2014/15 National Tariff Payment System: A Consultation Notice

Annex 4A: Additional information on currencies with national prices

3 October 2013

Annex 4A: Additional information on currencies with national prices

This annex is designed to assist with the implementation of the proposed *2014/15 National Tariff Payment System* and should be read in conjunction with Section 4 (on currencies with national prices) of this consultation notice. The annex provides information on the mandatory national currencies for which we propose mandatory national prices for 2014/15. Some information is also provided on proposed mandatory national currencies with non-mandatory prices. A list of mandatory currencies together with mandatory / non-mandatory prices can be found in Annex 5A and the national tariff information workbook respectively.

As explained in Section 5 (on the method for determining national prices) of the consultation notice, there are many currencies for which we use 2013/14 prices as the base for 2014/15 prices. Generally, this annex does **not** describe the methodology used for 2013/14, but in certain circumstances we have included some details where we think it may be helpful. Information on the 2013/14 national tariff can be found in the Department of Health's *Payment by Results (PbR) Guidance for 2013/14*.

This document provides implementation guidance on the following aspects of the proposed *2014/15 National Tariff Payment System*:

1. Chemotherapy and radiotherapy
2. Post discharge rehabilitation
3. Outpatient care
4. Best practice tariffs
5. Maternity pathway
6. Cystic Fibrosis
7. Looked After Children health assessments

1 Chemotherapy and radiotherapy

In this section, we provide information on the HRG sub-chapters that relate to chemotherapy and radiotherapy.

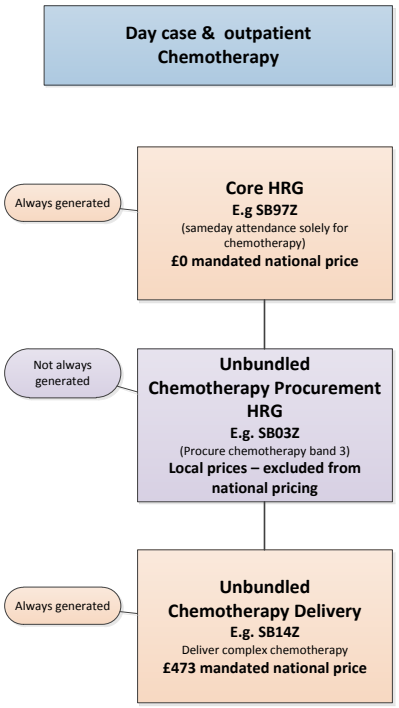
1.1 Chemotherapy delivery

Chemotherapy is split into three parts:

- a core HRG (covering the primary diagnosis or procedure) which is already included within prices;
- the unbundled HRG for chemotherapy drug procurement; and
- the unbundled HRG for chemotherapy delivery).

This is illustrated in Figure 4A-1 below.

Figure 4A-1: Chemotherapy HRGs



The procurement element of chemotherapy remains subject to local prices.

Following the removal of the regular attender service exclusion in 2013/14, this will continue to apply in 2014/15 along with that for external beam radiotherapy and renal services.

1.1.1 Structure

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.

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).

The chemotherapy delivery HRGs are assigned for each attendance for treatment to reflect the complexity of treatment and resource usage.

Table 4A-1 summarises the design of the delivery HRGs (not including oral administration).

Table 4A-1: Chemotherapy delivery HRGs

Definition	Explanation
Deliver simple parenteral chemotherapy	Overall time of 30 minutes nurse time and 30 to 60 minutes chair time for the delivery of a complete cycle.
Deliver more complex parenteral chemotherapy	Overall time of 60 minutes nurse time and up to 120 minutes chair time for the delivery of a complete cycle.
Deliver complex chemotherapy, including prolonged infusional treatment	Overall time of 60 minutes nurse time and over two hours chair time for the delivery of a complete cycle.
Deliver subsequent elements of a chemotherapy cycle	Delivery of any pattern of outpatient chemotherapy regimen, other than the first attendance, i.e. day 8 of a day 1 and 8 regimen or days 8 and 15 of a day 1, 8 and 15 regimen.

Table 4A-2 illustrates payment arrangements for chemotherapy HRGs.

