 2013/14 for at least 50% contract	eg SC22Z HRG generated – within scope of tariff, move at least half way from local to national prices in 2013-14

765. Planning codes do not include the consultation at which the patient consents to radiotherapy, nor does it cover any outpatient attendance or diagnostic imaging test for ongoing medical review or as required by any change in status of the patient. These activities would generate an appropriate outpatient HRG.

766. 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-fractionated radiotherapy, where two doses are delivered six hours apart, would generate two delivery attendances.

767. 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.

Stereotactic Radiosurgery (SRS) / Radiotherapy (SRT)

768. Stereotactic radiotherapy (SRT) and stereotactic ablative body radiotherapy (SABR) do not currently have their own HRGs, although both fall under subchapter SC.

769. Work is in progress to develop appropriate currencies and tariff for the whole of radiotherapy, multi-fraction stereotactic radiotherapy tariffs will be included in that work. This work will also link with a review of coding for stereotactic radiosurgery (SRS) currently associated with single fraction treatments for a range of malignant and non-malignant neurological disorders.

Section 12: Other currencies and non-mandatory prices

Introduction

770. Besides the mandatory tariff, a number of currencies are provided for use in 2013-14 on either a mandatory or non-mandatory basis.

771. For some of these currencies, 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: Outpatient care)
- d) where there are insufficient data flows to support a mandatory tariff, but we wish to make pricing information available.

772. The currencies and non-mandatory prices are as follows:

Currency	Basis	Non-mandatory prices available?
Specialist rehabilitation (paragraph 775)	Mandatory	Yes
Health assessments for looked after children placed out of area (paragraph 808)	Mandatory	Yes
Ambulance services (paragraph 811)	Mandatory	No
Critical care (paragraph 828)	Mandatory	No
HIV adult outpatient services (paragraph 833)	Mandatory	No
Renal transplantation (paragraph 851)	Mandatory	No
Acute phase of rehabilitation (paragraph 881)	Non-mandatory	Yes
Adult hearing services (paragraph 891)	Non-mandatory	Yes
Non face-to-face outpatient attendances (paragraph 893)	Non-mandatory	Yes
Previously mandatory maternity prices which are now covered by the pathway payment system (paragraph 630)	Non-mandatory, as there is now a mandatory pathway currency	Yes
Direct access plain film x-rays (paragraph 896)	Non-mandatory	Yes
Cochlear implants (paragraph 897)	Non-mandatory	Yes

Currency	Basis	Non-mandatory prices available?
Transcatheter aortic valve implantation (paragraph 898)	Non-mandatory	No
Genito-urinary outpatient attendances (paragraph 899)	Non-mandatory	No

773. Non-mandatory prices may be used as part of contract negotiations and varied to reflect local circumstances. Where currencies are non-mandatory, 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.

774. The following services will no longer have non-mandatory prices in 2013-14 because they are now covered by the mandatory tariff:

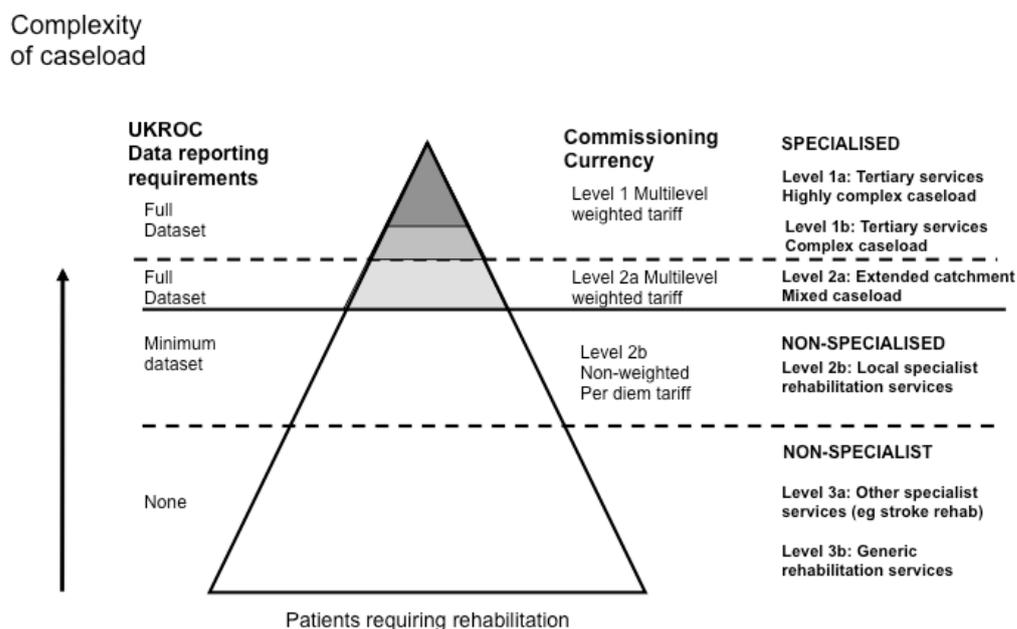
- a) Chemotherapy delivery (paragraph 736)
- b) External beam radiotherapy (paragraph 755)
- c) Cystic fibrosis year of care (paragraph 704)

Specialist rehabilitation

Introduction

775. In 2013-14 we are mandating a weighted per diem currency model which covers specialist rehabilitation services (levels 1, 2a and 2b) and releasing indicative tariffs (which are set out in the *tariff information spreadsheet*). Figure 4 shows the different levels of specialised and specialist rehabilitation service, and it should be noted that level 3 local non specialist rehabilitation services are outside the scope of this currency model.

Figure 4: Levels of specialised and specialist rehabilitation service



776. A multi-level weighted currency and tariff for specialist rehabilitation has been designed that is based on patient complexity and need, as opposed to a fixed per diem model. It is accepted that diagnosis is a poor predictor of rehabilitation costs.

Background

777. Specialist rehabilitation supports patients with complex disabilities whose rehabilitation needs are beyond the scope of local rehabilitation services. Such patients typically present with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems, which require specialist input from a wide range of disciplines including specialist medical input from consultants trained in rehabilitation medicine, and other relevant specialties such as neuropsychiatry.

778. A subgroup of specialist rehabilitation patients will have 'profound disability'. These are more severely affected patients who require help for all aspects of their basic care as well as specialist interventions for example spasticity management, postural support programmes and highly specialist equipment.

779. Specialist rehabilitation services deliver care for a selected caseload of patients with complex rehabilitation needs which requires specialist equipment, facilities and staffing levels to meet those needs. They provide adequately for a casemix complexity which is characterised as low volume but a high cost service.

Definitions

780. The Specialised Services National Definition Set (SSNDS) for Specialist Rehabilitation covers all the conditions and treatments agreed by clinical experts to require specialist rehabilitation. It defines four categories of rehabilitation needs (A to D) and three levels of service (levels 1, 2 and 3).¹³⁸ The specialist rehabilitation currency model only applies to patients with category A and B needs who require level 1 and 2 services.
781. Specialised and specialist rehabilitation units (level 1 and 2) have dedicated rehabilitation beds and a team led by an accredited consultant in rehabilitation medicine.
782. Within the specialist rehabilitation currency model, service level 2 services have been further subdivided into 2a and 2b. This is so the currency model meets the national British Society of Rehabilitation Medicine (BSRM) standards for specialist rehabilitation services.
783. Level 3 non-specialist rehabilitation services are not within the scope of this currency model. Local non-specialist (level 3) rehabilitation teams provide multi-professional rehabilitation and therapy support for a range of conditions within the context of acute services, intermediate care or community services.
784. The SSNDS will shortly be superseded by the scope and service specification for specialist rehabilitation under the national transition to NHSCB commissioning. The principles of the SSNDS will be carried forward although terminology may be adjusted.

Currency model

785. This specialist rehabilitation weighted per diem currency model is designed to work by using the Rehabilitation Complexity Scale (RCS-E) tool to assess the patient's needs and complexity during their admitted stay on a specialist rehabilitation unit.
786. At agreed time frames during the patient's stay (for example fortnightly for level 1 and 2a services and upon admitting the patient and discharging them for level 2b), patients are assessed and a RCS-E score is given to them which reflects their needs.
787. Intermittently over the patient's stay, providers will then be required to submit this patient level data to a central designated specialist

¹³⁸Specialised Services National Definitions Set (SSNDS), Specialised Rehabilitation Services for Brain Injury and Complex Disability (all ages) 3rd edition- Definition No. 7, Annex 1 http://www.specialisedservices.nhs.uk/library/21/Specialised_Rehabilitation_Services_for_Brain_Injury_and_Complex_Disability_adult.pdf

rehabilitation database – the UK Rehabilitation Outcomes Collaborative (UKROC) database¹³⁹.

- 788. All specialist rehabilitation services for levels 1, 2a and 2b are required to register with the UKROC national clinical database for specialist rehabilitation services.
- 789. It is important that commissioners and providers understand whether their patient activity falls within the specialist or non-specialist rehabilitation definition.
- 790. This currency model covers both adults and designated children services.
- 791. This currency model only covers the admitted patient stay.
- 792. This currency model has been designed for patients who will be on a specialist rehabilitation unit for 6 months or less.

Levels of Service within Specialist Rehabilitation

- 793. Level 1 - Tertiary 'specialised' rehabilitation services are high cost but low volume services, which provide for patients with highly complex rehabilitation needs that are beyond the scope of their local and district specialist services. They serve a catchment population > 1 million population, and carry a high proportion of complex cases (85% category A). They are required to report the full clinical dataset to the UKROC database and will be designated by the National Specialised Commissioning Group (NSCG).
- 794. Level 2 - This currency model meets the national¹⁴⁰ standards for specialist rehabilitation services – by further subdividing level 2 services into level 2a and 2b.
- 795. Level 2a units are supra-district services usually serving a catchment population of 750-1 million. They carry a mixed case load that includes at least 50% of Category A patients and have the appropriate facilities, expertise and staffing ratios to manage the complexity of their caseload.
- 796. Level 2b are local specialist rehabilitation services providing primarily for Category B patients, typically with a catchment area of 350,000 – 500,000 people. (It is expected that Level 2b services will have a small proportion of patients with Category A needs (<30% at any one time), where the patient's rehabilitation needs are best met locally and the unit has the appropriate skills and facilities to manage them).

¹³⁹UKROC is a National Institute Health Research programme which has been set up to identify cost efficient models of rehabilitation in relation to patient need, and develop a national database for collating case episode data for specialist rehabilitation. For more information please see <http://www.csi.kcl.ac.uk/ukroc>

¹⁴⁰ British Society of Rehabilitation Medicine (BSRM)

Operating the policy

797. Activity which meets the NHS Specialised Services Rehabilitation Services' criteria will be commissioned directly by the NHS Commissioning Board. This includes all level 1 activity and patients with Category A needs in level 2a services that are designated by the NHSCB (in areas where there is no or insufficient capacity in level 1 services).
798. Other specialist rehabilitation activity (patients with Category B needs in level 2a services and all level 2b) will be commissioned locally by CCGs.
799. All Specialist Rehabilitation services for Level 1, 2a and 2b are required to register with the UKROC national clinical database for specialist rehabilitation services.
800. Level 1 and 2a units must be complete the full UKROC dataset for all case episodes that they wish to have counted as specialist rehabilitation, with fortnightly serial RCS-E collection. Monthly data reporting will be required for services commissioned centrally through the NHS Commissioning Board.
801. Level 2b services commissioned on the 5-tier level tariff should also record fortnightly RCS-E scores which must be submitted to the UKROC dataset at least quarterly. They must also complete at least the minimum UKROC dataset for outcome and benchmarking data.

Specialist Rehabilitation and Core HRGs

802. As a separate data source, UKROC is being used for collecting specialised rehabilitation activity in 2013-14. For tariff purposes the impact on the activity left in the rest of the spell must be considered.
803. Under current grouper logic, all discrete rehabilitation is coded using OPCS codes which generate unbundled HRGs. A spell with unbundled rehabilitation will always still have a core HRG, which may or may not have a national tariff. This core HRG needs to be adjusted for any activity covered by specialist rehabilitation to ensure that the days are not double counted (once in the core and once in the specialist rehabilitation). Only a subset of total rehabilitation activity is covered by the new specialist rehabilitation currency.
804. Commissioners may wish to satisfy themselves that specialist rehabilitation is not being double counted and that local non-specialist rehabilitation remains funded through local agreement.

Summary of non-mandatory structure

805. In 2013-14 we are releasing non-mandatory tariffs for Specialist Rehabilitation which are set out in the *tariff information spreadsheet*. The non-mandatory tariffs have been based on data collected in 2012-13 from a number of specialist rehabilitation units that already providing information to UKROC.
806. By making available non-mandatory tariffs for use in 2013-14, we are enabling providers and commissioners to benchmark their services.
807. The non-mandatory tariff is weighted according to the complexity of needs and varies over time with the changing needs of the patient. A 5-tier model is used.

Health Assessments for Looked After Children (LAC)

808. When children are placed in care by local authorities, their responsible health commissioner has a statutory responsibility to commission an initial health assessment and review it either six monthly or annually. When the child is placed out of area, the originating commissioner retains this responsibility.
809. In April 2013, we are mandating a national currency for looked after children placed out of area with a non-mandatory tariff. For children placed in area the currency will be available for use but non-mandatory.
810. The currency is described in Annex H and has a checklist which sets out the components of the assessments, a reference for the competencies required for the staff carrying out the assessments and quality standards. Responsibility for ensuring that the health assessments comply with the standards will rest with the designated doctor or nurse for LAC within the commissioning CCG.

Ambulance services

811. In April 2012 we published a currency for the contracting of emergency and urgent ambulance services.
812. This currency was mandated for the 2011-12 reference cost collection and mandated for contracting in 2012-13. Prices will continue to be agreed locally for 2013-14.
813. Four categories were developed and agreed with ambulance trusts and commissioners as the basis for payment.

Ambulance service currency

814. The categories are:

a) Urgent and Emergency Calls Answered (AMB10)

The number of emergency and urgent calls presented to switchboard and answered.

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 contracts with non-NHS providers.

The unit is the price per incident.

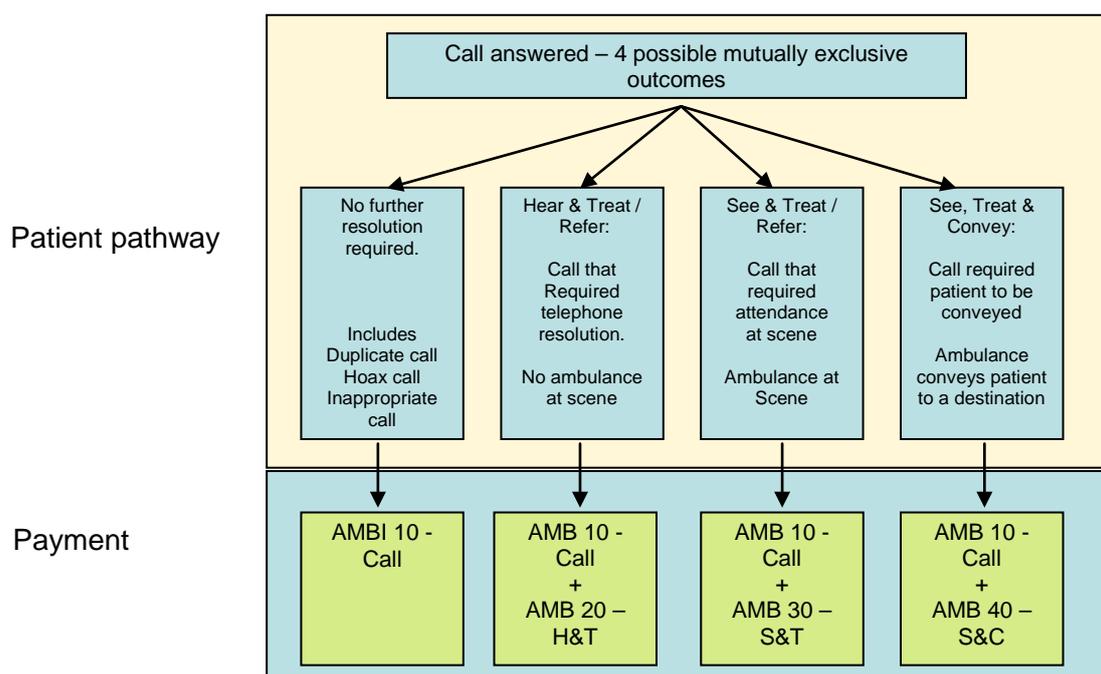
System of payment

815. The system of payment will be a set 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.

816. Only the latter two categories 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).

817. Figure 5 summarises this system.

Figure 5: 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 payment will be payable

Contracts - Outcomes, quality, patient experience

- 818. Commissioners must agree with provider organisations what they are trying to incentivise in terms of an emergency and urgent service, taking into account the need to provide the highest quality service for the local population as well as value for money.
- 819. Organisations should use the NHS Standard Contract to agree local outcome, quality and patient experience indicators, and the financial incentives and penalties of achieving or not achieving specified indicator levels.
- 820. Services provided by other organisations – such as 111 or NHS Direct – should be taken into account to prevent duplication of services across organisations, with an understanding of what these services can deliver, and an understanding of how patient experience may be affected by commissioning decisions.
- 821. Commissioners should judge providers on what they have achieved, not on how they choose to deliver their service.

