



Code of Conduct for Payment by Results in 2012-13

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1. Introduction - the purpose of the Code of Conduct

- 1.1. The effective implementation of Payment by Results (PbR) will depend on constructive relationships between all parties operating within the system.
- 1.2. PbR has created a degree of transparency in NHS financial flows. The system challenges organisations to manage successfully in a dynamic environment and creates incentives for increasing productivity and making efficient use of resources.
- 1.3. This seventh edition of the Code of Conduct ('the Code') is applicable to all those operating PbR, and is specifically aimed at all commissioners and providers, including those from the independent sector – and other bodies with regulatory and/or performance management responsibilities, but without prejudice to any future Government decision on extending the scope of PbR. Its purpose is to establish the principles that should govern organisational behaviour under PbR and set expectations as to how the system should operate. In this way, the Code of Conduct should minimise as well as guide the resolution of disputes under PbR.
- 1.4. However, the Code must be effective both now and in the context of any future changes to roles and responsibilities in the NHS. Therefore, the Code will be subject to regular review. This edition of the Code has also been reviewed to ensure that it is compatible with, and complementary to, the NHS standard contracts.
- 1.5. PbR should be operated according to the principles laid out in the Code and complying with relevant guidance. Moreover, it is essential for organisations operating under PbR to recognise their ongoing relationships as part of a wider healthcare system. This means taking a dynamic and long-term view that facilitates improvements to quality and service innovation, fitting with other key policy goals.
- 1.6. Under PbR, activity is paid for on the basis of the number and complexity (i.e. casemix) of cases treated. Importantly, the casemix classifications, prices and payment rules are set at national level and are not subject to local negotiation except as specifically defined in PbR guidance. However, PbR does not negate the need for contracts between commissioners and providers, which must continue to specify the range of services commissioned as well as any referral or treatment protocols (i.e. care pathway description) and relevant performance criteria.
- 1.7. The Code is not intended to deal with outstanding policy issues or give detailed guidance although the Department recognises the need for consistency between the Code and the wider policy framework. Furthermore, the Code will rely on effective contractual, regulatory and performance management mechanisms for its enforcement. In cases where this Code appears to be in conflict with agreed contracts, contract

terms will normally take precedence. The Payment by Results team at the Department of Health should be notified where such issues arise.

- 1.8. Mental health services are coming within the scope of the PbR system for the first time in 2012-13. A set of currencies, which are related to the level of need of an adult accessing the majority of mental health services, will be mandatory for commissioning purposes from April 2013. The currencies will initially be paid for using local prices. We recognise that costing the currencies is in many areas at an early stage. We have recommended the use of a Memorandum of Understanding (MOU) and risk sharing agreements between commissioners and providers during this first year. The PbR principles for information sharing, billing and paying should be adhered to as far as possible.

2. The scope and objectives of Payment by Results (PbR)

- 2.1 PbR has been designed to contribute towards the achievement of several of the key objectives of health system reform. These objectives are complementary but at times need careful management to ensure they work together successfully in practice.
- 2.2 The key objectives are summarised as follows:
- 2.2.1 Improve efficiency and value for money through enhanced service quality, as both commissioners and providers can retain and invest surpluses and savings to improve services;
 - 2.2.2 Facilitate choice, by enabling funds to go to the services chosen by patients;
 - 2.2.3 Facilitate plurality and increase contestability, enabling funds to go to any provider (whether NHS or Independent Sector) who can treat patients at tariff and at NHS standards, and enabling providers to compete to provide services on the basis of quality, not price;
 - 2.2.4 Enable service innovation and improve quality and promote equality, by rewarding providers whose services attract patients and focussing negotiations between providers and commissioners on quality and innovation, because the price is fixed;
 - 2.2.5 Drive the introduction of new models of care closer to where people live and work, by enabling funds to go to providers offering care in non-traditional and community based settings;
 - 2.2.6 Reduce waiting times, by rewarding providers for the volume of work done;
 - 2.2.7 Make the system fairer and more transparent, through consistent fixed price payments to providers based on volume and complexity of activity; and
 - 2.2.8 Get the price 'right' for services, by paying a price that ensures value for money for the taxpayer and incentivises the provision of innovative, high quality patient care that is responsive to individual needs.
- 2.3 PbR facilitates other strategic objectives, and as these change over time, so will PbR. The tariff is now seen as an increasingly vital means of supporting quality outcomes for patients and delivering additional efficiency in the NHS.