Table 4A-2: Payment arrangements for chemotherapy HRGs 2014/15

	Core HRG	**Unbundled Chemotherapy Procurement HRG**	**Unbundled Chemotherapy Delivery HRG**
Ordinary admission	e.g. LB35B National price includes cost of delivery	e.g. SB03Z HRG generated – excluded from national price. Local prices agreed	No HRG generated
Day case and outpatient	SB97Z (generated if no other activity occurs)	e.g. SB03Z HRG generated – excluded from national price. Local prices agreed	e.g. SB14Z Mandatory national prices for 2014/15
Day case and outpatient	If other activity occurs e.g. LB35B	e.g. SB03Z HRG generated – excluded from national price. Local prices agreed	e.g. SB14Z Mandatory national prices for 2014/15
Regular day and regular night admissions	As per day case & outpatient	e.g. SB03Z HRG generated – excluded from national price. Local prices agreed	e.g. SB14Z Mandatory national prices for 2014/15

As in previous years, SB97Z attracts a zero (£0) price to reflect appropriate reimbursement where a patient has attended solely for chemotherapy delivery and, in certain circumstances, removes the need for organisations to adjust local reimbursement arrangements for chemotherapy to take into account the core HRG for the chemotherapy diagnosis, SB97Z. These circumstances are where:

- chemotherapy has taken place;
- the activity has a length of stay less than one day; and
- the core HRG which would otherwise be generated is a diagnosis driven HRG (with no major procedures taking place).

Delivery codes do not include the consultation at which the patient consents to chemotherapy, nor does it cover any outpatient attendance for medical review required by any change in status of the patient. These activities would generate an appropriate outpatient HRG.

For chemotherapy regimens not on the national regimen list, the delivery HRG SB17Z must be negotiated locally as, by the nature of new regimens and potentially differential delivery methods, the costs will vary.

1.1.2 Additional drugs

Specified drugs which are not covered by national prices 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 specified. For example, Rituximab is listed on both the regimens list and the specified high cost drugs list.

Work is ongoing to resolve and clarify issues regarding the treatment of hormonal therapies and high cost supportive drugs. Table 4A-3 below shows the current treatment of such drugs.

Table 4A-3: 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

If a hormone treatment is not used as an intrinsic part of a regimen, or as a supportive drug to a regimen, it is not covered by national prices only when it appears on the specified high cost drugs list or when it is included in a BNF section or subsection that is wholly excluded from prices.

1.2 External beam radiotherapy

Radiotherapy can be split into two broad areas:

- external beam radiotherapy; and
- brachytherapy and liquid radionuclide administration.

In 2014/15, a mandated national price will be in place for external beam radiotherapy. Brachytherapy will not have a mandatory national price in 2014/15 and work is on-going to develop HRGs for this area.

The radiotherapy HRGs are similar to the design of the chemotherapy HRGs, in that an attendance may result in more than one HRG; i.e. both preparation and treatment delivery. The radiotherapy dataset (RTDS), introduced in 2009, must be used by all organisations.

Following the removal of the regular attender service exclusion in 2013/14, this will continue in 2014/15 along with that for chemotherapy and renal services.

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.

Table 4A-4 summarises the payment arrangements for external beam radiotherapy.

Table 4A-4: Payment arrangements for external beam radiotherapy

	Core HRG	**Unbundled Radiotherapy Planning HRG (one coded per course of treatment)**	**Unbundled Radiotherapy Delivery HRG**
Ordinary admission	e.g. LB35B National price applies	Treat as per RTDS (RT treatment delivered as OP)	Treat as per RTDS (RT treatment delivered as OP)
Day case and outpatient	SC97Z (generated if no other activity occurs)	e.g. SC45Z HRG generated Mandatory national prices for 2014-15	e.g. SC22Z HRG generated Mandatory national prices for 2014-15
Regular day and regular night admissions	As per day case & outpatient	e.g. SC45Z HRG generated Mandatory national prices for 2014-15	e.g. SC22Z HRG generated Mandatory national prices for 2014-15

As in previous years, SC97Z attracts a zero (£0) price to reflect appropriate reimbursement where a patient has attended solely for external beam radiotherapy. This 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:

- External beam radiotherapy has taken place
- the activity has a length of stay less than one day
- the core HRG which would otherwise be generated is a diagnosis driven HRG (with no major procedures taking place).