Commissioner Risk Sharing

- 822. Ambulance NHS trusts and NHS foundation trusts will have a number of different commissioners.

823. 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.
824. The Department suggests that commissioners should collectively agree a risk-sharing budget allocation model that allows a single price to be agreed.

Scope

825. 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).
826. 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 for treatment to healthcare provider.
 - d) No action: call was a duplicate, inappropriate, did not complete or a hoax.
827. 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 – unless otherwise specified in Section 14:
Other operational issues
 - (e) decontamination units
 - (f) emergency bed service (EBS)
 - (g) emergency planning
 - (h) the provision of 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

828. 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 2013-14. 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. This “national currency: local price” model is described in *Guidance on NHS commissioning and contracting of adult and neonatal critical care services in 2011-12*¹⁴¹.
829. 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 (eg major trauma). We do not expect any contracts to be agreed on a 100% fixed model (ie a block contract).
830. Comparative benchmark activity and costing information for adult critical care HRGs based on 2010-11 reference costs is shown in Table 27.

141

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 ⁽ⁱ⁾	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)} (2013-14 prices)
XC01Z	6	1.0%	NA	NA	£1,642
XC02Z	5	5.3%	NA	NA	£1,581
XC03Z	4	11.3%	13	19%	£1,461
XC04Z	3	20.7%	9	29%	£1,307
XC05Z	2	27.1%	5	33%	£1,087
XC06Z	1	32.9%	3	50%	£793
XC07Z	0	1.6%	2	67%	£239

Sources:

- (i) Department of Health critical care project 2007
- (ii) Department of Health reference costs 2010-11

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

831. Benchmark bed day costs for the neonatal critical care HRGs, based on 2010-11 reference costs, are shown in Table 28.

Table 28: Neonatal critical care benchmark data

HRG code	Description	Benchmark bed day data ⁽¹⁾ (2010-11 prices)
XA01Z	Neonatal critical care – intensive care	£1077
XA02Z	Neonatal critical care – high dependency care	£752
XA03Z	Neonatal critical care – special care without external carer	£449
XA04Z ⁽²⁾	Neonatal critical care – special care with external carer	£407
XA05Z ⁽²⁾	Neonatal critical care – normal care	£407

Source: Department of Health reference costs 2010-11

- (1) Excludes MFF
- (2) Costs have been equalised to remove relativity issues

832. Work undertaken for the 2011-12 reference cost guidance focussed on the submission of comprehensive 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.

HIV adult outpatient services

833. In 2013-14 we are mandating the HIV adult outpatients currency which covers adult HIV outpatient services post diagnosis.

834. As HIV is a long term condition where clinical management of care does not always require attendance at an HIV service, especially with ongoing changes in service delivery, a 'Year of Care' is considered the most appropriate currency.

835. The 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 antiretroviral therapy (ART) drugs)
- Category 2: (stable patients)
- Category 3: (medically complex patients)

Category 1: new patients

836. Category 1 patients are those who have been newly diagnosed **or** have newly started ART. The grouping methodology does not make an assumption on how patients are referred to HIV care.

837. This category allows for the recognition that patients in the first year of diagnosis require more intensive clinical and/or psychosocial input than stable patients. This will include a greater number of initial and more complex diagnostic tests and more frequent clinic visits with a greater input from the Multi Disciplinary Team.

838. A newly diagnosed patient will be a category 1 patient for 1 year, after which they will automatically become a category 2 patient.

839. Similarly a patient starting ART for the first time will be a category 1 patient for 1 year when they will automatically become a category 2 patient.

Category 2: stable patients

840. Category 2 covers stable patients not on ART or stable and started ART more than 1 year ago. This category will cover the majority of patients and therefore should be used as the default category unless category 1 or 3 criteria can be demonstrated and validated.

Category 3: medically complex patients

841. HIV care and treatment is by its very nature a specialist service and all patients have an inherent level of complexity. Patients who fall into category 3 have a medical complexity that identifies them as a special patient group, needing high levels of maintenance, or being highly dependent patients.
842. A set of supporting documents can be found on the DH PbR website¹⁴².
843. A dataset to provide pseudonymised patient numbers to support commissioning, outcomes and the epidemiology of HIV adult outpatient activity, the HIV and AIDS reporting system (HARS) will be rolled out by the Health Protection Agency¹⁴³. HARS will be rolled out across the country with the expectation that all HIV outpatient services should have adopted HARS by the end of March 2014.
844. 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.
845. 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.
846. There will then be a quarterly reconciliation process of patient case mix and volumes from the HPA.
847. Commissioners and providers need to apply the new currency from 2013-14 with local prices. Providers will need to start collecting data against these currencies. It has been recognised in some areas that there is a need to allow time to update information systems to capture against the new HARS dataset.
848. Commissioners and providers will need to discuss and agree an implementation plan for collecting the underlying data to support the delivery of the currency either through the HARS dataset or local systems so that patients can be categorised. Providers need to establish robust reporting systems in sufficient time in 2013-14 to support accurate forecasting and planning for 2014-15.

¹⁴² <http://www.dh.gov.uk/health/2012/04/pbr-sexual-health/>

¹⁴³ <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVAndAIDSReportingSystem>

Exclusions

849. The HIV adult outpatient currency currently excludes the provision of any antiretroviral (ARV) drugs cost.
850. It is useful to read this guidance with the HIV Outpatient Clinical Care Pathway v10 and the *HIV Adult Outpatient Services Simple Guide* on the PbR website¹⁴⁴.

Renal Transplantation

851. A new adult renal transplantation currency (>18 years) is being mandated in 2013-14. The currency is being mandated to support a consistent and transparent approach to activity recording and data collection.
852. The currency uses existing HRGs to collect activity and covers all care directly related to the preparation and provision of a transplant episode, including living donation, and the required post transplant care delivered in both transplant and specialist renal centres. This currency does not apply to kidney transplants performed as part of simultaneous pancreas and kidney transplants, and of other multi-organ transplants incorporating a kidney transplant.
853. The currency is made up of three components:
1. preparation for transplantation outpatient attendances
 2. the transplant episode plus post discharge drugs
 3. post transplantation outpatients

Coverage

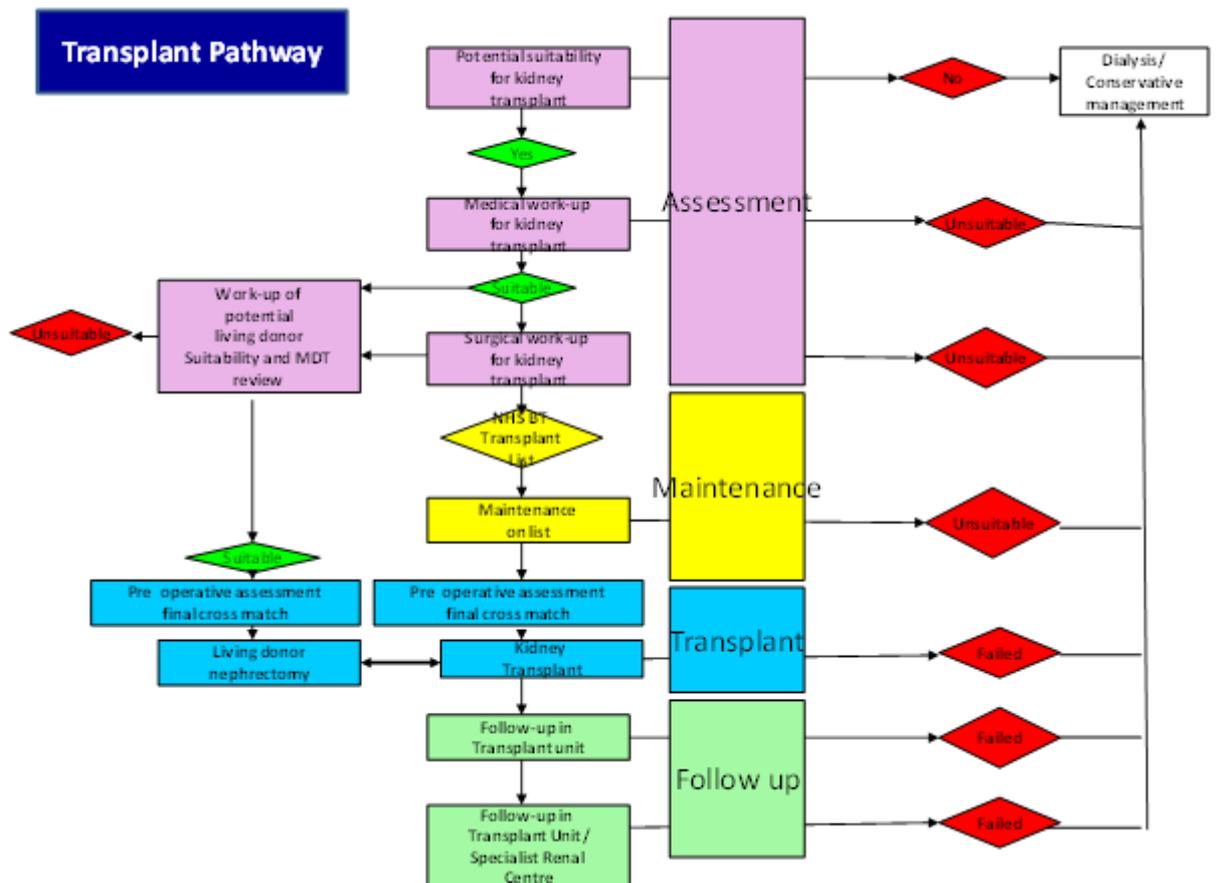
854. There are already HRGs relating to this activity. In the absence of a mandatory currency the capturing of data and allocation against these HRGs has not been consistent.
855. The currency covers activity relating to HRGs: LAO1A, LAO2A, LA03A, LA10Z, LA11Z, LA12A, LA13A, LA14Z and LB46Z and for outpatient procedure codes, M171, M172, M173, M174 and M175.
856. During 2013-14, we will be monitoring activity against these HRGs. It is very important that providers ensure the accuracy of their data coding as the development of any future tariff will be based on this activity and reported reference costs. Providers may wish to develop mechanisms which allow comparisons between existing currencies and the mandated currency and share this information with commissioners to inform future forecasting and planning.

¹⁴⁴ <http://www.dh.gov.uk/health/2012/04/pbr-sexual-health/>

857. We will be working with a number of transplant and specialist renal centres to pilot the application of this currency to ensure that it is fit for purpose.

858. An FAQ document is available on the NHS Kidney Care website.¹⁴⁵

Figure 6: Renal transplantation pathway



1. Preparation for transplantation

859. All chronic kidney disease stage 5 patients who are considered medically suitable, should be considered for transplantation.

860. The consultation at which all modalities of renal replacement therapy are considered is excluded from the pathway. This can be defined as an outpatient clinic where the primary purpose is to formally assess a patient's suitability for transplantation. This will include a relevant history and examination; counselling regarding the risks and benefits of transplantation; and arranging the necessary investigations. This is distinct from a clinic where the various options for renal replacement therapy are considered and an informal consideration of potential suitability for transplantation is considered.

¹⁴⁵ <http://www.kidneycare.nhs.uk/document.php?o=1727>

Assessment

861. Preparation for transplant and therefore the pathway starts after the patient has been identified as potentially suitable for transplantation, and when work up of the patient as a potential transplant recipient commences.
862. Assessment should involve a nephrologist and a transplant surgeon. At this initial assessment tests will be undertaken to identify suitability for transplantation. For patients that are more complex further tests may be required.
863. Further tests may be undertaken, dependant upon the patient's complexity, prior to placing the patient on the transplant list. Histocompatibility and Immunogenetics (H&I) tests may be arranged by either the nephrologist or the transplant surgeon depending on local practice.
864. Some patients may present with complex conditions or have borderline assessments. Patients are often discussed at Multi Disciplinary Team meetings to establish their suitability and/or to plan their management.

Maintenance

865. When patients have completed their assessment and are considered suitable for transplantation they will be entered onto the national transplant list. Where a living donor is possible, they must be assessed using a protocol based upon British Transplantation Society / Renal Association guidelines (UK Guidelines for Living Donor Kidney Transplantation).
866. Kidney transplant centers must adhere to the national specialist society guidelines for acceptance on to the waiting list.
867. Patients should receive an annual transplant focused review, which may require further investigations. During this period, patients should also receive a three monthly measurement of antibodies undertaken through Histocompatibility and Immunogenetics (H&I) laboratories.
868. Some patients may present with other conditions ie pregnant women with a pre-existing kidney transplant may require personalised assessment and management from a specialist local secondary maternity care. The transplantation pathway is only responsible for the transplant care, and not for any of the maternity care as this will be picked up through a separate tariff mechanism.
869. If a pre-emptive living donor transplant is not available, the patient will be listed for a deceased donor transplant. For patients waiting longer than three years for a transplant, discussions will need to take place

between providers and commissioners regarding any ongoing costs that are beyond the annual maintenance reimbursement.

2. The transplant episode plus post discharge drugs

870. Transplants covered in this pathway are Kidney Transplant from donation after circulatory death (DCD) 19 years and over, Kidney Transplant from donation after brain death (DBD) 19 years and over, Kidney Transplant from Live donor 19 years and over and Live Donation of Kidney.

Operative and Postoperative complications

871. Any readmission to theatre due to internal bleeding or required removal of kidney will not attract additional activity based payments, and are included within the transplant pathway.

3. Post transplant outpatients (adult - recipient)

872. The management of post transplant patients can be divided into three phases and should be commissioned on this basis:

- (a) an early post transplant phase (first 90 days)
- (b) medium term follow-up (90 days to one year)
- (c) long term follow-up (after 1 year)

(a) Early post transplant phase (first 90 days)

873. This period is where the most intensive follow up will be required when prevention of rejection, optimisation of graft function and prevention of infection are paramount.

874. Patients will be seen 2-3 times a week in clinic for the first few weeks and less as time goes on to monitor progress post transplant. A patient can be returned to a specialist renal centre at any time during this period. The handover of patients post-transplant will be at the mutual agreement of the transplant centre and the specialist renal centre and must be supported by clear communication and documentation.

b) Medium term follow-up (90 days to one year)

875. Routine monitoring and review is required less frequently as the patients progress improves and the focus is on the preservation of good graft function, continued prevention of rejection and infection and optimal treatment of co-morbidity.

c) Long term follow-up (beyond one year)

876. Transplant care will be continuous and extend for the life of the functioning transplant (and beyond if necessary) with an annual payment for these patients.
877. For patients referred from a specialist renal centre, the care of the transplant recipient will normally transfer within the first 12 months post-transplant from the transplant centre to the care of the nephrologist within the transplant centre or at a specialist renal centre.
878. Regular transplant follow up in outpatients will identify patients who have a failing transplant and arrangements should be made for another transplant or dialysis.
879. Any post discharge admissions which are transplant related are usually multifactorial and may relate to rejection, infection surgical complications or any other form of transplant dysfunction. These readmissions should be excluded from the pathway.