- 2.4 PbR can and should be implemented in a way that contributes towards achieving its objectives. However, it is important that all parties operating in the system are also clear what the policy is not designed to achieve. This includes increasing the overall amount of cash in the system. The NHS works within fixed spending limits at national and local level. PbR is not a mandate for providers to undertake activity. The impact of PbR locally will therefore be dependent on the technical efficiency of service provision and on the flow of funds under contracts between commissioners and providers.

3 Tariff setting

3.1 The following principles have been followed in the development and setting of the tariff for the 2012-13 financial year:

3.1.1 The Secretary of State is responsible for maintaining the system of Payment by Results – including the tariff setting function – consistent with his/her obligations to provide a national health service in England and other applicable Law.¹

3.1.2 The Department of Health will involve key stakeholders in establishing or reviewing the tariff setting function.

3.1.3 The remit and responsibilities of the governance structure will be set out in published Terms of Reference.

3.1.4 The tariff setting process shall be open and transparent. The Department of Health is committed to publishing a 'Step by step guide to the tariff calculation' each year.

3.1.5 The Department of Health will ensure that exercise of the tariff setting function involves key stakeholders.

3.1.6 In exceptional circumstances and only to the extent necessary in pursuit of his/her obligations to provide a health service in England, the Secretary of State may require particular, in-year changes to the national tariff and will ensure that:

- proposals for such changes take account of input from key stakeholders;
- the process for implementing such changes is open and transparent; and,
- commissioners and providers are given reasonable notice of the details of such changes.

3.2 For the purposes of this Code, 'key stakeholders' shall include a representative group of commissioners and providers as well as those bodies responsible for performance management and regulation, including Monitor and the Care Quality Commission.

¹ As defined under the National Health Service Act 2006

4 General conduct of commissioners, providers and other organisations participating in Payment by Results (PbR)

- 4.1 PbR should support the provision of a service that is:
 - 4.1.1 responsive to the needs of all patients and the public
 - 4.1.2 responsible and accountable to patients and public
 - 4.1.3 high quality, striving for excellence
 - 4.1.4 efficient and effective in its use of resources.
- 4.2 This means that all organisations operating PbR, and individuals working within them, will:
 - 4.2.1 put patients' interests first, balancing the health needs of individuals with those of the wider population served
 - 4.2.2 ensure that patients get appropriate, responsive, high quality care, close to home where possible and when it's needed with pathways designed to meet their needs
 - 4.2.3 ensure that patients have a choice when it is appropriate
 - 4.2.4 provide appropriate, transparent and accessible information for patients, their carers and the wider public
 - 4.2.5 ensure care is provided efficiently with the best possible outcome for the whole population
 - 4.2.6 work together to innovate, developing better services, closer to where people live and work
 - 4.2.7 behave and treat each other transparently, openly and fairly
 - 4.2.8 share information with each other wherever appropriate
 - 4.2.9 ensure that the quality of data underpinning PbR is sufficient for payment purposes, and for further secondary uses
 - 4.2.10 work together to anticipate and resolve problems
 - 4.2.11 consult and involve each other in decisions and changes wherever appropriate.