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

Delivery codes will be assigned to each attendance for treatment (only one fraction (HRG) per attendance will attract a national price). The only exception to this rule is if two different body areas are being treated when a change in resources is identified, rather than treating a single site. The delivery of hyper-fractioned radiotherapy, where two doses are delivered six hours apart, would generate two delivery attendances.

Preparation codes are applied to and reported on the day of the first treatment (all set out within the RTDS). Each preparation HRG within a patient episode[1] will attract a national price.

1.2.1 Stereotactic Radiosurgery (SRS)/ Radiotherapy (SRT)

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

Work is in progress to develop appropriate currencies and prices for the whole of radiotherapy and multi-fraction stereotactic radiotherapy prices 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.

[1] For a definition of 'episode', see the NHS Data Dictionary.

2 Post discharge rehabilitation

The post discharge national prices were first introduced in 2012/13 to encourage a shift of responsibility for patient care following discharge to the acute provider who treated the patient. This was in response to increasing emergency readmission rates in which many patients were being readmitted to providers following discharge.

There are four mandatory post discharge national prices which must be used where a single trust provides both acute and community services. Other providers may choose to use these prices. The post discharge prices cover four areas of care. These are:

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

For cardiac rehabilitation and pulmonary rehabilitation, there are associated commissioning packs.

2.1 Cardiac rehabilitation

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 national price.

The currency is based on the pathway of care outlined in the Department of Health's Cardiac Rehabilitation Commissioning Pack. Commissioners must pay the mandatory national price 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 required and how it is provided.

Based on clinical guidance, the post discharge price 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 - that is, those patients discharged having had an acute spell of care for:

- acute myocardial infarction;
- percutaneous coronary intervention or heart failure; or
- coronary artery bypass grafting (CABG).

The areas of care are characterised by the following list of spell primary diagnoses and spell dominant procedures:

- Acute myocardial infarction: A spell primary diagnosis of: I210, I211, I212, I213, I214, I219, I220, I221, I228 or I229;
- Percutaneous coronary intervention or heart failure: A spell dominant procedure of: K491, K492, K493, K494, K498, K499, K501, K502, K503, K504, K508, K509, K751, K752, K753, K754, K758 or K759; and
- 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.

The post discharge price is only payable for patients discharged from acute care within this defined list of diagnoses and procedures and who subsequently complete a course of cardiac rehabilitation.

2.2 Pulmonary rehabilitation

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 price. The currency is based on the pathway of care outlined in the Department of Health's Chronic Obstructive Pulmonary Disease (COPD) Commissioning Pack. Commissioners must pay the mandatory national price 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.

The post discharge price will apply to patients discharged having had an acute episode of care for COPD. The mandatory price can only be paid for patients discharged from acute care with an HRG for the spell of care of DZ21A to DZ21K, who subsequently complete a course of pulmonary rehabilitation. The 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.

2.3 Hip replacement rehabilitation

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 price.

The pathway for post discharge activity for primary non-trauma total hip replacements, suggested by clinical leads, consists of:

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

The national price applied therefore represents the funding for this pathway of rehabilitation and will act as a maximum level of post discharge rehabilitation payment. Local agreement will need to be reached on the price level 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 price will fund the pathway for the first three months after discharge and does not cover long term follow-up treatment.

The mandatory price can 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.

2.4 Knee replacement rehabilitation

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 price.

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; and
- consultant-led clinic visits.

The national price applied therefore represents the funding for this pathway of rehabilitation and will act as a maximum level of post discharge rehabilitation payment. Local agreement will need to be reached on the price level 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 price will fund the pathway for the first three months after discharge and does not cover long term follow-up treatment.

The price can only be paid for patients discharged from acute care with an episode of care with a spell dominant procedure coding of W401, W411, W421 or O181. The post discharge currencies for hip and knee replacement cover the defined clinical pathway only for post discharge activity.