What is excluded from the currency?

880. The following are excluded from the currency:
1. Antibody incompatible transplantation
 2. Any deceased donor organ donation and costs related to the associated organ retrieval which are the responsibility of NHSBT
 3. The initial assessment clinic covering all modalities of renal replacement therapy.

Acute phase of rehabilitation

881. HRG4 introduced unbundled HRGs for rehabilitation. As in previous years, 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 rehabilitation 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.
882. The rehabilitation External Reference Panel (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).
883. For acute stroke care, we are carrying forward guidance from 2012-13 on how organisations may wish to redistribute funds from the acute tariff to the immediate post-acute phase of rehabilitation.

884. 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 AA22A&B and AA23A&B 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 2010-11 costs and activity will not reflect this diversity.
885. 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.
886. *Payment by Results for stroke and TIA services (2007)*¹⁴⁶ 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)*¹⁴⁷ recognised a need for improved access to specialist community stroke care and early supported discharge (ESD).
887. Because the tariff prices for the stroke HRGs 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 economics¹⁴⁸ to support organisations achieve these changes.

¹⁴⁶http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077130

¹⁴⁷<http://www.nao.org.uk/publications/0910/stroke.aspx>

¹⁴⁸www.improvement.nhs.uk/stroke

888. 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 AA22/23A&B. 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.
889. The current tariff structure is based on 2010-11 data with an average length of stay of 16 days across the four stroke HRGs. This has decreased from 34 days in 2001. The trim points for these HRGs range from 13 to 47 days but these, by definition, apply only to outlier¹⁴⁹ 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
890. 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. Local discussions about unbundling the tariff to foster implementation of these evidence based interventions in stroke should take place.

Adult hearing services

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

Neurology and neurosurgery

892. We are again publishing non-mandatory prices for neurology (TFC 400), neurosurgery (TFC 150) and paediatric neurology (TFC 421) consultant-led outpatient attendances. We calculated these in the same way as other outpatient attendance tariffs for 2013-14, ie with diagnostic imaging unbundled.

¹⁴⁹ 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).

Non face-to-face outpatient attendances

893. 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.
894. 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.
895. 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.

Direct access plain film x-rays

896. Following requests from the NHS, we have introduced a non-mandatory tariff for direct access plain film x-rays.

Cochlear implants

897. As set out in Section 9: Exclusions, we have excluded activity for cochlear implants from the tariff for 2013-14, pending a national procurement exercise for the device. The NHS Commissioning Board will use the published non-mandatory tariff until such time as the cost of the devices has reduced.

Transcatheter Aortic Valve Implantation (TAVI)

898. As set out in Section 9: Exclusions, we have excluded activity for TAVI from the tariff for 2013-14, pending a national procurement exercise for the devices.

Genito-urinary medicine outpatient attendances

899. With commissioning responsibility for GUM outpatient attendances transferring to local authorities, we are not publishing a mandatory tariff for this activity. We are however making a non-mandatory tariff available for organisations to use if they wish. We understand that there may be circumstances where local authorities are 'cosignatories' to NHS standard contracts, and in these case it may be appropriate for this non-mandatory tariff to be adopted.

Any Qualified Provider

900. The PbR team has supported the any qualified provider team and NHS partners in developing a set of implementation packs for eight currency areas.¹⁵⁰ 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

Assistive technology - telehealth and telecare

901. Through the 3 Million Lives partnership programme, up to 100,000 more people will be given access to telehealth services across 7 'pathfinder' sites in 2013. Aligned to this programme there will be a workstream to develop currency models for telehealth services. To support this work the 3 Million Lives team are keen to learn from other service areas that are already considering tariff approaches for payment of telehealth services. If you have experience in this area please contact the team via info@3millionlives.co.uk.

¹⁵⁰ Further information available at <http://www.supply2health.nhs.uk/AQPResourceCentre/Pages/AQPHome.aspx>

Section 13: Flexibilities

Introduction

902. The national tariff and accompanying ‘rules’ on the operation of Payment by Results are mandatory. Providers and commissioners are however able to agree to vary the prices payable under the national tariff, for example to support innovation in service delivery, integration of services or unbundling of services to enable components of care to be delivered and paid for separately, where this would be in patients’ best interests. Where such variations are agreed, the commissioner is required to keep and publish a written statement of all such variations.¹⁵¹
903. As part of the work arising from the NHS Chief Executive’s *Innovation, Health and Wealth* review, the NHS Institute for Innovation and Improvement has created a range of informative case studies in collaboration with NHS commissioners and providers. A number of the case studies show how local health economies have successfully used tariff flexibilities to support innovation. Additional examples show how commissioners and providers have developed innovative care pathways, introduced new technologies and negotiated local prices. Whilst some of these services are outside the scope of mandatory national tariff, these case studies nonetheless provide useful insights into the change processes adopted and the benefits achieved. To see these case studies, along with good practice guidance and other useful links, please visit the NHS Institute for Innovation and Improvement’s High Impact Innovations website¹⁵² and click on the relevant link.
904. In implementing any of the permitted flexibilities, all of the following rules must be adhered to:
- (a) **the flexibility must be the product of local agreement** – with due regard to the PbR Code of Conduct, flexibilities should be agreed in advance by commissioners and providers
 - (b) **the flexibility must be clearly established and documented** – an audit trail for the agreed flexibility is necessary and it should be documented as part of contract negotiations;
 - (c) **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.
905. There are three main criteria, at least one of which should be met before a proposed flexibility can be introduced. These are:

¹⁵¹ Section 116 of the Health & Social Care Act 2012 refers to tariff flexibilities

¹⁵² <http://innovault.innovation.nhs.uk>

- Criteria 1 - the flexibility supports the provision of care that is better for the patient and the NHS
- Criteria 2 - the flexibility supports material service redesign or more efficient pricing
- Criteria 3 - the flexibility should enable appropriate reimbursement where casemix is significantly different from the norm

906. These criteria are set out in more detail below, along with examples of where flexibilities can be agreed which meet these criteria.

Criteria 1 - the flexibility supports the provision of care that is better for the patient and the NHS – any local flexibility should be supporting better care for patients, whether it is closer to home, more convenient or of higher quality. A flexibility may also benefit the NHS as a whole, by reducing the costs to the whole care system

Examples

Outpatient procedures and day cases

907. Offering patients treatment in a day case setting or, where possible in outpatients, can be beneficial for many reasons. Where the activity data supports it, the Department of Health has provided tariffs for similar services in a variety of settings to encourage the movement of those services to less acute settings where this is appropriate.

908. In some cases however, tariffs based on the average costs of patterns of established service provision may result in new providers who are able to offer treatment in less intensive settings being prevented from doing so. An example may be a GP provider offering a procedure historically undertaken in a day case setting where the average outpatient procedure tariff would not cover costs.

909. 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.

Dialysis away from base

910. Patients who require dialysis might sometimes struggle to find a dialysis provider when they are away from home. In order to ensure that as much choice as possible is available, commissioners can pay higher prices to providers whose main business (85-90%) is providing dialysis away from base. In addition the price paid for dialysis away from base is set at the higher rate normally only applicable to patients with an arteriovenous fistula or graft. Further information can be found in the best practice tariffs section of the guidance at paragraph 337.

Innovation payments

911. Where patients can benefit from the introduction of new devices, drugs, treatments and technologies or a new application of existing technologies which are not reflected in the mandatory tariff price, commissioners can agree to make additional payments, known as innovation payments. These should only be used 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, for example reducing the likelihood of the need to repeat a procedure.
912. It may 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.
913. 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 procedures¹⁵³
 - 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.
914. The NHS Technology Adoption Centre (NTAC) *How to Why to* guides¹⁵⁴ may help inform discussions between commissioners and providers on implementing and funding specific technologies.
915. Please e-mail us at pbrcomms@dh.gsi.gov.uk with details of agreed innovation payments, with “innovation payments” as the subject heading.

¹⁵³ http://www.nice.org.uk/aboutnice/whatwedo/aboutinterventionalprocedures/about_interventional_procedures.jsp

¹⁵⁴ <http://www.ntac.nhs.uk/HowToWhyToGuides/>

Criteria 2 - the flexibility supports material service redesign or more efficient pricing – local flexibilities can be a means of driving further efficiency as long as patient interests are not compromised.

916. The tariff is generally based on historical patterns of activity. Where there are plans to redesign services to support better care for patients, whether it is closer to home, more convenient or of higher quality, or to provide 'one stop shops' or 'see and treat' services there is the flexibility to adapt the tariff to the new pattern of delivery. These initiatives may also benefit the NHS as a whole, by reducing the costs to the whole health system.

Examples

Variations to tariff

917. There may be circumstances, where commissioners and providers agree to reduce the price being paid under the tariff perhaps, for example, to release funds to pump prime service redesign.

918. This does not mean replacing the national 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.

919. 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.

920. 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 reduction to the national price that enables the provision of services to patients which would not otherwise be possible without some flexibility on price.

Bundling for pathways

921. Although some tariffs are set using patient pathways their number is currently limited. If commissioners and providers want to introduce local care pathways and fund them using a locally agreed tariff which incorporates some episodic tariffs, then there is the flexibility to do so.

This might be particularly suitable for patients with long term conditions and named patients with frequent admissions to hospital.

Unbundling

922. Unbundling should only take place where a substantive case can be made that it is necessary to achieve significant policy objectives. Unbundling may be suitable where the costs of a particular activity cannot be predicted from standard casemix measures, or where the activity is split over more than one provider. Commissioners and providers may continue to unbundle services where it is consistent with these principles. Commissioners and providers should share patient data and any relevant cost data in order to facilitate unbundling.

923. Set out below is a case study of where unbundling the tariff has been successfully undertaken.

Case study

From 1 April 2012, NHS Mid Essex commissioned a pathway for stroke patients from both an acute and private sector provider, the latter based in the community. This has been achieved by unbundling the service and the existing tariff payment and transferring resources previously invested in the acute provider to the community provider within the existing resource envelope. It also means that each part of the service could be tendered independently in the future.

Initial Stage – 2012-13

- commissioners signalled the intent to the main acute provider to unbundle the tariff in October 2011, the HRGs concerned being AA22Z and AA23Z.
- Early Supported Discharge (ESD) pilot started in December 2011 with local community service provider- an independent social enterprise
- existing clinical forums used to develop proposals for the stroke pathway
- clinically led paper produced by the main acute provider including the proposed allocation of resources along the acute phase of the pathway
- unbundling limited to 2 HRGs irrespective of whether the patient is transferred to the ESD service or not. Equally, patients grouping to a different HRG would still follow the ESD pathway if clinically appropriate
- four-part payment implemented in April 2012:
 1. spell tariff: based on length of stay with a set percentage of the national tariff paid at set points with the optimum payment at day 7. At day 16, the payment would reach 100% of the national tariff
 2. best practice: the additional payment for the stroke scan is paid in line with national PbR rules/criteria
 3. excess bed days are paid in line with national trim points and tariffs
 4. delayed discharge penalties are payable by commissioners to ensure the acute provider is not disadvantaged if patients are ready

for discharge to the community provider but insufficient capacity exists to transfer the patient out of hospital. Delayed discharge penalties are payable by the acute provider if there is an unnecessary delay in transferring patients to the community provider where capacity exists to transfer

- unbundling the tariff generated £440k towards the implementation of the ESD pilot and created bed capacity in the acute provider.

Next Stage – 2013-14

The plans involve:

- moving to a tariff-based payment for the ESD service (pilot is a block) to provide a financial incentive to transfer patients efficiently from the acute phase
- moving to a lead provider model with both payments (acute and ESD) being made to the lead to incentivise the optimum pathway and enable staff rotation throughout the service while improving recruitment, service development and staff training
- providing stronger support and access to medical staff for community based staff
- removing the delayed discharge penalties
- reducing the overall cost quantum for the same cohort of patients while improving service quality.

Criteria 3 - the flexibility should enable appropriate reimbursement where casemix is significantly different from the norm

Examples

Patient or procedure selection

924. 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, we introduced a new flexibility in 2012-13 designed to ensure fair reimbursement for the services delivered to patients. Under this flexibility, commissioners should adjust the tariff price if, under the terms of a contract, a provider limits the type of patients it treats resulting in lower costs than the average of the tariff category.

925. We recognise that patient or procedure selection may happen on justifiable safety grounds, such as where providers are bound by contract terms which prevent them from treating patients above a certain BMI or with complications or comorbidities or where providers only offer a narrow range of services. Consideration of price adjustments under this flexibility will be limited to where contractually-agreed patient exclusion criteria exist.

926. The Government committed to strengthening the guidance on patient or procedure selection, and in support of this we have undertaken a review of NHS activity undertaken in different settings. This builds on published research undertaken by the University of York.¹⁵⁵ Working with clinicians representing the relevant Colleges, we identified high volume activity that is most likely to be carried out in different settings. The list of HRGs and associated procedure codes is set out in Table 29. It should be noted that this is not an exhaustive list nor is it the case that all of this activity can be regarded as having been 'cherry picked'. This list is intended to provide a starting point for commissioners in reviewing if providers are receiving a fair level of reimbursement for the activity they are carrying out.
927. 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. Commissioners will be required to base any decision to reduce tariffs on clear evidence which shows that the provider would be over reimbursed at the national tariff rate. They must also give consideration to the potential for other providers to be left with an altered, more costly, casemix which may therefore also require a funding adjustment.

¹⁵⁵ Street A, Sivey P, Mason A, Miraldo M, Siciliani L. Are English treatment centres treating less complex patients? *Health Policy* 2010;94(2):150-57

Table 29: High volume activity most likely to be carried out in different sectors and settings

HRG (11/12 payment)	Name	Procedure	Name	Additional comments
AB03Z	Complex Pain Procedures	A521	Therapeutic lumbar epidural injection	
		A522	Therapeutic sacral epidural injection	
		A574	Injection of destructive substance into spinal nerve root	
		A577	Injection of therapeutic substance around spinal nerve root	
AB04Z	Major Pain Procedures	A521	Therapeutic lumbar epidural injection	
		V544	Injection around spinal facet of spine	
CZ01V	Minor Mouth or Throat Procedures 19 years and over with CC	E253	Diagnostic endoscopic examination of nasopharynx NEC	
CZ01Y	Minor Mouth or Throat Procedures 19 years and over without CC	E253	Diagnostic endoscopic examination of nasopharynx NEC	
CZ02X	Intermediate Mouth or Throat Procedures 19 years and over with Intermediate CC	E369	Unspecified diagnostic endoscopic examination of larynx	
		F093	Surgical removal of wisdom tooth NEC	
		F094	Surgical removal of tooth NEC	
		F095	Surgical removal of retained root of tooth	
CZ02Y	Intermediate Mouth or Throat Procedures 19 years and over without CC	E369	Unspecified diagnostic endoscopic examination of larynx	
		F094	Surgical removal of tooth NEC	
		F104	Extraction of multiple teeth NEC	
FZ03A	Diagnostic and intermediate procedures on the upper GI tract 19 years and over	G451	Fibreoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointestinal tract	Maps to FZ61Z or FZ64Z in 13/14
		G459	Unspecified diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract	Maps to FZ60Z or FZ63Z in 13/14
FZ18A	Inguinal Umbilical or Femoral Hernia Repairs 19 years and over with Major CC	T202	Primary repair of inguinal hernia using insert of prosthetic material	
FZ18B	Inguinal Umbilical or Femoral Hernia Repairs 19 years and over with Intermediate CC	T202	Primary repair of inguinal hernia using insert of prosthetic material	
		T242	Repair of umbilical hernia using insert of prosthetic material	
FZ18C	Inguinal Umbilical or Femoral Hernia Repairs 19 years and over without CC	T202	Primary repair of inguinal hernia using insert of prosthetic material	
		T212	Repair of recurrent inguinal hernia using insert of prosthetic material	
FZ23Z	Minor Anal Procedures	H523	Injection of sclerosing substance into haemorrhoid	
		H524	Rubber band ligation of haemorrhoid	
FZ26A	Endoscopic or Intermediate Large Intestine Procedures 19 years and over	H201	Fibreoptic endoscopic snare resection of lesion of colon	Maps to FZ53Z or FZ65Z in 13/14
		H206	Fibreoptic endoscopic resection of lesion of colon NEC	Maps to FZ53Z or FZ65Z in 13/14
		H221	Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion of colon	Maps to FZ52Z or FZ64Z in 13/14
		H229	Unspecified diagnostic endoscopic examination of colon	Maps to FZ51Z or FZ63Z in 13/14
		H231	Endoscopic snare resection of lesion of lower bowel using fibreoptic sigmoidoscope	Maps to FZ56Z or FZ65Z in 13/14
		H251	Diagnostic endoscopic examination of lower bowel and biopsy of lesion of lower bowel using fibreoptic sigmoidoscope	Maps to FZ55Z or FZ64Z in 13/14
		H259	Unspecified diagnostic endoscopic examination of lower bowel using fibreoptic sigmoidoscope	Maps to FZ54Z or FZ63Z in 13/14
GA10D	Laparoscopic Cholecystectomy with length of stay 1 day or more without CC	J183	Total cholecystectomy NEC	
GA10E	Laparoscopic Cholecystectomy with length of stay 0 days without CC	J183	Total cholecystectomy NEC	