- 4.3 In implementing PbR in 2012-13, commissioners and providers jointly will also observe the following principles:
 - 4.3.1 PbR is a national, rules-based system maintained by the Secretary of State and defined in Department of Health guidance as amended from time to time
 - 4.3.2 All casemix classifications, prices, payment rules, data definitions, information standards and reporting obligations applicable to PbR are as defined in national guidance, as amended from time to time.
- 4.4 PbR is largely based on average costs, and therefore it is anticipated that providers will generate surpluses and deficits against individual cases arising from the delivery of agreed commissioner contracts. Unless otherwise specified, providers have the autonomy to retain and invest surpluses gained under PbR. They are also free to enter into time limited gain or loss sharing agreements with commissioners where significant service redesign is proposed. Where a provider proposes to cease a service on the grounds of financial viability, exit arrangements are set out in their contracts with commissioners, and for FTs, under their Terms of Authorisation held by Monitor.
- 4.5 The tariff is not calculated with regard to the cost of activities outside the scope of PbR. Equally, any funding for activities outside the scope of PbR should be negotiated regardless of the costs of activity to which the tariff applies. The only exception to this general principle is where funding is agreed to reimburse specific costs that are incurred incidentally in the provision of services under PbR, but are excluded from the tariff, in line with national guidance (eg innovation payments for new technologies).
- 4.6 The national guidance that constitutes PbR is not subject to local negotiation, except for, and only to the extent afforded by, any flexibilities specified in such guidance, including the Operating Framework.
- 4.7 Under the arrangements for unbundling of tariff, providers and commissioners will need to engage with each other in adjusting tariffs, particularly where local plans include commissioners seeking to move part of the care pathway to an alternative setting. Refusal to agree to a local unbundling approach by either commissioner or provider must not be an obstacle to service redesign.
- 4.8 Unbundling agreements should be properly documented, and the supporting information flows established, so that they can be effectively applied.

- 4.9 Good quality information is integral to the effective running of PbR, and that same information underpins the delivery of effective patient care. Ultimate responsibility for the quality of data rests with the organisation producing it. Providers and commissioners should work together to improve data quality by understanding and addressing the issues causing poor quality data, as set out in contracts.

5 Commissioner responsibilities

- 5.1 The following principles shall apply to commissioners for the operation of PbR in 2012-13. PCTs will continue to have legal responsibility for commissioning functions until their planned abolition in April 2013, but will increasingly be delegating commissioning responsibilities to emerging clinical commissioning groups (CCGs) for those services that will in future be CCG responsibilities (subject to the Health and Social Care Bill). The principles set out below therefore encompass the functions undertaken by emerging CCGs on a delegated basis as well as the statutory responsibilities of PCTs.
- 5.1.1 'Commissioning' is the process that determines how the health and healthcare budget is used and must result in better health, better care and better value for patients and taxpayers.
 - 5.1.2 Commissioners will undertake regular health needs assessment and forecast demand for health services and keep these under review, taking account of advice from providers and the accuracy of previous assessments and forecasts. [See also 8.1.3]
 - 5.1.3 Commissioners should support providers to improve the quality of data underpinning PbR, using contract management and their own scrutiny of the data.
 - 5.1.4 Commissioners will collaborate with GP practices to ensure that taxpayers' money is used to best effect on behalf of patients. Commissioners will carry out the analysis to support assessment of local needs and to provide the clinical and management information that will be needed by their GP practices.
 - 5.1.5 Commissioners will look to identify gaps in existing services and pathways that need improvement. Commissioners, working with GP practices and local authorities, will use local intelligence and needs assessments to identify their strategic commissioning priorities. These will include broader requirements for service change or development. Commissioners will signal the future service needs to providers and engage with clinical networks to ensure effective delivery of complex care pathways.
 - 5.1.6 Commissioners will secure contracts with providers for the provision of health services – including elective and unscheduled care – in line with their health needs assessment and demand forecasts having regard to patient preferences and patient choice.
 - 5.1.7 PCTs will remain responsible for the actions of GP practices and other primary care professionals in referring patients to providers and for services under PbR.

- 5.1.8 Commissioners will specify care pathways – including referral and treatment protocols – in line with patient preferences and on the basis of available evidence as to clinical and cost effectiveness. Such specification changes may require explicit agreement on unbundling of services.
- 5.1.9 Commissioners will adhere to, and ensure that their agents adhere to, any specified care pathways in line with the principle set out above.
- 5.1.10 In line with clause 41.18 of the NHS standard contract for 2012-13², commissioners should consult with providers and observe appropriate notice periods before revising criteria for their population to enable providers to fulfil their obligations to implement prior approval arrangements.
- 5.1.11 Under PbR, for activity within the scope of mandatory tariff, commissioners will pay at tariff plus the relevant market forces factor³ for all activity that is delivered on behalf of their populations. This should be in line with their statutory obligations and with their agreed contracts and any contractual conditions which enable them to withhold payments, either temporarily or permanently, in specific circumstances. Where Specialised Commissioning Groups (SCGs) or successor body or bodies commission services, they shall be bound by the same responsibilities as PCTs in terms of payment.
- 5.1.12 Anyone participating in the commissioning process who is a provider of services – or has a financial or other interest in a provider organisation - will act transparently to enable the commissioner to manage any conflict of interests.
- 5.1.13 In the event of disputes relating to who pays for a patient's care commissioners and providers should refer to guidance "*Who pays? Establishing the responsible commissioner*"⁴