3 Outpatient care

In this section, we provide detailed information on the structure of currencies used for the following areas of outpatient care:

- consultant led and non-consultant led;
- first and follow-up attendances;
- non face-to-face outpatient attendances;
- multi-professional and multi-disciplinary; and
- diagnostic imaging.

3.1 Consultant led and non-consultant led

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*." A consultant led service does not apply to nurse consultants or physiotherapist consultants.

There is no national price 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 Commissioning Data Set (CDS) and HES by a pseudo main specialty 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.

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 care (TFC 560 midwife episode), is included in the maternity pathway price.

3.2 First and follow-up attendances

There are separate national prices 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 a new referral occurs and the patient returns to the clinic run by the same consultant, this is classified as a first attendance. The end of a financial year does not necessarily signify the end of a particular outpatient series. If two outpatient attendances for the same course of treatment are in two different financial years but are less than six months apart, or where the patient attends having been given a further appointment at their last attendance, the follow-up national price applies.

To disincentivise unnecessary follow-ups, a portion of the costs of follow-up attendances have been added to the price of first attendances. This doesn't apply to infectious diseases and nephrology, where correct clinical management demands a follow-up regime.

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 captured in the data flow as first attendances are, as far as the patient is concerned, follow-up visits.

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 the recording of these types of attendance and their reimbursement.

3.3 Non face-to-face outpatient attendances

A non-mandatory price for non face-to-face outpatient activity is available for use in 2014/15, further information on which is provided in the national tariff information workbook. Commissioners and providers may wish to use this to facilitate changes to outpatient pathways, such as introducing video, telephone and web-enabled consultations.

3.4 Multi-professional and multi-disciplinary

There are separate national prices for multi-professional and single-professional outpatient attendances, which reflect service and cost differences. The multi-professional price is payable for two types of activity, distinguished by the following OPCS-4 codes:

- X622 - assessment by multi-professional team not elsewhere classified – for multi-professional consultations; and
- X623 - assessment by multi-disciplinary team not elsewhere classified – for multi-disciplinary consultations.

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 at least two consultants are present. Where there is joint responsibility across consultants then this should be discussed and agreed between commissioner and provider.

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.

The OPCS code can only be applied 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. They do not apply if one professional is supporting another, clinically or otherwise (e.g. in the taking of notes, acting as a chaperone, training, professional update purposes, operating equipment and passing instruments). They also do not apply where a patient sees single professionals sequentially as part of the same clinic. Such sequential appointments count as two separate attendances and should be reported as such in line with existing NHS Data Model and Dictionary guidance on joint consultant clinics.

The multi-disciplinary attendance definition does not apply to multi-disciplinary meetings (i.e. where care professionals meet in the absence of the patient).

Commissioners and providers should exercise common sense in determining which attendances are to be counted as multi-professional and which are multi-disciplinary, and appropriately document this in their contracts.

An example of a multi-professional attendance is where an orthopaedic nurse specialist assesses a patient and a physiotherapist provides physiotherapy during the same appointment.

Some examples of multi-disciplinary attendances are where:

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

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

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

3.5 Diagnostic imaging

3.5.1 Diagnostic imaging undertaken in outpatients

Separate diagnostic imaging national prices have been set for those services for which there are unbundled HRGs in sub chapter RA. These services are:

- Magnetic resonance imaging scans;
- Computerised tomography scans;
- Dexa scans;
- Contrast fluoroscopy procedures;

- Non-obstetric ultrasounds;
- Nuclear medicine; and
- Simple echocardiograms.

This excludes plain film x-rays, obstetric ultrasounds, pathology, biochemistry and any other diagnostics that generate an HRG outside sub-chapter RA.

Where patient data groups to a procedure-driven HRG without a mandatory national price, the diagnostic imaging national prices apply.

The proposed rules for managing the financial impact of the introduction of separate prices for diagnostic imaging in outpatients are set out in Section 6 of the consultation notice.