HRG (11/12 payment)	Name	Procedure	Name	Additional comments
HB12B	Major Hip Procedures for non Trauma Category 1 with CC	W371	Primary total prosthetic replacement of hip joint using cement	
		W381	Primary total prosthetic replacement of hip joint not using cement	
		W391	Primary total prosthetic replacement of hip joint NEC	
		W941	Primary hybrid prosthetic replacement of hip joint using cemented femoral component	
HB12C	Major Hip Procedures for non Trauma Category 1 without CC	W381	Primary total prosthetic replacement of hip joint not using cement	
		W391	Primary total prosthetic replacement of hip joint NEC	
HB21A	Major Knee Procedures for non Trauma Category 2 with Major CC	W401	Primary total prosthetic replacement of knee joint using cement	
HB21B	Major Knee Procedures for non Trauma Category 2 with CC	W401	Primary total prosthetic replacement of knee joint using cement	
		W421	Primary total prosthetic replacement of knee joint NEC	
		W581	Primary resurfacing arthroplasty of joint	
HB21C	Major Knee Procedures for non Trauma Category 2 without CC	W401	Primary total prosthetic replacement of knee joint using cement	
		W421	Primary total prosthetic replacement of knee joint NEC	
HB22B	Major Knee Procedures for non Trauma Category 1 with CC	W822	Endoscopic resection of semilunar cartilage NEC	
HB22C	Major Knee Procedures for non Trauma Category 1 without CC	W742	Reconstruction of intra-articular ligament NEC	
		W822	Endoscopic resection of semilunar cartilage NEC	
HB23B	Intermediate Knee Procedures for non Trauma with CC	W822	Endoscopic resection of semilunar cartilage NEC	
		W913	Manipulation of prosthetic joint NEC	
HB23C	Intermediate Knee Procedures for non Trauma without CC	W742	Reconstruction of intra-articular ligament NEC	
		W822	Endoscopic resection of semilunar cartilage NEC	
HB24B	Minor Knee Procedures for non Trauma Category 2 with CC	W879	Unspecified diagnostic endoscopic examination of knee joint	
HB24C	Minor Knee Procedures for non Trauma Category 2 without CC	W851	Endoscopic removal of loose body from knee joint	
		W879	Unspecified diagnostic endoscopic examination of knee joint	
HB25E	Minor Knee Procedures for non Trauma Category 1 19 years and over with CC	W903	Injection of therapeutic substance into joint	
HB25F	Minor Knee Procedures for non Trauma Category 1 19 years and over without CC	W903	Injection of therapeutic substance into joint	
HB34D	Minor Foot Procedures for Non - Trauma Category 2 19 years and over with CC	A611	Excision of lesion of peripheral nerve	
HB34E	Minor Foot Procedures for Non - Trauma Category 2 19 years and over without CC	A611	Excision of lesion of peripheral nerve	
		W083	Excision of excrescence of bone	
		W283	Removal of internal fixation from bone NEC	
HB55B	Minor Hand Procedures for non Trauma Category 2 with CC	A651	Carpal tunnel release	
HB55C	Minor Hand Procedures for non Trauma Category 2 without CC	A651	Carpal tunnel release	
HB63Z	Minor Shoulder and Upper Arm Procedures for non Trauma	A671	Cubital tunnel release	
		W781	Release of contracture of shoulder joint	
		W903	Injection of therapeutic substance into joint	
JC14Z	Skin Therapies level 2	S561	Debridement of skin of head or neck NEC	
JC15Z	Skin Therapies level 3	S065	Excision of lesion of skin of head or neck NEC	
		S068	Other specified other excision of lesion of skin	
		S069	Unspecified other excision of lesion of skin	
JC16Z	Skin Therapies level 4	S641	Excision of nail bed	

HRG (11/12 payment)	Name	Procedure	Name	Additional comments
		S642	Chemical destruction of nail bed	
		S682	Excision of wedge of nail	
LB15B	Bladder Minor Procedure 19 years and over with Intermediate CC	M459	Unspecified diagnostic endoscopic examination of bladder	Maps to LB14E in 13/14
LB15C	Bladder Minor Procedure 19 years and over without CC	M451	Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder NEC	Maps to LB14E in 13/14
		M459	Unspecified diagnostic endoscopic examination of bladder	Maps to LB14E in 13/14
		M473	Removal of urethral catheter from bladder	Maps to LB15E in 13/14
MA10Z	Upper Genital Tract Laparoscopic / Endoscopic Minor Procedures	Q181	Diagnostic endoscopic examination of uterus and biopsy of lesion of uterus	
		Q188	Other specified diagnostic endoscopic examination of uterus	
		Q189	Unspecified diagnostic endoscopic examination of uterus	
		Q352	Endoscopic bilateral clipping of fallopian tubes	
QZ10B	Primary Unilateral Varicose Vein Procedures without CC	L841	Combined operations on primary long saphenous vein	
		L882	Radiofrequency ablation of varicose vein of leg	

Section 14: Other operational issues

Market forces factor

928. 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 is 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.
929. MFF applies to any published prices but locally agreed prices will reflect local costs and therefore do not need an explicit MFF adjustment.
930. 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.
931. Organisations merging on 1 April 2013 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 2014. Organisations should notify the PbR team of any planned mergers so that we can calculate and confirm the new MFF value. Organisations should notify the PbR team of any changes to the organisation of community services that may impact on the MFF index.
932. 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 the patient's choice of provider.

Monthly reporting

933. The four key stages in the process for providers submitting national data to the Secondary Uses Service (SUS) are as follows:
- a) inclusion date – means the 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 the date when the PbR activity is available to the commissioner to facilitate reconciliation between provider and commissioner
 - c) post-reconciliation inclusion date – means the 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 the date when the final reconciliation report is available for the month in question.

934. Commissioners should be diligent in checking the completeness of CDS data submitted to SUS by providers, including the NHS number.

935. The timetable for monthly activity reporting and report availability for 2013-14 is set out below.

Table 30: Monthly reporting dates

Month	Inclusion date	First reconciliation point	Post-reconciliation inclusion date	Final reconciliation point
April 2013	17/05/2013	28/05/2013	19/06/2013	27/06/2013
May 2013	19/06/2013	27/06/2013	22/07/2013	30/07/2013
June 2013	22/07/2013	30/07/2013	19/08/2013	28/08/2013
July 2013	19/08/2013	28/08/2013	19/09/2013	27/09/2013
August 2013	19/09/2013	27/09/2013	21/10/2013	29/10/2013
September 2013	21/10/2013	29/10/2013	19/11/2013	27/11/2013
*October 2013	19/11/2013	27/11/2013	20/12/2013	02/01/2014
*November 2013	20/12/2013	02/01/2014	20/01/2014	28/01/2014
*December 2013	20/01/2014	28/01/2014	19/02/2014	27/02/2014
*January 2014	19/02/2014	27/02/2014	13/03/2014	21/03/2014
*February 2014	13/03/2014	21/03/2014	24/04/2014	02/05/2014
*March 2014	24/04/2014	02/05/2014	20/05/2014	29/05/2014

Notes:

- i) Dates in the months marked * are subject to possible change during the processing year.

Non-contract activity

936. The prices for non-contract activity in 2013-14 will be as follows:

- the mandatory national tariff (including any adjustments) and MFF
- where there are no mandatory national tariffs, then locally agreed prices, ie prices agreed by the provider with their coordinating commissioner
- where there are neither mandatory national tariffs nor locally agreed prices, then 2010-11 national average reference costs minus 4.5%¹⁵⁶.

¹⁵⁶ The -4.5% figure represents a combination of the -1.5% adjustment to prices in 2011-12, -1.8% in 2012-13 and -1.3% in 2013-14.

937. A document titled *Who pays? Determining responsibility for payment to providers* has been published¹⁵⁷ which provides information on invoicing arrangements for non-contract activity.

Devolved administrations

938. The NHS Commissioning Board is discussing with the Welsh Government a new *Protocol on cross-border commissioning between England and Wales*, to replace the interim protocol that has been in place in recent years. The protocol will apply to patients who live in Gloucestershire, Herefordshire, Shropshire County and West Cheshire, and Betsi Cadwaladr University, Powys Teaching and Aneurin Bevan Local Health Boards (LHBs).

939. The protocol will require Welsh Local Health Boards to commission activity from English providers as per the PbR rules set out in guidance, eg tariff plus MFF. Where there is no applicable tariff, the protocol will encourage Welsh commissioners to follow, as near as reasonably practicable, the provider's pricing arrangements agreed by their English commissioners.

940. For guidance on establishing the responsible commissioner for cross-border treatment, please refer to Section 3 of the document *Who pays? Determining responsibility for payments to providers*¹⁵⁸.

Emergency treatment

941. This guidance covers the following categories of emergency treatment outside of contracts:

- 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

942. 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 ideally within 30 days of the quarter end

¹⁵⁷ <http://www.commissioningboard.nhs.uk/files/2012/12/who-pays.pdf>

¹⁵⁸ <http://www.commissioningboard.nhs.uk/files/2012/12/who-pays.pdf>

- 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

943. For patients whose responsible commissioner is in the DAs and who are treated by providers in England, the amount to be charged for emergency treatment outside of contracts is set out in Table 31.

Table 31: Charges for emergency treatment outside of contracts

Activity	Price payable
Within scope of mandatory tariff	(Mandatory tariff* + any appropriate adjustment or top-up) * Market Forces Factor (MFF) of the provider *Includes all mandatory best practice tariffs
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	2010-11 average reference cost * -4.5% ¹⁵⁹

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.

¹⁵⁹ The -4.5% figure represents a combination of the -1.5% adjustment to prices in 2011-12, -1.8% in 2012-13 and -1.3% in 2013-14.

944. 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.
945. 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.
946. Commissioners should not use this mechanism and the associated prices in place of contracts where they exist.

Elective (planned) treatment

947. Where cross-border elective admitted patient or outpatient referrals occur outside of 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 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.
948. 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.
949. 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.
950. 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.
951. The arrangements to be adhered to for elective treatment are the same as for emergency treatment as set out at paragraph 942 above, with the exception of the "no pre-treatment agreement needed" bullet point.

952. 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 contracts is the same as for emergency treatment as set out in Table 25 above.
953. 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.
954. 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.

A&E attendances

955. When a patient whose responsible commissioner is in one of the devolved administrations is treated in an English A&E department, this is paid for by the host commissioner in England, and vice versa.

Never events

956. Never events are serious patient safety events that are largely preventable. Commissioners should use the list of never events which are published on the Department's website¹⁶⁰ 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.
957. The NHS standard contract requires that no payment is made for treatment that results in one of the national never events, and/or for treatment to deal with the consequences of a never event.
958. 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

959. NHS organisations are expected to use the NHS number consistently in 2013-14 and commissioners should link the use of the NHS number to contractual payments. 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.

¹⁶⁰ <http://www.dh.gov.uk/health/2012/10/never-events/>

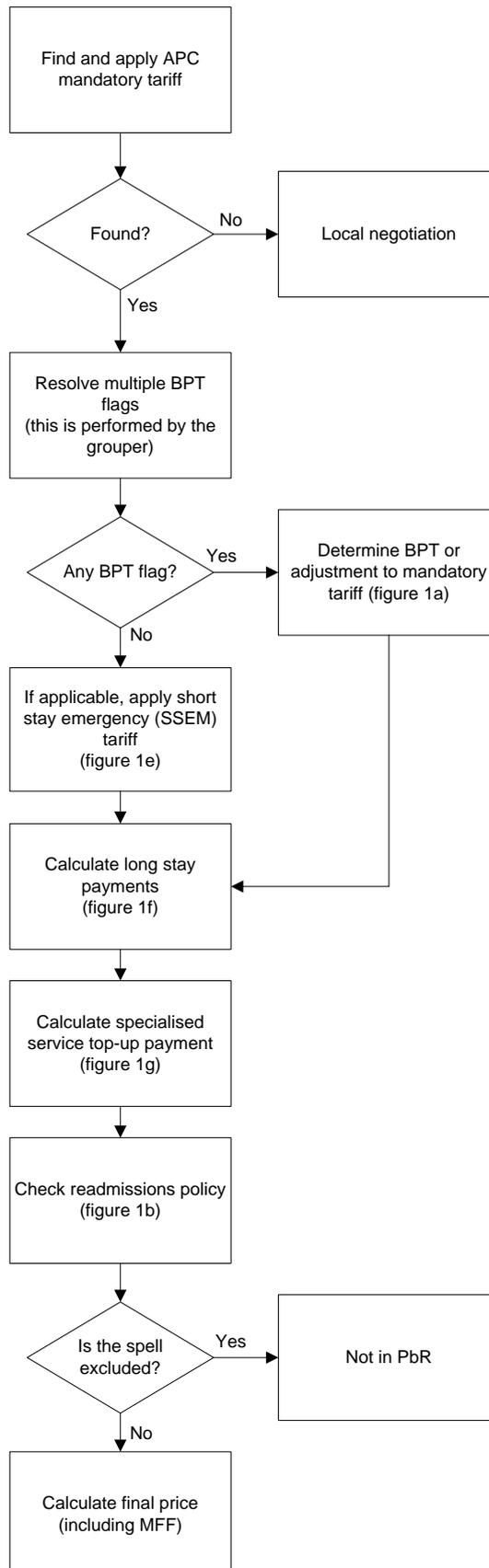
960. For patients who fall into the specific confidentiality rules, SUS PbR is able to calculate an HRG and tariff where appropriate. Where the NHS number is missing from the CDS submission for other reasons, SUS PbR will still attempt to group and apply tariff using other supplied data items. Users may find the “Match Criterion Indicator”¹⁶¹ 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.¹⁶²