² Available at: <http://www.dh.gov.uk/health/2012/01/standard-contract-bilateral/>

³ Please see the 2012-13 MFF Payment Index Values on the PbR pages on the DH website.

⁴ Who pays? guidance is available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466

6 Provider responsibilities

- 6.1 The following principles shall apply to providers for the operation of PbR in 2012-13:
- 6.1.1 Providers will remain responsible for developing and maintaining services and for the performance of those services.
 - 6.1.2 Providers will enter into contracts with commissioners to provide services to patients as a condition of claiming payment under PbR. The exception to this general principle is for Non-Contract Activity as defined under national guidance as it applies to unscheduled care.
 - 6.1.3 In consideration of the prices paid for services under PbR, providers will deliver high quality care in line with good clinical practice and any specific performance requirements enshrined in their contracts with commissioners.
 - 6.1.4 Under PbR, for activity within the scope of mandatory tariff, providers will charge at tariff plus any relevant adjustments, plus the relevant market forces factor⁵ and any excluded items, for all activity that is delivered.
 - 6.1.5 Providers will specify any clinical criteria that they intend to apply systematically and in order to decline to treat particular groups of patients, either in their Directory of Services⁶ where appropriate, or in contracts with commissioners. These criteria will be used to ensure the clinical appropriateness of referrals and treatments and will be set in the interests of the patient rather than to maximise income. Furthermore, providers should not make unilateral changes to such criteria without having agreed the corresponding changes to contracts with commissioners.
 - 6.1.6 Providers will adhere to, and ensure their agents adhere to, any specified care pathways in line with their contractual obligations and consistent with commissioners' responsibilities set out above.
 - 6.1.7 In support of the commissioners' responsibilities regarding health needs assessment and demand forecasting, providers will supply information about demand and activity, including demand for unscheduled care, in line with their contracts.

⁵ Please see the 2012-13 MFF Payment Index Values on the PbR pages on the DH website.

⁶ A provider's Directory of Services must therefore include any Service Specific Booking Guidance to be used to determine the eligibility of patients for services

- 6.1.8 Providers will be responsible for the timeliness and accuracy of data required as part of the transaction process under PbR and in support of commissioners' responsibilities in reviewing health needs assessment and demand forecasts. As such, providers should ensure that data is sufficiently accurate for its intended purposes, utilising internal and external reviews to highlight areas for improvement, ensuring staff with responsibilities for coding and recording activity use processes in line with the latest national guidance, and that there is senior level accountability for data quality within the organisation.
- 6.1.9 Providers will not discriminate against or disadvantage particular patients or commissioners when operating PbR, including when accepting or declining to treat individual patients and in the provision of services generally.
- 6.1.10 Providers are expected to treat patients in the most appropriate and efficient setting taking into account clinical need.
- 6.1.11 Participants who are both commissioners and providers of services will act transparently to avoid conflict of interests.