3.5.2 Where diagnostic imaging costs remain included in national prices

Diagnostic imaging does not attract a separate payment in the following instances:

- where the patient data groups to a procedure-driven HRG with a mandatory national price (i.e. not from HRG4 sub-chapter WF);
- where the mandatory price is zero (e.g. LA08E, SB97Z and SC97Z, which relate only to the delivery of renal dialysis, chemotherapy or external beam radiotherapy), any diagnostic imaging is assumed to be connected to the outpatient attendance;
- where diagnostic imaging is carried out during an admitted patient care episode or during an A&E attendance;
- where imaging is part of a price for a pathway or year of care (e.g. the best practice tariff for early inflammatory arthritis); or
- where imaging is part of a specified service for which a mandatory price has not been published (e.g. cleft lip and palate).

For the avoidance of doubt, sub-contracted imaging activity must be dealt with as for any other sub-contracted activity, i.e. if Provider A provides scans on behalf of Provider B, Provider B will pay Provider A and Provider B will charge their commissioner for the activity.

3.5.3 Processing diagnostic imaging data

It is expected that providers will use SUS[2] submissions as the basis for payment. Where there is no existing link between the radiology system and the Patient Administration System (PAS), the diagnostic imaging record must be matched to any relevant outpatient attendance activity, for example using NHS number or other unique identifier and scan request date. This will enable identification of which radiology activity must and must not be charged for separately. Where the scan relates to outpatient activity that generates a procedure-driven HRG with a mandatory price, the scan must be excluded from charging.

The Terminology Reference-data Update Distribution Service (TRUD) provides a mapping between National Interim Clinical Imaging Procedure (NICIP) codes and OPCS-4 codes. The grouper documentation published by the Health and Social Care Information Centre 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. It is necessary 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 HRG for diagnostic imaging will be generated where more than one scan has been carried out, and each HRG will attract a separate price. 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 (e.g. MRI) on the same day.

[2] The Secondary Uses Service (SUS) is the single, comprehensive repository for health care data in England which enables a range of reporting and analyses to support the NHS in the delivery of health care services. Further detail is available here.

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 be related to the first outpatient attendance that day; and
- 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 sub-chapter RA. SUS PbR will not generate a price for this unbundled HRG if the core HRG is a procedure-driven HRG with a mandatory price (i.e. not from HRG4 sub-chapter WF).

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 must 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 price 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 we would recommend a pragmatic approach. 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.

Table 4A-5 below shows the different scenarios, and how SUS PbR will process the data:

Table 4A-5: How SuS PbR processes the data

Scenario	**How will SUS PbR process the data?**
Core HRG in WF (with a mandatory price)	It will price the core HRG activity
Core HRG in WF (with a mandatory price) with one or more unbundled HRGs in RA (with a mandatory price)	It will price the core HRG activity and the unbundled imaging activity
Core HRG in WF (**without** a mandatory price) with one or more unbundled HRGs in RA (with a mandatory price)	It will not price the core HRG activity but will price the unbundled imaging activity
Core procedure-based HRG (with a mandatory price)	It will price the core HRG activity
Core procedure-based HRG (with a mandatory price) with one or more unbundled HRGs in RA (with a mandatory price)	It will price the core HRG activity only
Core procedure-based HRG (**without** a mandatory price) with one or more unbundled HRGs in RA (with a mandatory price)	It will price the equivalent WF core activity (if relevant) and the unbundled imaging activity

4 Best practice tariffs

In the following subsections we describe each of the best practice tariffs (BPTs) that we propose will be in operation in 2014/15.

4.1 Acute stroke care

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.

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 Strategy, NICE clinical guideline CG68 and the NICE quality standard for stroke QS2.

The BPT is made up of three conditional payments which supplement the base national price. The three conditional payments, one for each of the three characteristics of best practice, are payable separately where:

- patients are admitted directly[3] to an acute stroke unit[4] either by the ambulance service, from A&E or via brain imaging. Patients must not be directly admitted to a Medical Assessment Unit. Patients must then also spend the majority[5] of their stay in the acute stroke unit;

[3] Due to the variety of routes into the stroke unit, we define direct admission as intending to be within four hours of arrival in hospital.

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

[5] 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.

- initial brain imaging is delivered in accordance with best practice guidelines as set out in *Implementing the National Stroke Strategy – An Imaging Guide*. The scan must not only be done in the stated timescales[6] but immediately interpreted and acted upon by a suitably experienced physician or radiologist; and
- patients are assessed for thrombolysis, receiving alteplase if clinically indicated in accordance with the NICE technology appraisal guidance on this drug[7].