¹⁶¹ Available in SUS PbR guidance: <http://www.ic.nhs.uk/sus/pbrguidance>
¹⁶²

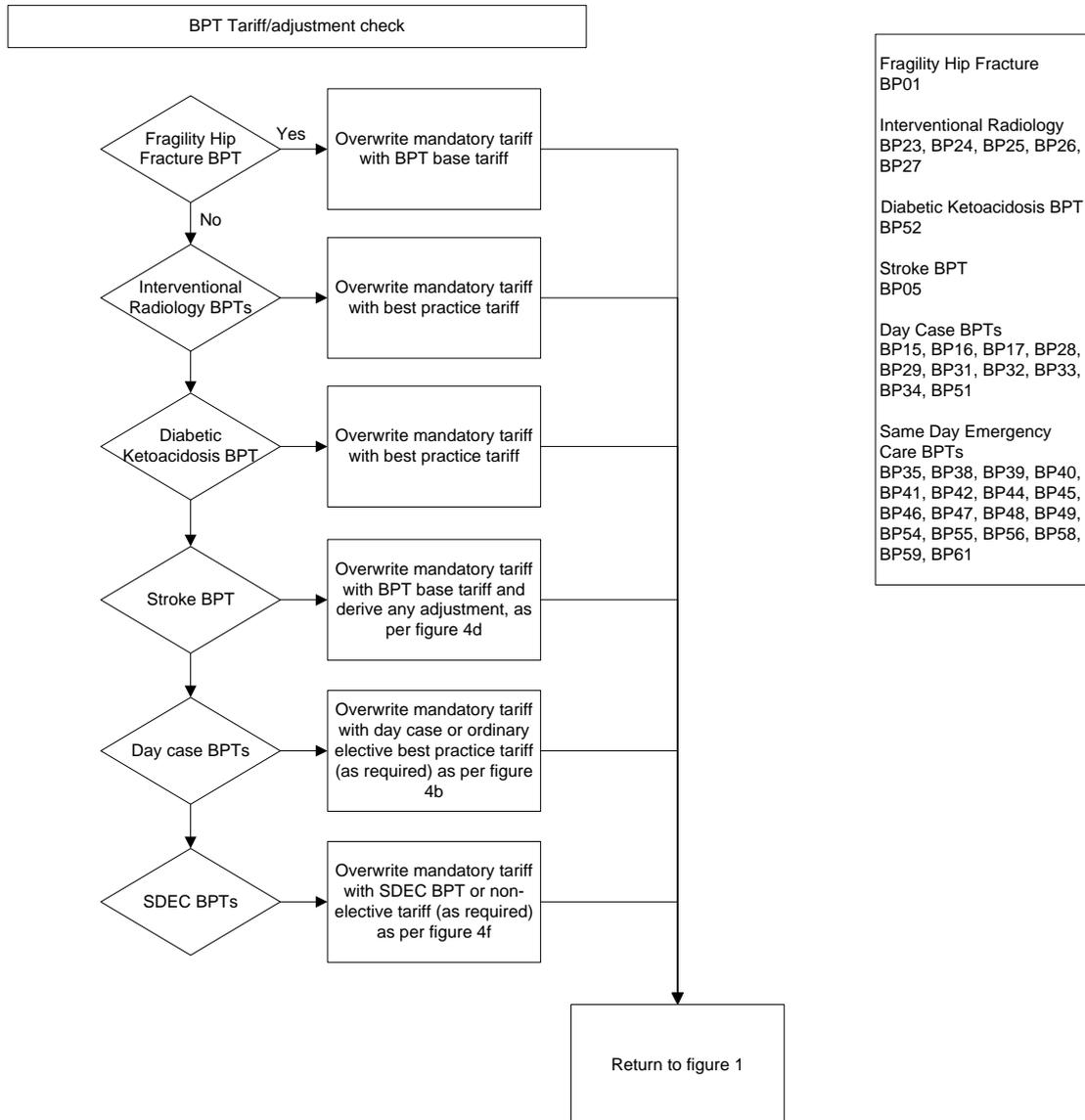
<http://www.connectingforhealth.nhs.uk/systemsandservices/nhsnumber/staff/commissioning>

Annex A Figure 1: Admitted patients

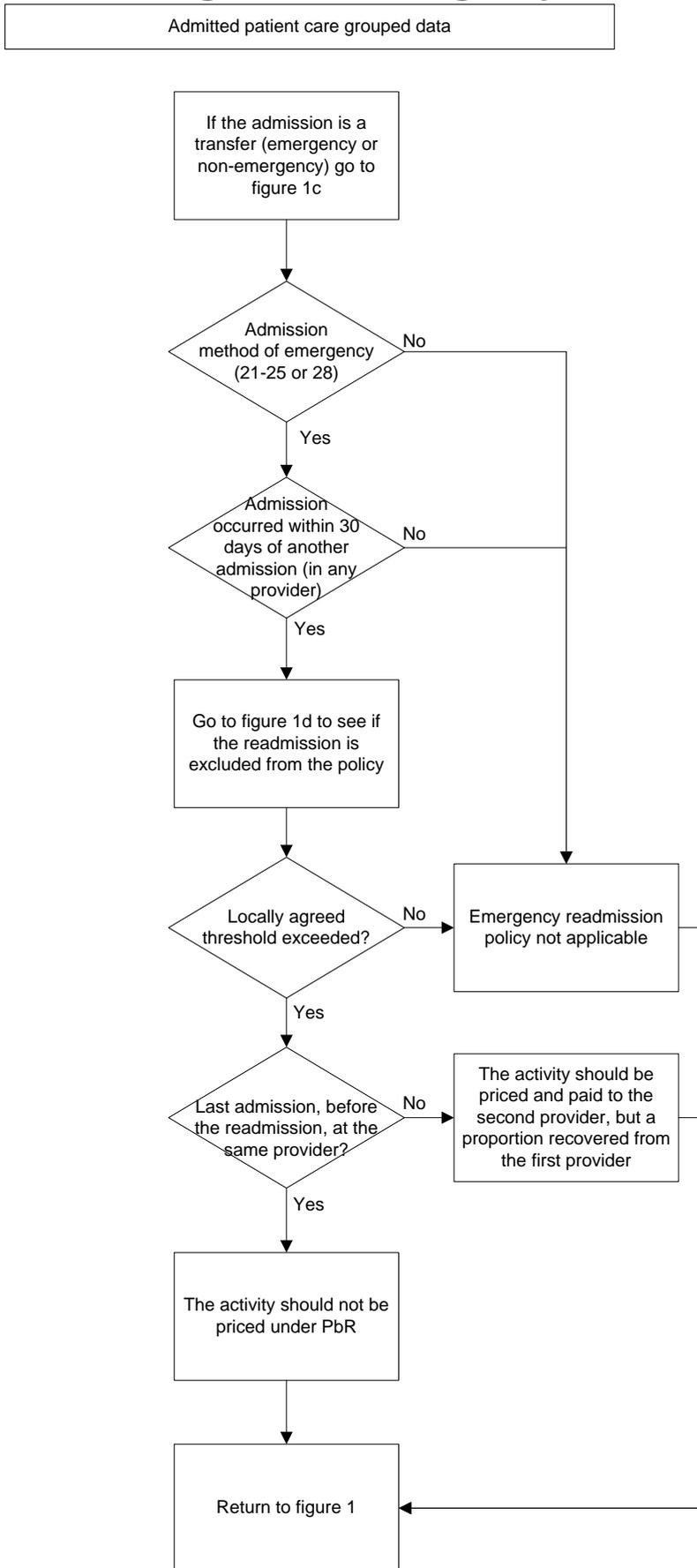
Admitted patient care (APC) grouped data – for each spell



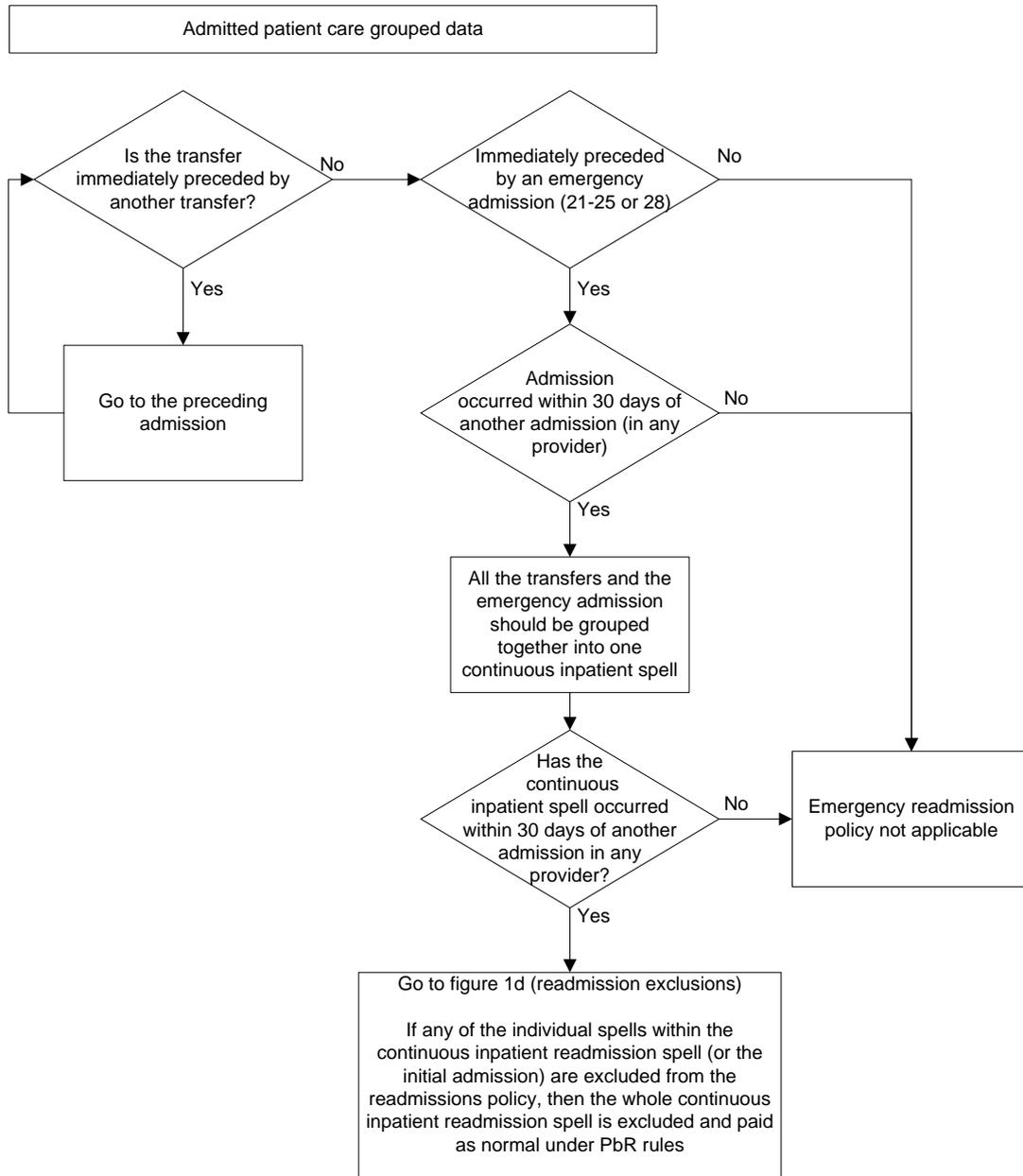
Annex A Figure 1a: Best practice tariffs