7 Information sharing

- 7.1 The following principles shall apply to all parties within the system for the operation of PbR in 2012-13:
- 7.1.1 Commissioners will give patients the support and information they need to make the right healthcare choices and providers will support commissioners in this by maintaining an up-to-date Directory of Services. Information needs to be accessible to all groups and communities in the local population.
 - 7.1.2 The Department of Health and commissioners will make available to all providers, including Independent Sector providers, the same information about forecast demand, capacity and performance requirements, proposed service changes/developments, and other procurements to ensure equity of access across the system.
 - 7.1.3 Providers will make available to commissioners information about capacity and quality, in accordance with their contracts.
 - 7.1.4 Providers may implement changes to clinical coding and counting practice in pursuit of improvements in data quality and the accuracy of transactions under PbR.
 - 7.1.5 Any changes to coding and counting practices, other than those contained in the annual PbR guidance or NHS Classifications Service (NCS) guidance, will be subject to standard notice periods as set out in the NHS standard contracts. Providers will notify commissioners of the details of any proposed changes to coding and counting practices in advance and agree the date from which such changes are to be implemented. If agreement cannot be reached, the default position will be that the standard notice period as set out in the NHS standard contracts shall apply.
 - 7.1.6 Where an agreed change to clinical coding will result in a 'material' financial difference ('materiality' to be proportionate to the provider's overall contract income), the change should be introduced to a mutually agreed timetable, with best practice being to implement changes at the beginning of a new financial year. The financial impact of any change may be subject to transition over a period of up to three years, with the arrangements for any such transition subject to local agreement.
 - 7.1.7 Any changes to counting and coding practices shall be demonstrably in line with best practice.
 - 7.1.8 Where national guidance does not address local issues around the counting or recording of activity, the provider and commissioner should ensure they agree methods of data capture and reporting that not only support service provision and ensure

accuracy of the data, but also do not lead to inappropriate financial gain for either organisation.

- 7.1.9 The Department of Health will keep under review the risk of activity inflation (such as volume or casemix) associated with improved coding and counting.
- 7.1.10 Commissioners should furnish providers with patient data and any relevant costing data in order to facilitate unbundling.
- 7.1.11 Commissioners and providers should co-operate in support of the Data Assurance Framework, particularly the external audits of clinical coding and other data being undertaken by the Audit Commission or successor bodies. Providers will need to allow access to records to allow external clinical coding and data audits to be undertaken.

8 Activity specification, care and resource utilisation and capacity

8.1 The following principles shall apply to commissioners and providers for the operation of PbR in 2012-13:

8.1.1 Ensuring clinical and cost effectiveness (care and resource utilisation) is a joint responsibility between commissioners and providers. Decisions on the use of healthcare resource should be made in the best interests of patients, the public, and not the financial interests of individual organisations.

8.1.2 Managing the demand for secondary care services is a shared responsibility between PCTs and providers. It is the responsibility of PCTs to manage the volumes and flows of new referrals made to providers and the case mix of those referrals and external demand for the services. This will require co-operation across the system but commissioners carry the financial risk of failure to get it right. Providers should co-operate with commissioners in this and will take steps to mitigate the risk of providers conducting activity exceeding that agreed in the Activity Plan⁷, including:

- periodically reviewing admission/intervention thresholds, length of stay and consultant-to-consultant referrals; and,
- by participating in periodic utilisation reviews and prior approval schemes, or other initiatives deemed appropriate by commissioners.

8.1.3 Providers are responsible for managing their capacity, for honouring patient appointments and for their obligations in meeting demand for unscheduled care. Commissioners should co-operate with providers in this and will be responsible for the accuracy of their activity forecasts and keep these under regular review to mitigate the risk of 'under-commissioning'. In addition, PCTs will be responsible for the actions of their agents both in referring patients to hospital and in providing unscheduled or 'out of hours' care as these affect the accuracy of activity demand forecasts and therefore capacity management and risk across the system.

8.1.4 Under PbR, anticipated activity volumes for elective care are important management tools, but will not determine payment. The use of rigid 'caps and floors' on activity is inconsistent with the

⁷ Supplier-induced demand may include any lowering of admission or treatment thresholds and/or non-compliance with referral and treatment protocols

fundamental principle of PbR that payment should be based on the number and complexity of cases treated. That is not to say that the NHS standard contracts should not be followed in the event of unplanned fluctuations in activity.