This design provides additional per patient funding to meet the anticipated costs of delivering best practice, and creates an incentive for providers to deliver best practice care.

Whilst not a criterion to receive the BPT, contribution to national clinical audits should be considered a characteristic of best practice for providers of high quality stroke care. The Stroke Improvement National Audit Programme (SINAP) is one of the audits in the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

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 be able to meet the requirement of direct admission to a stroke unit and so qualify for the corresponding incentive payment.

One criterion of the BPT is that patients are admitted directly to an acute stroke unit either by the ambulance service, from A&E or via brain imaging. To qualify, acute stroke units must meet all the markers of a quality service set out in the National Stroke Strategy quality marker 9, which are:

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;

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[6] These timescales 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.

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

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; and

e) appropriately qualified clinicians are available to address respiratory, swallowing, dietary and communication issues.

The base price 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:

- patient aged 19 or over (on admission);
- 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 code from the list in Annex 5A; and
- HRG from the list in Annex 5A.

SUS PbR will apply the base price to spells with the relevant BPT flag. Of the three best practice characteristics, SUS PbR will only apply the additional payment for alteplase when OPCS-4 code X833 (fibrinolytic drugs) is coded to create an unbundled HRG XD07Z (fibrinolytic drugs band 1) from AA22A or AA22B. For the other two best practice characteristics, organisations will need to agree local reporting and payment processes. The SINAP will be a useful source of information and support to organisations in establishing these processes.

4.2 Adult renal dialysis

This BPT covers haemodialysis, home haemodialysis and dialysis away from base only. However, for completeness Table 4A-6 below shows the complete set of the currencies for adult renal dialysis. Note the BPT only applies to adult patients with chronic kidney disease[8] and not those with acute kidney injury[9].

Table 4A-6: Adult renal dialysis currencies

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

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

4.2.1 Haemodialysis

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:

- Renal Association guidelines (guidelines 1.1 and 1.2);
- Vascular Society and Renal Association joint guidelines; and
- National Service Framework for renal services (standard 3) 47.

[8] For payment 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).

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

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.

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.

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.

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, previous guidance published by the Department of Health under the PbR system set out an intention to set the BPT to incentivise a movement to this proportion over the coming years. As in 2013/14, the BPT is based on providers achieving a rate of 80% in 2014/15, although providers should continue to work towards the rate recommended in the guidance.

The BPT requires vascular access to be undertaken via a functioning ateriovenous fistula. Therefore, renal units will need to collaborate with surgical services to establish processes that facilitate timely referral for formation of vascular access.

4.2.2 Home haemodialysis

The aim of the mandatory national prices for home haemodialysis is to provide a real choice of home haemodialysis for patients. It is intended that the BPT price and structure offer incentives to both providers and commissioners to offer home haemodialysis to all patients who are suitable.

The BPT 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.

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

4.2.3 Dialysis away from base

A review of funding for dialysis away from base found that there may be associated additional costs. However, because the reference costs include these additional costs, the BPT price should adequately fund, on average, providers dialysing a mix of regular and away from base patients. Nevertheless, in recognition of the importance to patients of being able to dialyse away from base, and given some providers will have a significantly disproportionate mix of patients, local payment arrangements may be agreed as follows:

- All patients who require haemodialysis away from base will be paid the arteriovenous fistula or graft BPT price. Any additional payments will need to be actioned locally as there is no method of reimbursing providers under the existing mechanism;
- Commissioners will have the flexibility to pay above the national price 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.

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.

The national prices contained in this consultation notice apply at HRG level. The proposed HRGs and prices are set out in Annex 5A.

The HRGs are generated by data items from the National Renal Dataset (NRD). Commissioners must include, as a minimum, the data items listed in Table 4A-7 in information schedules of NHS contracts where these services are provided.