Annex A Figure 1b: Emergency readmissions rule

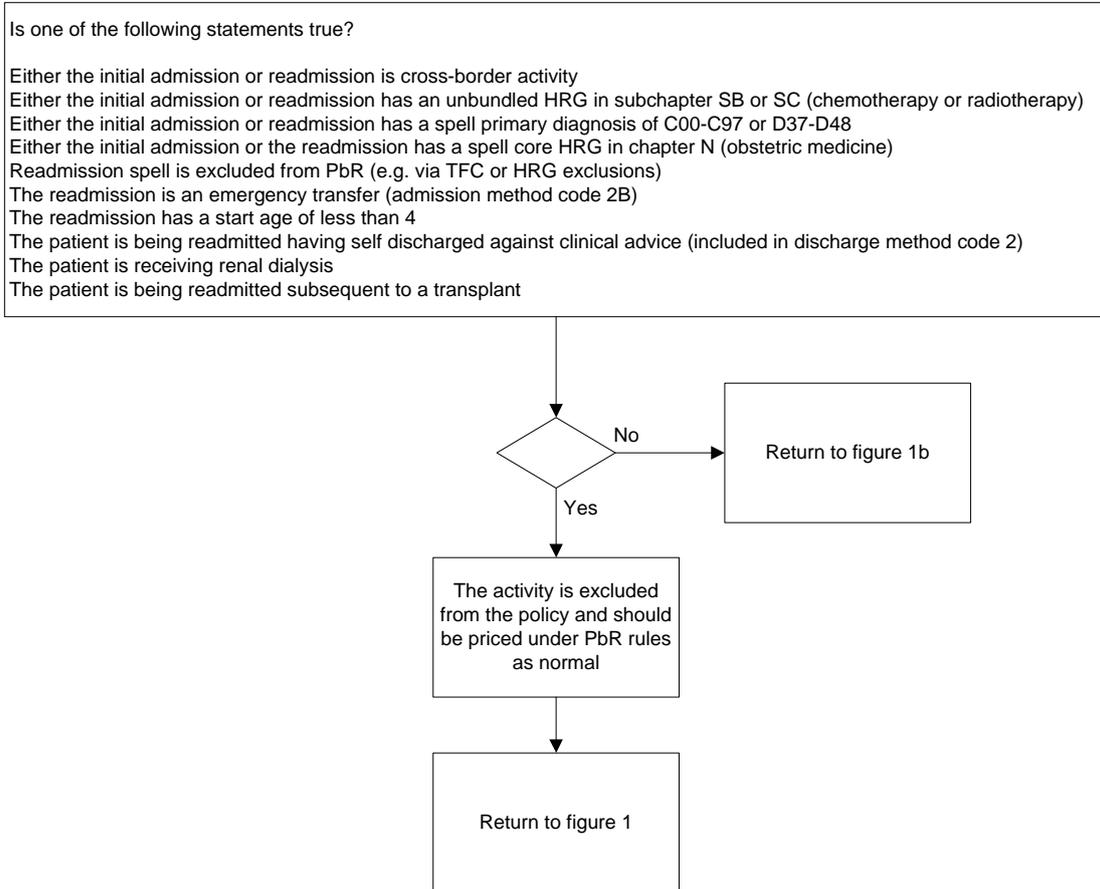


Annex A Figure 1c: Emergency readmissions rule and transfers

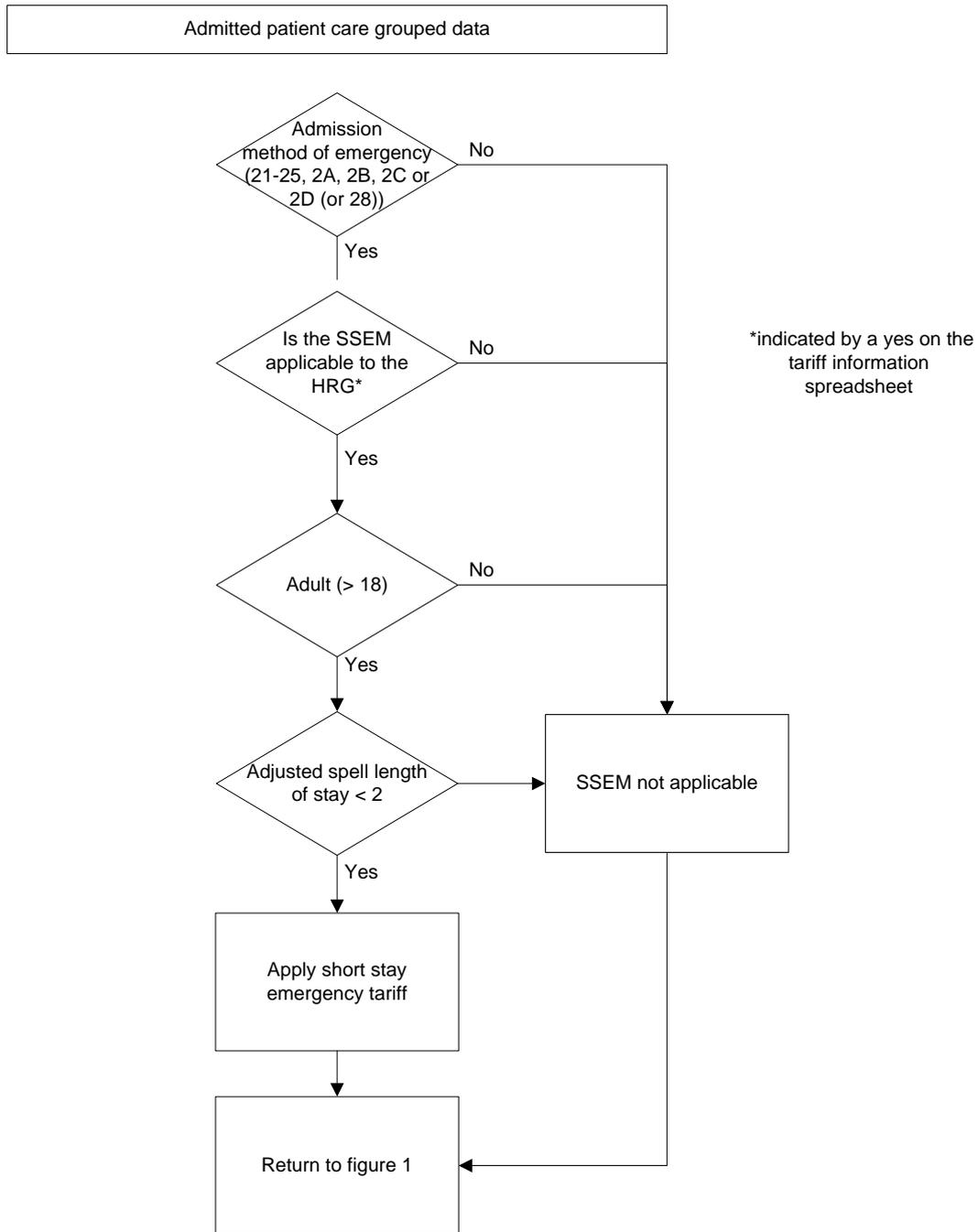


Annex A Figure 1d: Emergency readmissions and exclusions

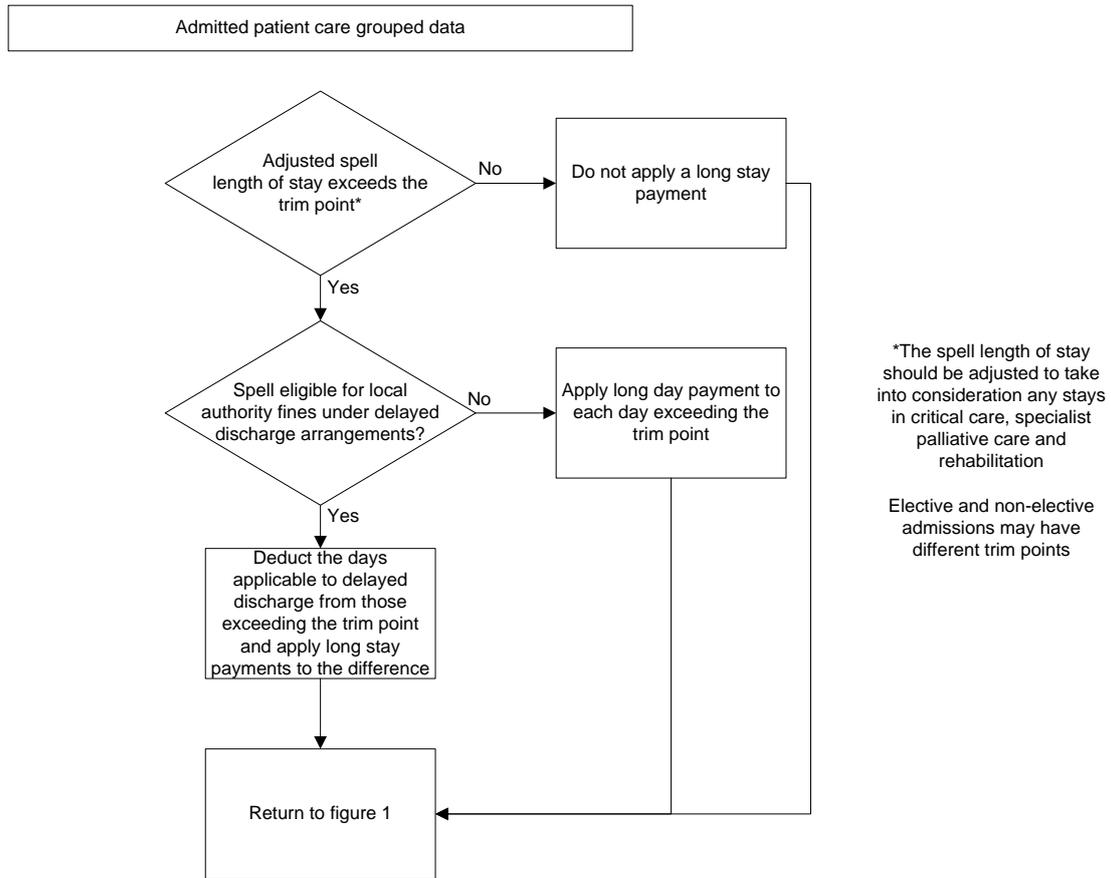
Admitted patient care grouped data



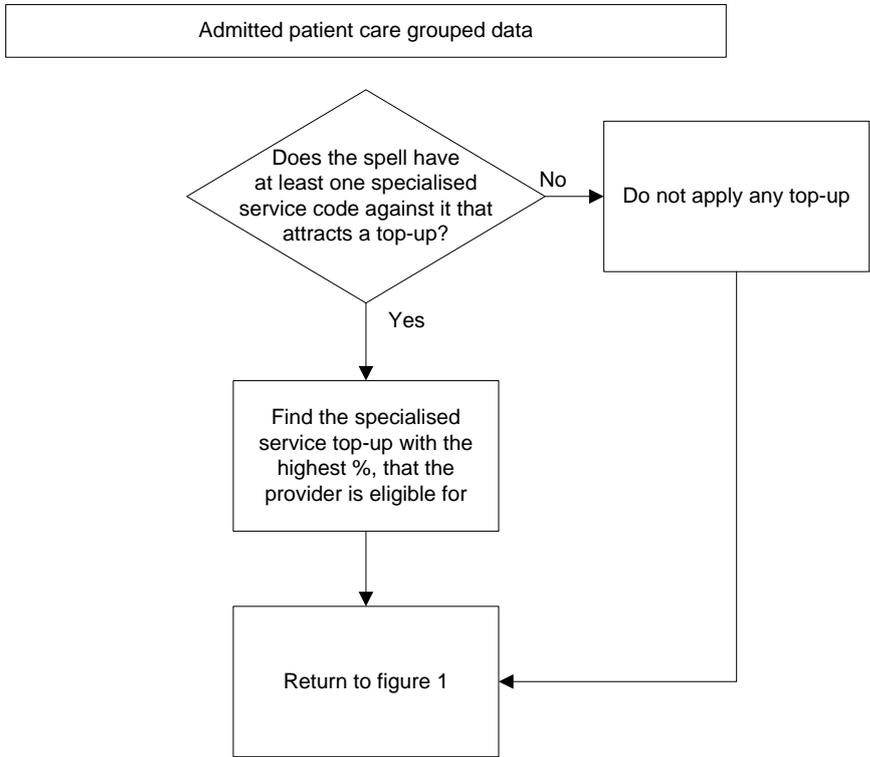
Annex A Figure 1e: Short stay emergency adjustment



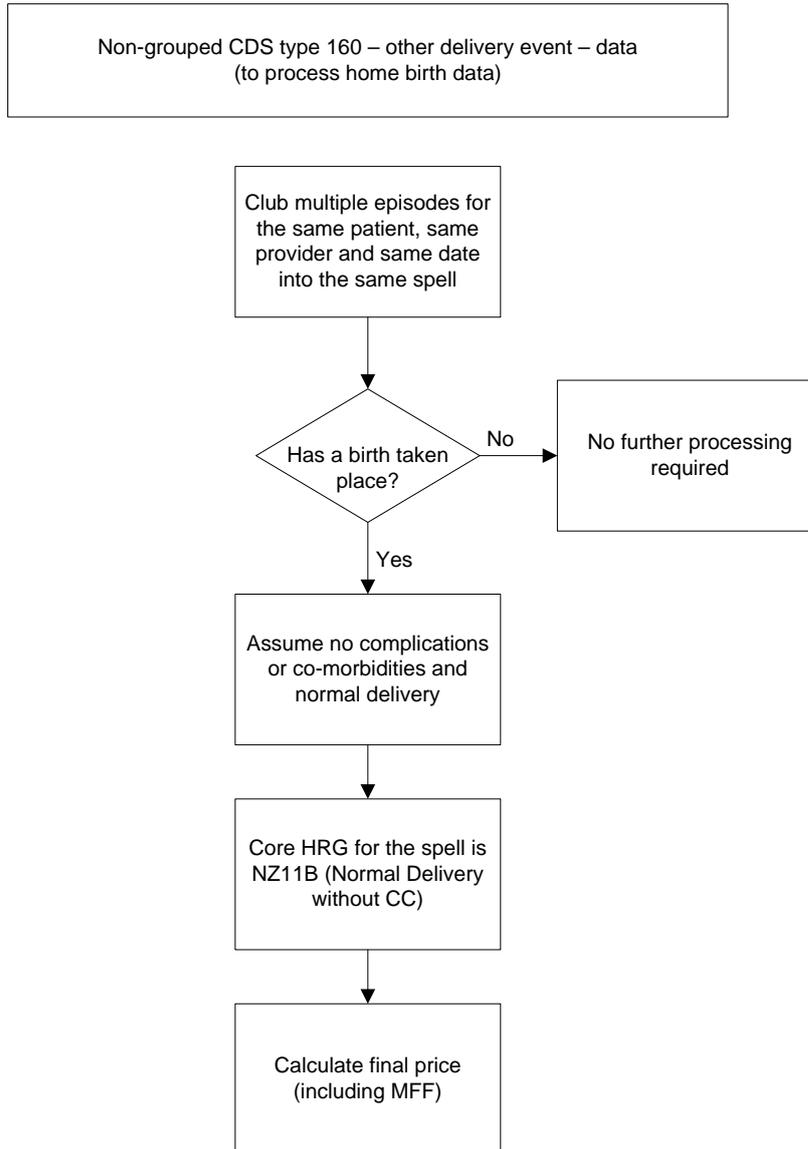
Annex A Figure 1f: Long stay payments



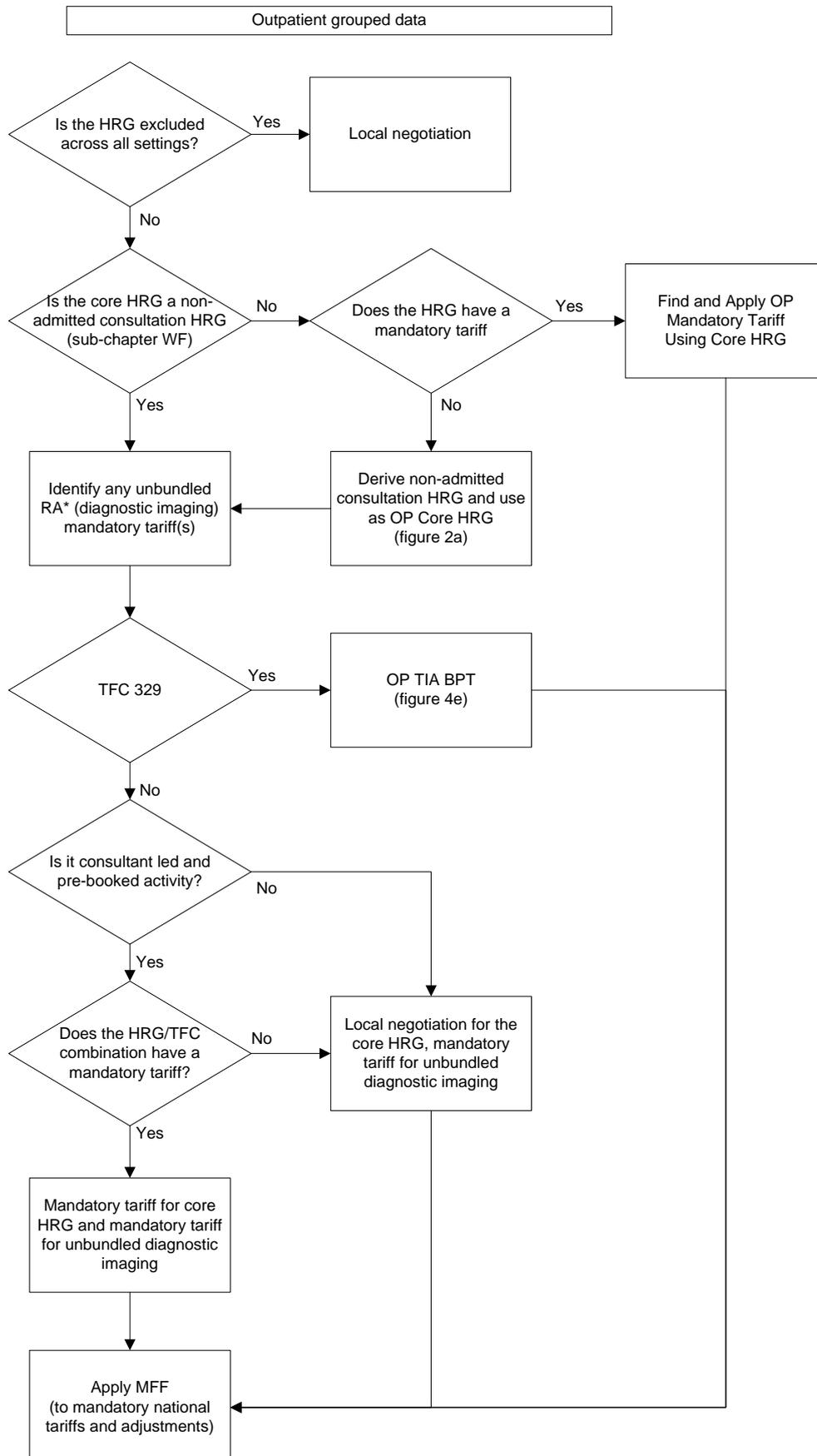
Annex A Figure 1g: Specialised services top-ups