- 8.1.5 The expectation is that practices and PCTs will establish strategies for care and resource utilisation to ensure that patients receive the most appropriate care in the right setting, ensuring that healthcare resource is maximised.
- 8.1.6 It is good practice for commissioners and providers to specify trigger points in the monitoring of planned activity as part of an overall strategy for managing demand and capacity. The NHS standard contract sets out the steps providers and commissioners should take to identify the causes of activity levels which exceed agreed thresholds and requires them, where necessary, to agree appropriate actions. Such action may include changes, on the basis of clinical need, to referral and treatment protocols to ensure that limited resources are targeted effectively. These actions should not discriminate against individual providers.
- 8.1.7 Where additional elective activity is driven by an increase in demand, commissioners should revise their forecasts and demand management strategies accordingly. The provider must be paid in full for the additional activity. Where the additional activity is driven by provider actions rather than any increase in demand (ie supplier-induced) a remedial action plan must be agreed to return to the agreed levels of activity. If the agreed actions are breached the commissioner will be entitled not to pay for the resulting excess activity.
- 8.2 Specific rules will apply with regard to reimbursement for emergency admissions and readmissions. Full details are set out in the 2012-13 PbR guidance. Providers will however remain responsible for treating emergency patients according to their clinical need regardless of the funding arrangement.
- 8.3 While these principles will continue to apply as PbR is expanded to cover other services, it is important to bear in mind that appropriate casemix classifications may not always be based on individual patient attendances, procedures or hospital admissions, for example, the new mental health currencies.

9 Patient choice, referrals and treatment thresholds

- 9.1 Under Payment by Results patient choices for elective care, and where patients are treated in emergencies, will determine how around one-third⁸ of NHS funds are spent.
- 9.2 The following principles shall apply to all parties within the system:
- 9.2.1 Providers may offer a restricted range of services to patients only to the extent this is consistent with their contracts with commissioners and based on the provider's Directory of Services on the date the contract was agreed or subsequently amended. For NHS foundation trusts any restrictions on the range of services offered to patients must also be consistent with their Terms of Authorisation.
 - 9.2.2 For services provided under Patient Choice, once a patient appointment has been booked this must be honoured and appropriate treatment subsequently provided. Furthermore, patients choosing a particular provider must be treated by that provider as long as this is clinically appropriate as well as being in the patient's interest, unless the patient chooses another provider. The responsible commissioners should pay – in line with contracts where applicable – whether the service is covered by the tariff or not.
 - 9.2.3 Finally, providers will work with commissioners to monitor treatment thresholds and ensure patients are treated appropriately. It would not be appropriate for patient pathways to be adversely affected or disrupted inappropriately.

⁸ 2010-11 figures

10 Innovation to improve access to, or quality of, services

10.1 The following principles shall apply to all parties operating within the system in 2012-13:

10.1.1 Commissioners and providers will collaborate to innovate in services and care pathways.

10.1.2 The tariff is a fixed price and should not be subject to local negotiation. However, certain 'local flexibilities' may be provided for under PbR guidance and some of these can be used to support technical innovation and/or improved access to services in the interest of NHS patients.

10.1.3 As a point of principle, local flexibilities under PbR must be applied as defined in national guidance as amended from time to time.

10.1.4 Moreover, such arrangements should only occur if the flexibility:

- supports the provision of care that is better for the patient and the NHS;
- supports material service redesign and is not simply a change to national price;
- is the product of local agreement;
- is clearly established and documented;
- is time limited and reviewed as appropriate.

10.1.5 Where the service to be provided does not take place on the secondary care provider's premises, but is the same as an existing hospital service, and is within the scope of PbR, payment should be at tariff rate.

10.1.6 For a service to be the same as a hospital based service it would need to satisfy the relevant HRG and/or OPCS definitions and it should not be capable of being delivered through any contractual option to provide GP services including GMS, PMS or APMS. Commissioners will need to ensure that payment at tariff, which is based on full absorption rate costing, does not lead to double payment where the provider organisation is already in receipt of NHS funding for some elements of their expenses.

10.1.7 Where the service takes place at home, or differs from that being offered in hospital, then the activity should be subject to local pricing.

10.1.8 The procurement of services by commissioners under PbR must be open and transparent to ensure contestability and equity of access among providers.

10.1.9 Commissioners and providers will make information available about services procured using local flexibilities under PbR to inform patients' choices (eg as part of a commissioner's advice to patients about the choice of services available and in a provider's Directory of Services) and will publish the tariffs used for local flexibilities to ensure transparency across the system.