Table 4A-7: National Renal Dataset fields

Renal Care [1] renal treatment modality, e.g. haemodialysis, peritoneal dialysis [6] renal treatment supervision code, e.g. home, hospital Person observation [75] blood test HBV surface antigen [77] blood test HCV antibody [79] blood test HIV Demographics [19] PCT organisation code[10] Dialysis [182] type of dialysis access, e.g. fistula [23] dialysis times per week Organisations will also need to derive: • a unique patient identifier • patient age (in years derived from date of session – date of birth)

The reporting process for renal dialysis will differ from other 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 2014/15 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.

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 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 price set to zero.

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 payment arrangements for this activity are for local agreement.

[10] CCG code will now be recorded in this field.

If a patient with acute kidney disease requires dialysis whilst in hospital during an unrelated spell, then the dialysis price is payable in addition to the price for the core spell.

Due to the variation in funding and prescription practices across the country, the BPT price for renal dialysis is not intended to fund the following drugs in 2014/15:

- ESAs: Darbopoetin alfa; Epoetin alfa, beta (including methoxy polyethylene glycol-epoetin beta), theta and zeta; and
- drugs for mineral bone disorders: Cinacalcet; Sevelamer; Lanthanum.

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 BPT prices are intended to reimburse the associated costs of the drugs.

Patients with iron deficiency anaemia of chronic kidney disease will require iron supplementation. For patients on haemodialysis, the 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 price, either in outpatients or admitted patient care, depending on the type of drug and method of administration (slow infusion or intravenous).

4.3 Cataracts

As in 2013/14, the BPT for cataract surgery will remain a non-mandatory price[11]. Commissioners wishing to reimburse on the basis of the BPT will not require the approval of the provider organisation but should share the administrative effort in operating the currency.

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 Ophthalmologists' guidelines.

The BPT applies to adults only. The price 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.

[11] Please see the *National tariff information workbook* for the cataracts BPT non-mandatory prices.

The currency corresponds to the elements of the best practice pathway as set out in Table 4A-8. The first eye BPT price covers levels 2-5 of the pathway and the second eye BPT price covers levels 6-7. Reimbursement for a patient who follows a pathway covering levels 2-7 is therefore the sum of the two prices.

Table 4A-8: Cataracts pathway

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

Since April 2010, additional functionality has been available in SUS PbR to help commissioners implement this pathway BPT. Commissioners and providers can access an extract that links events along a patient pathway using the Patient Pathway ID field[12], returning records in chronological order per patient. More information is available in the SUS PbR documentation via the Health and Social Care Information Centre's website. If providers and commissioners agree, they can implement local solutions for paying for cataract pathways.

As cataracts can be a bilateral procedure, the pathway BPT 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.

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.

The BPT 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 BPT prices must be reduced accordingly.

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, e.g. 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.

[12]This is a field in SUS PbR which allows commissioners and providers to access an extract that links events along a patient pathway. It was one of the 18 weeks (referral to treatment) fields mandated for compliance in January 2010. Further information is available in SUS PbR guidance.

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

While the BPT 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, i.e. a follow-up attendance price paid either in full or at a percentage.

The pricing approach is designed to adequately reimburse the cost of best practice. It is achieved by a single price per pathway, set on the costs of a streamlined pathway. Where best practice is not met, the same price applies, and so there is a cost to the provider of not meeting the best practice criteria.

4.4 Day case procedures

Performing procedures as a day case (where clinically appropriate) 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.

The British Association of Day Surgery (BADS) publishes a directory of procedures that are suitable for day case admissions[13] or short stays[14] along with rates that they believe are achievable in most cases.

[13] A day case is defined as an admission where the patient is discharged before midnight.

[14] BADS publishes different target rates for short stays: stays of less than 23 hours and stays of less than 72 hours.

The BPT is made up of a pair of prices for each procedure: one applied to day case admissions and one applied to ordinary elective admissions. By paying a relatively higher price for day case admissions, the BPT creates an incentive for providers to manage patients on a day case basis without costing commissioners any more money.

The procedures selected for BPTs come from the third edition of the BADS 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.

In a number of cases, the day case rate used to calculate the relative prices differs from those published in the BADS directory because clinical feedback suggested that the BADS rates may be too ambitious for some providers to achieve in one step. For each procedure covered by the BPT, Table 4A-9 lists the BADS day case rate, an estimate of the current average rate across all providers and those rates used to calculate the relative prices.