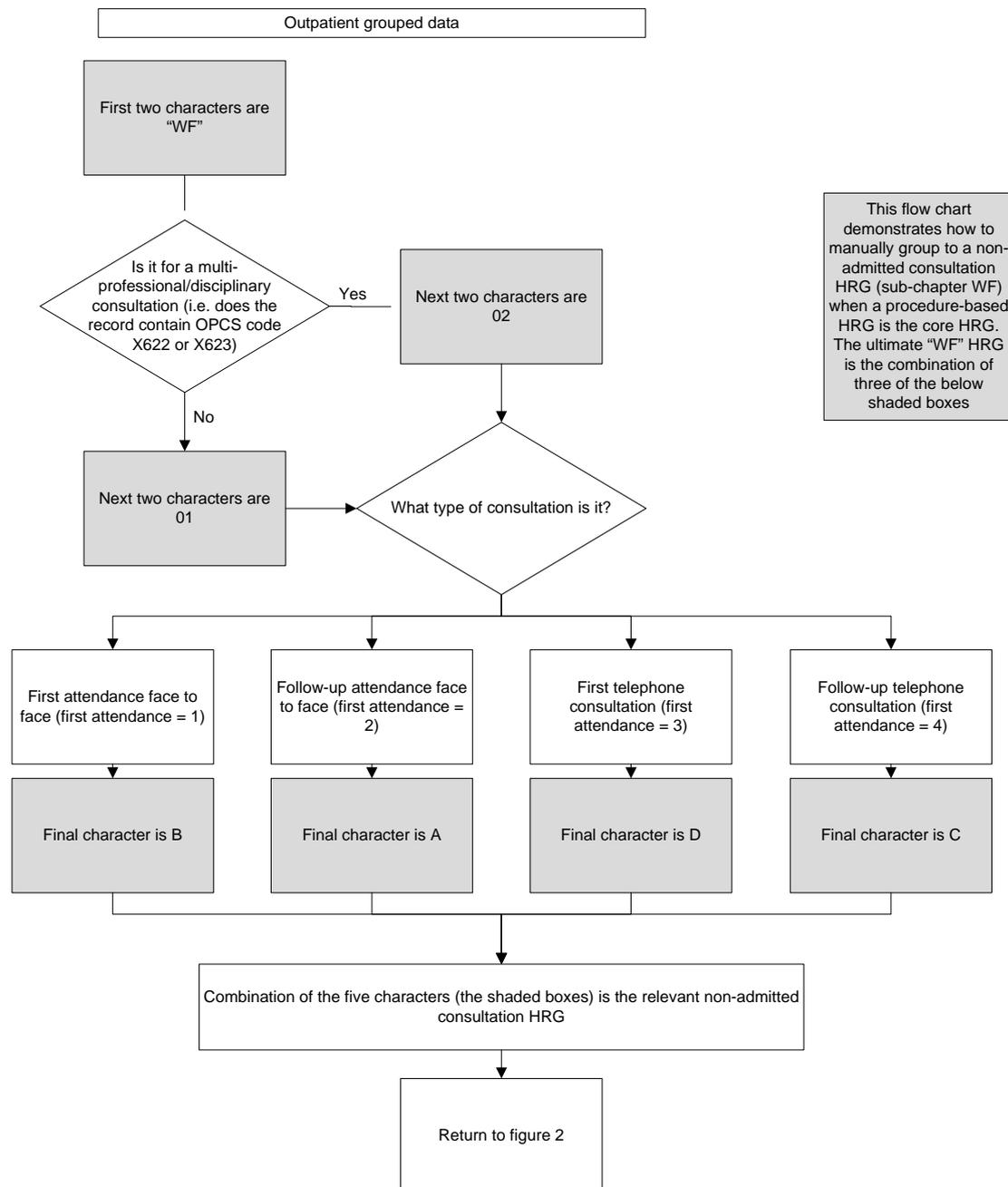
Annex A Figure 1h: Home births



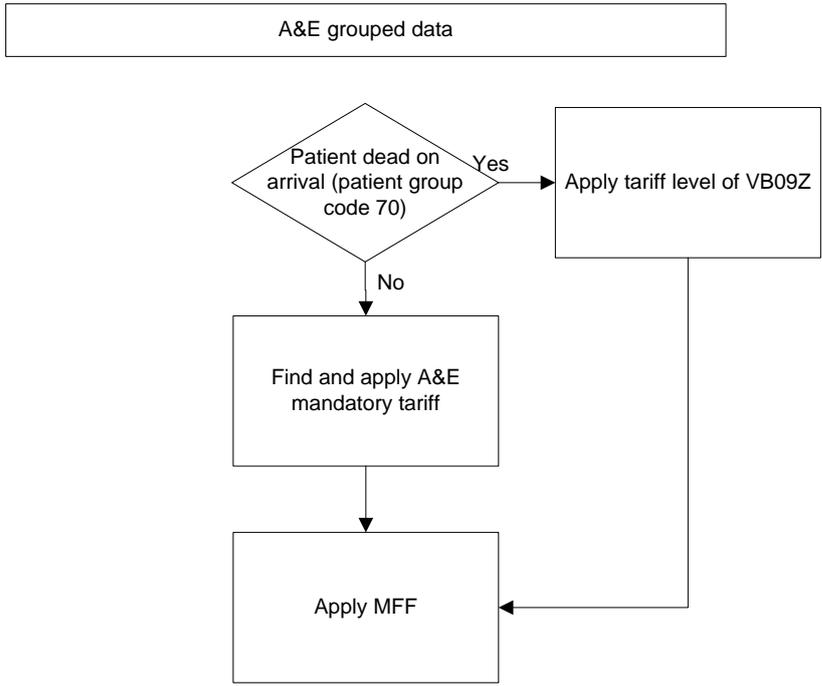
Annex A Figure 2: Outpatients



Annex A Figure 2a: Outpatient attendance HRG

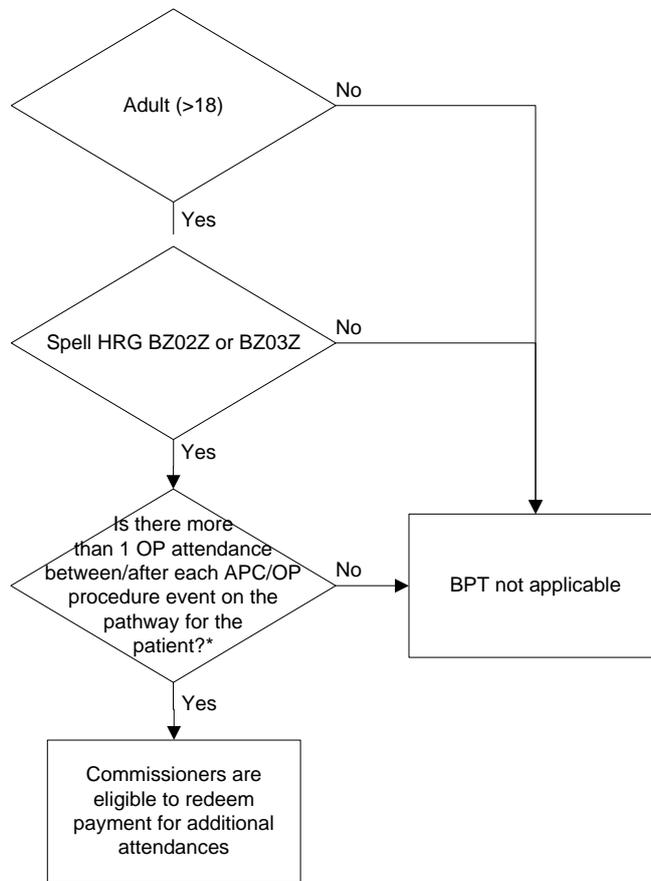


Annex A Figure 3: A&E



Annex A Figure 4a: Cataracts best practice tariff

Admitted patient care grouped data and outpatient grouped data

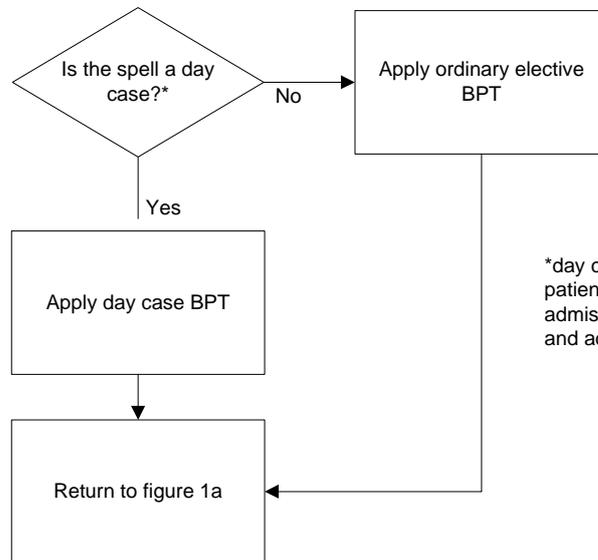


This diagram should be followed after other data adjustments and processing

*SUS uses the referral to treatment Patient Pathway Identifier (PPI)

Annex A Figure 4b: Day case best practice tariffs

Admitted patient care grouped data with a BPT flag of BP15-BP17, BP28-BP34, BP43 or BP51

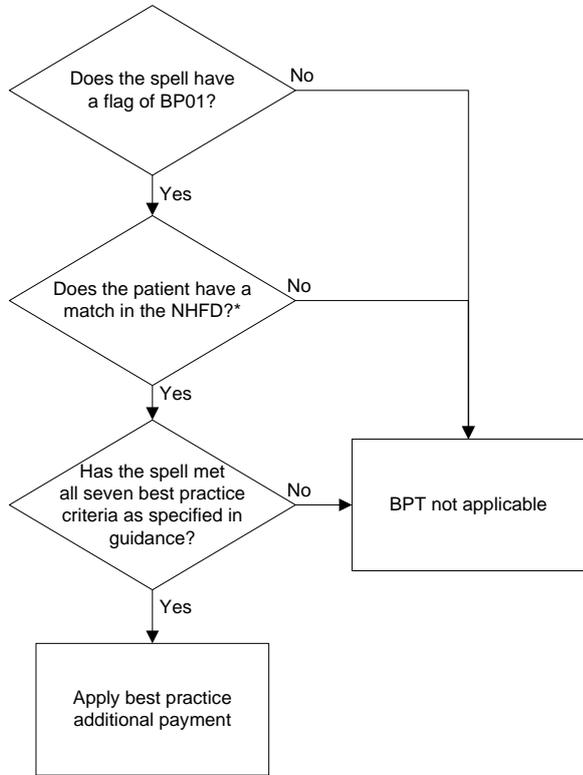


*day case is defined as:
patient classification = 2
admission method = 11,12 or 13
and adjusted spell length of stay is < 1

Annex A Figure 4c: Fragility hip fracture best practice tariff

Quarterly data extract from NHFD and SUS PbR

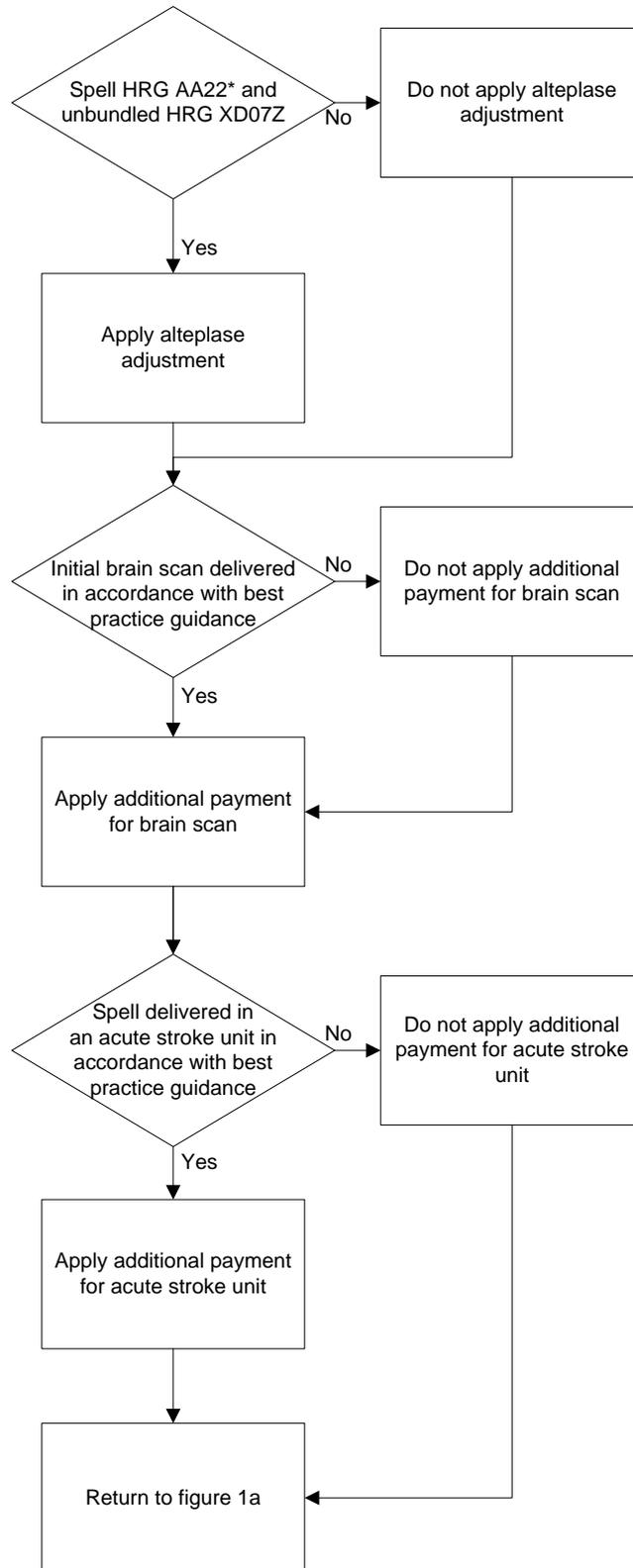
This diagram should be followed after other data adjustments and processing on a quarterly basis when the NHFD report is available



*NHS Number, date of operation and date of admission are available from NHFD for matching, if required

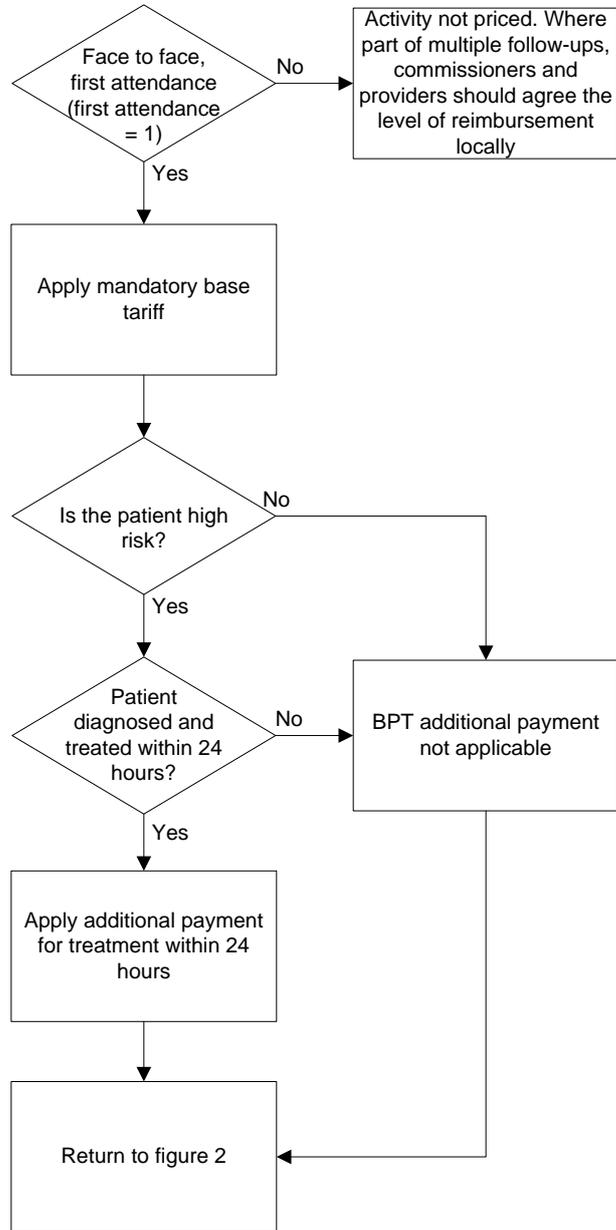
Annex A Figure 4d: Stroke best practice tariff

Admitted patient care grouped data with a BPT flag of BP05



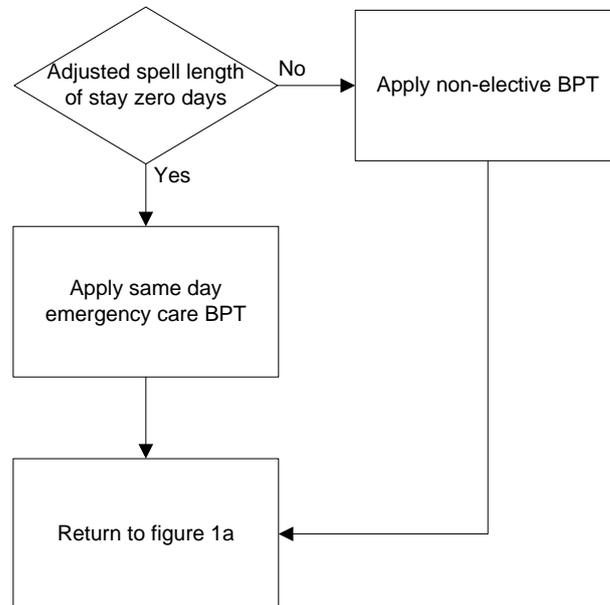
Annex A Figure 4e: TIA best practice tariff

Outpatient grouped data against TFC 329 (TIA service)