11 Billing and payment

11.1 The following principles shall apply to all parties operating within the system in 2012-13:

- 11.1.1 Billing and payments will be prompt, fair and accurate.
- 11.1.2 Providers and commissioners will agree definitions of activity, and timescales within which activity is paid for, through contracts.
- 11.1.3 Providers will code and bill for activity fairly, accurately and promptly in line with national guidance on reporting under PbR and the provisions of the contract. This guidance will be reviewed annually and reporting timescales will be reduced in support of the principle that billing and payment should be 'right first time.'
- 11.1.4 Commissioners will pay invoices promptly, as defined in their contracts. Any queries raised about an invoice shall be confined to specific and substantive items and should not delay payment for the remaining items. Any query that remains outstanding at the point an invoice becomes due shall be referred to dispute resolution and will not be grounds for delaying payment of the undisputed amount.
- 11.1.5 Commissioners and providers will agree processes for resolving disputes in line with the cross-government pledge on alternative dispute resolution, as illustrated by national standard contracting arrangements.⁹
- 11.1.6 Commissioners and providers will collaborate to resolve disputes in a timely fashion and by the end of the next billing period or as appropriate to their contracts. Regulators and performance managers will monitor instances of dispute and take action to address risks associated with organisations involved in frequent or protracted disputes.¹⁰ In addition, the Department of Health will consider the merits of collecting data on disputes so that details of organisations involved in frequent or protracted disputes may be made public.

⁹ The process for resolving disputes should be set out in contracts. SHAs will be the final arbiter of disputes between commissioners and NHS trusts. Where a dispute involves PCTs in two or more SHAs, both or all of the SHAs will adjudicate. For disputes involving NHS foundation trusts and independent sector providers, the NHS standard contract sets out an independent dispute resolution procedure.

¹⁰ The monitoring of disputes will be at the discretion of regulators and performance managers and any subsequent intervention against organisations will be proportionate to the risk to either the commissioning or provision of NHS services or the wider public interest in minimising NHS transaction costs.

- 11.1.7 The number of payment disputes will be kept to a minimum.
 - 11.1.8 Disputes should not take place where the financial sums or other matters concerned are not substantive.
 - 11.1.9 When a payment is disputed, the undisputed amount should be paid forthwith and only the disputed amount should be held in an escrow account until the dispute has been resolved. In addition, contracts may provide for payment of interest on such sums, for the period held in an escrow account, as part of any settlement of a dispute and in favour of either the commissioner or provider.
- 11.2 As a general principle, billing and payment should not be disputed in bad faith or to manage cash flow.

12 Enforcement

12.1 The following principles shall apply to all parties operating within the system in 2012-13:

- 12.1.1 It is an overarching principle of this Code that it should be enforceable through contracts and embedded in NHS regulatory and performance management arrangements.
- 12.1.2 Contracts for services provided under PbR should be consistent with this Code but in the unlikely event that there is conflict between the Code and the terms of an agreed contract the contract will normally take precedence.
- 12.1.3 The Secretary of State requires compliance with the Code by all NHS Bodies operating PbR, including Health Authorities, NHS trusts and PCTs. Organisations responsible for performance management will be expected to take action to address non-compliance. Persistent non-compliance by individual NHS trusts or PCTs may be penalised through intervention and/or direction on behalf of the Secretary of State.
- 12.1.4 Independent Sector providers and foundation trusts will be required to accept compliance with the Code as a condition of the standard contract to provide NHS services.
- 12.1.5 Non-compliance will be addressed through the relevant mechanisms outlined above and in a manner proportionate to the extent and impact of the non-compliance.
- 12.1.6 A data assurance framework, currently managed by the Audit Commission, has been established to underpin improvements to data quality under PbR. This includes a targeted audit programme using national benchmarking information. Audit reports will be provided to the host PCT and the PCT should ensure this is shared with the provider and other commissioning PCTs.
- 12.1.7 Any cases of suspected fraud involving an organisation operating PbR activity will be referred to and dealt with by the appropriate authorities.

13. Glossary of terms

All parties operating within the system

Parties include all commissioners and providers (as defined below), the tariff setting body (Department of Health) and all other bodies involved in the administration of PbR and/or with relevant regulatory or performance management responsibilities.

Caps and floors

The term 'cap' refers to a pre-agreed limit on the amount of activity for which a commissioner will pay a provider. The term 'floor' refers to a pre-agreed minimum amount of activity for which a commissioner commits to pay a provider.

Code (i.e. 'the Code')

The PbR Code of Conduct as amended from time to time.

Commissioners

The term commissioners covers all organisations or groups or organisations operating under PbR to the extent they participate in the procurement of services for NHS patients including Primary Care Trusts, Primary Care Practices, Local Authorities and their authorised agents, including any Procurement Agency (eg Shared Service). The term also applies to Clinical Commissioning Groups.

Contracts

These are relationships of rights and obligations between (at least) two parties operating under PbR and normally including a commissioner and a provider. A contract is formed by the parties (or their authorised agents') offer and acceptance (ie agreement) where there is an intention to create a legally binding relationship, and each gives "consideration". Its terms and conditions are specified in writing and amended from time to time by agreement. For the purposes of this Code, contracts shall include NHS contracts as defined in section 9 of the National Health Service Act 2006 (which under that section must not be regarded for any purpose as giving rise to contractual rights or liabilities); as well as legally binding contracts subject to the jurisdiction of the courts.

Directory of Services

A list and description of each provider's services – including any Service Specific Booking Guidance – compiled and made available to commissioners and patients to underpin the operation of Patient Choice and as required by Department of Health guidance as amended from time to time.

Independent Sector Providers

All providers other than NHS trusts, PCTs, NHS foundation trusts or other statutory body providing NHS funded services.

Law

The law in England, including any enforceable community right within the meaning of S2 (1) European Communities Act 1972.

Monitor

The independent regulator of NHS foundation trusts established under the Health & Social Care (Community Health & Standards) Act 2003.

Operating Framework

An annual statement on the 'rules' governing how the system should operate.

PCT (Primary Care Trust)

Any Primary Care Trust in England.

Providers

The term providers covers all organisations who either currently, or in future may provide services within the scope of PbR, including: NHS acute trusts, NHS foundation trusts, mental health trusts, consultants, independent sector providers, primary care practices, GPs, pharmacies, community services, social services and the voluntary sector.

Service Specific Booking Guidance

Guidance for use by commissioners and their agents in making referrals and bookings on behalf of patients that details any criteria to be used systematically by a provider to determine patients' eligibility for specific services.

SHA (Strategic Health Authority)

A Strategic Health Authority in England.

Stakeholders

The term stakeholders covers all parties operating within the system, and groups within those stakeholders, including clinicians and managers. It also includes patients and members of the public.

Terms of Authorisation

The terms under which NHS foundation trusts may be authorised to provide services is covered in the Health and Social Care Act 2006.

Treatment thresholds

Treatment thresholds refer to the clinical threshold above which a specific treatment is judged appropriate for a specific condition.

Trigger points

The term trigger points refer to pre-agreed levels of referrals and/or activity, indicating unplanned increases in demand.

Unbundling

Unbundling refers to the splitting of the fixed tariff price between one or more providers who are providing different elements of the treatment covered by the fixed price.

14. Useful links

This section provides links to associated documents and websites referred to in this document, and links to other useful information to be used when operating PbR in 2012-13:

- **PbR pages on the Department of Health website:**

<http://www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/payment-by-results/>

- **2012-13 NHS Operating Framework and NHS standard contracts**

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

- **Non-Contract Activity (included in: 'Who Pays? Establishing the Responsible Commissioner')**

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466

- **NHS Connecting for Health website:**

www.connectingforhealth.nhs.uk

- **NHS Information Centre for health and social care website**

www.ic.nhs.uk

- **SUS and SUS PbR information:**

www.ic.nhs.uk/services/secondary-uses-service-sus

www.connectingforhealth.nhs.uk/systemsandservices/sus

- **Audit Commission website**

<http://www.audit-commission.gov.uk/health/audit/paymentbyresults/pages/default.aspx>