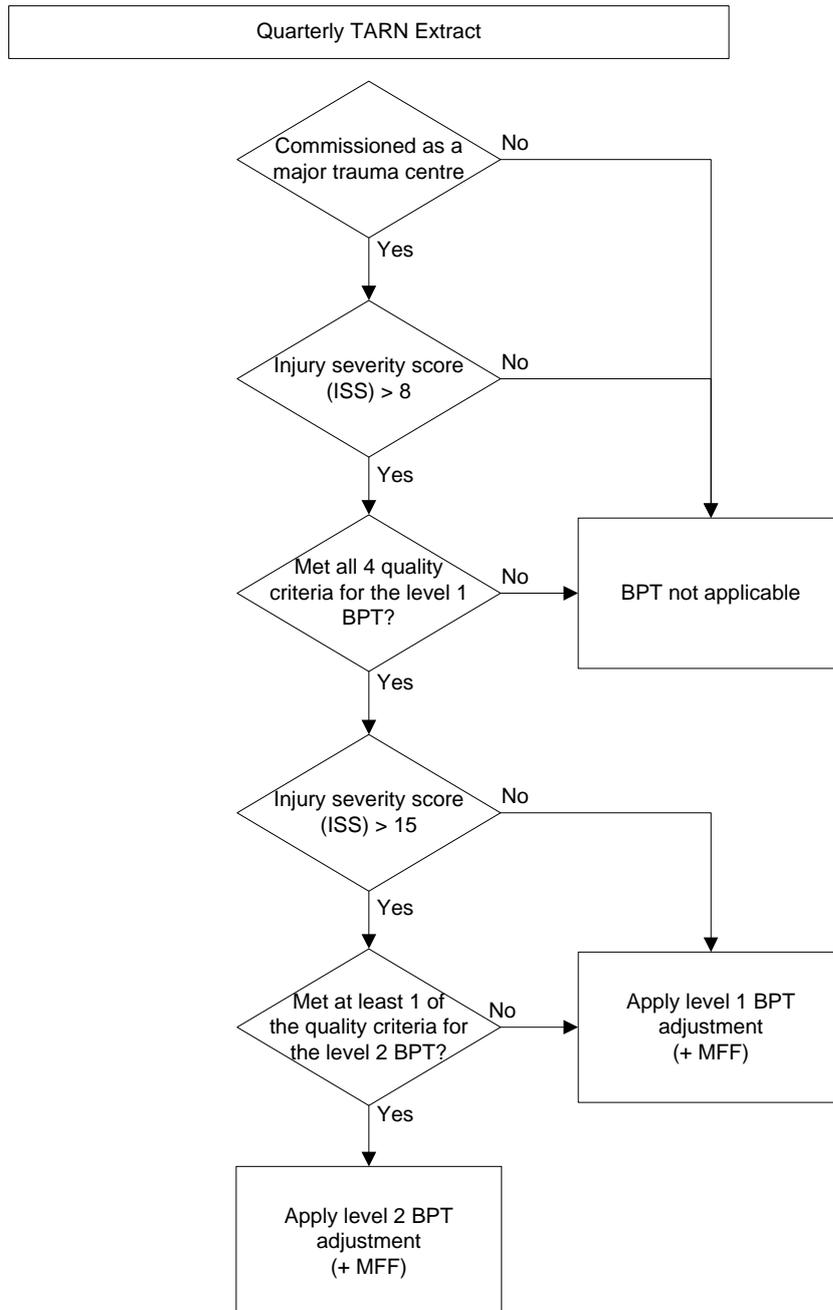


Annex A Figure 4f: Same day emergency care best practice tariffs

Admitted patient care grouped data with a BPT flag of BP35, BP38, BP39, BP40, BP41, BP42, BP44, BP45, BP46, BP47, BP48 or BP49

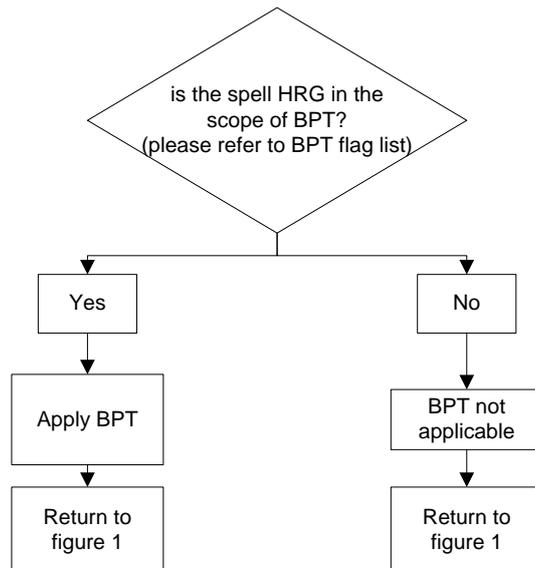


Annex A Figure 4g: Major trauma best practice tariff



Annex A Figure 4h: Interventional radiology best practice tariffs

Admitted patient care grouped data with a BPT flag of BP23-BP27



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-uniliac 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)¹⁶³ 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)¹⁶⁴ 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)¹⁶⁵. As with other procedures, this is on the proviso that patients are appropriately selected.

NICE guidance (Interventional Procedure Guidance 156)¹⁶⁶ 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’¹⁶⁷.

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

¹⁶³ www.nice.org.uk/TA167

¹⁶⁴ <http://www.nice.org.uk/IP20>

¹⁶⁵ <http://guidance.nice.org.uk/IPG127>

¹⁶⁶ <http://guidance.nice.org.uk/IPG156>

¹⁶⁷ 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>

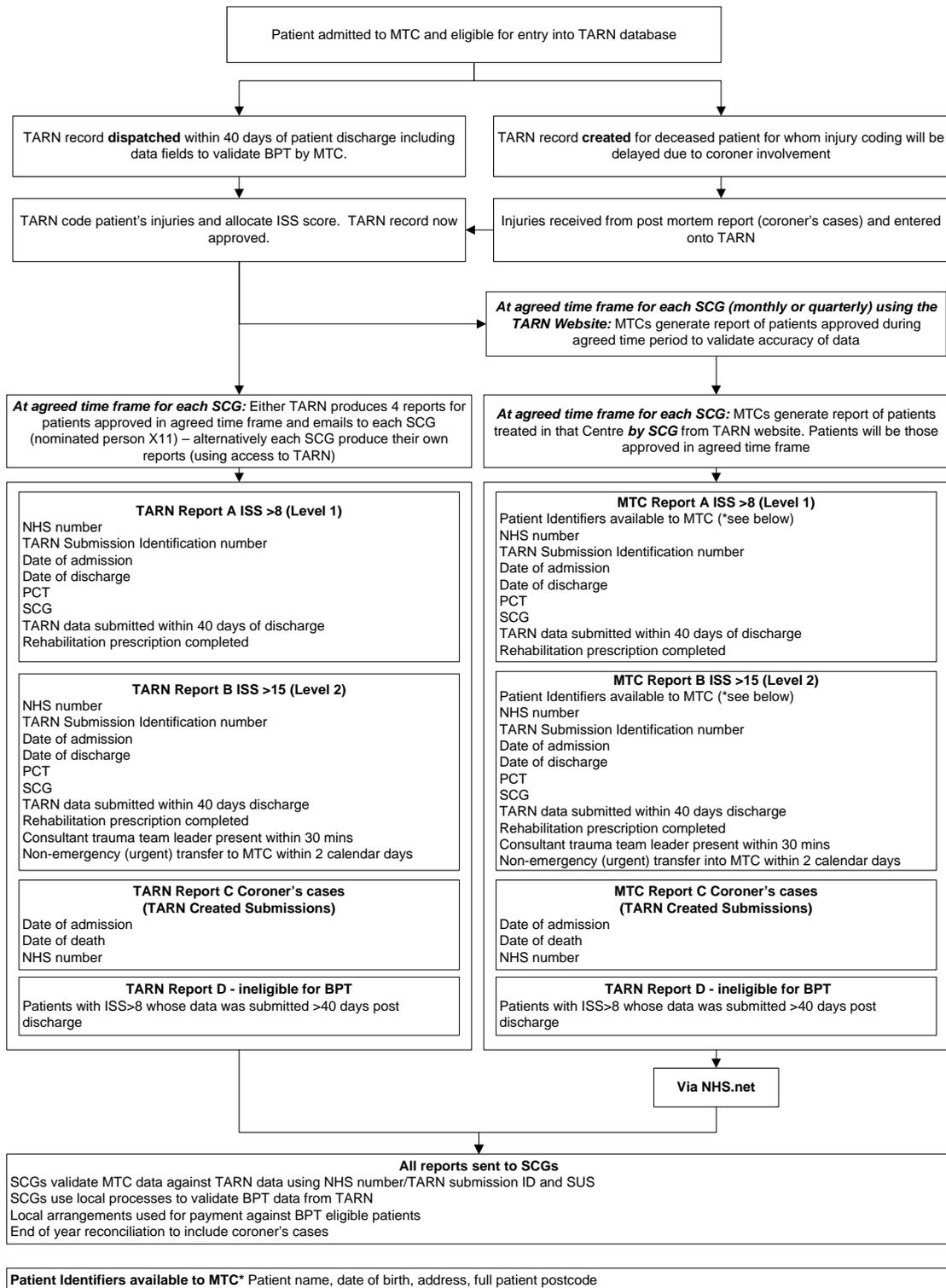
Source of evidence: NHS Institute

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)

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

Annex G: Processing diagnostic imaging data

As referenced in paragraph 54, the Terminology Reference-data Update Service (TRUD) provides a mapping between National Interim Clinical Imaging Procedure (NICIP) codes, and OPCS-4 codes. The Grouper documentation referenced in paragraph 58 sets out how these OPCS-4 codes map to HRGs. Please note when using the “code-to-group” documentation that diagnostic imaging data is subject to “pre-processing”. This means that some of the OPCS-4 codes relating to scans do not appear on the code-to-group sheet, and need to be pre-processed according to the code-to-group documentation. This process will be carried out automatically by the grouper and SUS PbR

The first stage is to map the NICIP codes to OPCS-4 codes, using the mapping held on TRUD. In some systems it may be necessary to map local diagnostic imaging codes to the NICIP codes before mapping to OPCS-4.

National clinical coding guidance both for the OPCS-4 codes and their sequencing must be followed. More than one unbundled HRG for diagnostic imaging will be generated where more than one scan has been carried out, and each unbundled HRG should attract a separate tariff. However, where a patient has a scan of multiple body areas under the same modality, this should be recorded using OPCS-4 codes to indicate the number of body areas, and this will result in one HRG which reflects the number of body areas involved. Therefore, you would not generally expect more than one HRG for a given modality (eg MRI) on the same day.

Where there is no existing link between the radiology system and the PAS, the diagnostic imaging record should be matched to any relevant outpatient attendance activity, using NHS number or other unique identifier and scan request date. It is recognised that a scan will not necessarily be carried out on the same day as an outpatient attendance.

If there is more than one outpatient attendance on the day that the scan was requested, and if local systems do not allow identification of which attendance the scan was requested from, the following steps should be followed:

If the diagnostic imaging occurs on the same day as the outpatient activity, and there is more than one outpatient attendance, the scan should be assumed to be related to the activity that it follows, using time to establish the order of events. If the scan occurs before any outpatient activity on that day, it should be assumed to related to the first outpatient attendance that day.

If the diagnostic imaging occurs on a different day from the outpatient activity, for simplicity the scan can be assumed to be related to the first attendance on the day that the scan was requested.

The diagnostic imaging record should be submitted to SUS PbR as part of the outpatient attendance record, and will generate an unbundled HRG in subchapter RA. SUS PbR will not generate a tariff for this unbundled HRG if

the core HRG is a procedure-driven HRG (ie not from HRG4 sub-chapter WF) with a mandatory tariff, or the appropriate diagnostic imaging tariff otherwise.

If the diagnostic imaging is not related to any other outpatient attendance activity, for example a direct access scan or a scan post discharge, it should be submitted to SUS PbR against a dummy outpatient attendance of TFC 812 Diagnostic Imaging. As outpatient attendances recorded against TFC 812 are zero priced, this will ensure that no tariff is generated for the record apart from that for the diagnostic imaging activity.

If there is a practical reason why it is difficult to submit the diagnostic imaging record as part of an outpatient attendance record, for example because the scan happens after the flex and freeze date for SUS relevant to the outpatient attendance, then pragmatism should be used. For example, the scan could be submitted as for a direct access scan, using a dummy outpatient attendance of TFC 812 Diagnostic Imaging to ensure that no double payment is made for the outpatient attendance tariff.

The table below shows the different scenarios, and how SUS PbR will process the data:

Scenario	SUS PbR Processing
Core HRG in WF (with a mandatory tariff)	Will tariff the core HRG activity
Core HRG in WF (with a mandatory tariff) with one or more unbundled HRGs in RA (with a mandatory tariff)	Will tariff the core HRG activity and the unbundled imaging activity
Core HRG in WF (without a mandatory tariff) with one or more unbundled HRGs in RA (with a mandatory tariff)	Will not tariff the core HRG activity but will tariff the unbundled imaging activity
Core procedure-based HRG (with a mandatory tariff)	Will tariff the core HRG activity
Core procedure-based HRG (with a mandatory tariff) with one or more unbundled HRGs in RA (with a mandatory tariff)	Will tariff the core HRG activity only
Core procedure-based HRG (without a mandatory tariff) with one or more unbundled HRGs in RA (with a mandatory tariff)	Will tariff the equivalent WF core activity (if relevant) and the unbundled imaging activity

Annex H: Health Assessment for Looked after children checklist tool

This should be completed by the health assessor and sent to the **responsible commissioner / designated professional**. The checklist will be reviewed by the **responsible commissioner / designated professional** to support payment against the agreed quality.

For additional guidance on roles, competences of healthcare staff please see: Looked after children, Knowledge, skills and competence of health care staff. Intercollegiate role framework, Published by the Royal College of Nursing and the Royal College of Paediatrics and Child Health - May 2012

http://www.rcpch.ac.uk/system/files/protected/page/RCPCH_RCN_LAC_2012.pdf

Child's Name			
NHS Number			
Date of Health Assessment ¹⁶⁸			
Date of request for Health Assessment			
Assessment completed by:			
Qualification: Nurse, Midwife, Doctor			
Competent to level 3 of the Intercollegiate Competency Framework	Yes	No	Please delete as appropriate
Section 2			
The Summary Report and Recommendations should be typed and include:			
<ul style="list-style-type: none"> • Pre-existing health issues • Any newly identified health issues 			
<ul style="list-style-type: none"> • Recommendations with clear time scales and identified responsible person 			
<ul style="list-style-type: none"> • Evidence that referrals to appropriate services have been made. 			
<ul style="list-style-type: none"> • A chronology or medical history including identified risk factors. 			
<ul style="list-style-type: none"> • An up to date Immunisation summary 			
<ul style="list-style-type: none"> • Summary of Child Health Screening 			
<ul style="list-style-type: none"> • Any outstanding Health Appointments 			
Section 3			
Child or Young Person's Consent for Assessment (where appropriate)			
Where the Young Person is over 16years written consent has been obtained for release of GP summary records, including immunisations and screening to a third party.			
Evidence that the child or young person was offered the opportunity to be seen alone.			
Evidence that child or young person's concerns/comments have been sought and			

¹⁶⁸ This should be within 28 days of the request.

recorded			
Evidence that Carer's concerns/comments have been sought and recorded.			
Evidence that information has been gathered to inform the Assessment from from the placing Social Worker other health professionals providing care eg (CAMHS, Therapies, Hospital services, GP)			
Is the child or young person is registered with a GP in the area			
The child or young person is registered with a Dentist or has access to dental treatment. .			
Date of most recent Dental check or if the subject has refused this intervention			
The child or young person has been seen by an optician Date of most recent eye test or if the subject has refused this intervention.			
Any developmental or learning needs have been assessed and any identified concerns documented			
Emotional, behavioral needs have been assessed and any identified concerns documented			
Lifestyle issues discussed and health promotion information given.			
Recommendations have clear time scales and identified responsible person (s)			
Signed			
Dated:			

Please also see the following guidance

1) Promoting the health and wellbeing of looked after children - revised statutory guidance

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108501

2) Who pays? Determining responsibility for payment to providers

<http://www.commissioningboard.nhs.uk/files/2012/12/who-pays.pdf>