Table 4A-9: Day case BPT services

Procedure	BADS rate (4th edition)	BPT calculation rate	Current rates (2011-12 HES)
Breast surgery			
Excision of breast – Excision/biopsy of breast tissue including wire guided – Wide local excision	95% 75%	75% (weighted average)	55%
Simple mastectomy	30%	15%	5%
Sentinel lymph node biopsy	80%	80%	52%
Axillary clearance	80%	40%	11%
Gynaecology			
Operations to manage female incontinence	60%	45%	41%
Urology			
Endoscopic resection of prostate (TUR)	15%	15%	3%
Resection of prostate by laser	75%	60%	4%
General surgery			
Cholecystectomy	60%	60%	44%
Repair of range of hernia (umbilical, inguinal, recurrent inguinal and femoral)	90%	90%	69%
Orthopaedic surgery[15]			
Arthroscopic subacromial decompression	80% (75%)	Calculation of prices for these BPTs	60%

[15] The figures in parentheses in the BADs rate column are the 75th percentile day case rates from HES 2009-10.

Procedure	BADS rate (4th edition)	BPT calculation rate	Current rates (2011-12 HES)
Bunion operations with or without internal fixation and soft tissue correction	85% (72%)	was informed by clinical advice	62%
Dupuytren's fasciectomy	95% (90%)		83%
Ear, nose and throat			
Tympanoplasty (including myringoplasty; mastoidectomy; ossiculoplasty; and stapedectomy)	80%	50%	37%
Tonsillectomy			
– Children	70%	70%	40%
– Adults	80%	80%	40%
Septoplasty	60%	60%	54%

Around a third of the BPTs apply at the HRG level, and for the remainder a flag is required to identify the relevant activity. In all cases SUS PbR will automate payment of the appropriate price.

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 Annex 5A; and
- HRG from the list in Annex 5A.

Annex 5A details the prices, whether they apply at HRG or BPT flag level and the relevant OPCS codes[16].

4.5 Diabetic ketoacidosis and hypoglycaemia

Diabetic ketoacidosis (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. 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.

The aim of this BPT is to ensure the involvement of a diabetes specialist team and patient 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.

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

The BPT applies to adults admitted as an emergency with DKA or hypoglycaemia only. It is made up of two components: a base price and a conditional payment. The base price 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:

- referred to the Diabetes Specialist Team (DST) on admission, and seen within 24 hours by a member of the DST;

[16] OPCS codes for procedures for which the BPT applies at HRG level are detailed in the BADS Directory available to download in the definition document on the NHS Better Care, Better Value indicators website.

- have an education review by a member of the DST prior to discharge[17];
- be seen by a Diabetologist or DSN prior to discharge;
- be discharged with a written care plan, a process that allows the person with diabetes to have active involvement in deciding, agreeing and taking responsibility for how their diabetes is managed. This must be copied to the GP; and
- patients to be offered access to structured education, with the first appointment scheduled to take place within 3 months of discharge[18].

There is variation across the country in the provision of structured education in terms of access and waiting lists. Structured education should be delivered in line with the criteria laid out in the Diabetes UK Care Recommendation Education of People with Diabetes.

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.

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)
- NICE Type 1 diabetes guidance
- 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

[17] In some circumstances not all elements of the review are applicable (e.g. 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.

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

- The Hospital Management of Hypoglycaemia in Adults with Diabetes

The BPT applies at the sub HRG level and SUS PbR will apply the base price to spells with a BPT flag only. SUS PbR will not apply the conditional payment, and compliance with the characteristics of best practice will need to be monitored and paid for accordingly.

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));
- a diagnosis from the list in Annex 5A; and
- one of the HRGs from the list in Annex 5A.

Where providers do not achieve best practice, commissioner expenditure will reduce. It is expected that commissioners will engage with providers to improve services.

The base price is set at 85% of the conventional HRG price, with the conditional component equal to the remaining 15%.

4.6 Early inflammatory arthritis

The aim of the BPT is to ensure timely diagnosis of patients with early inflammatory arthritis (EIA) and, where appropriate, the initiation of therapy. The BPT has been developed in association with the British Society for Rheumatology and Arthritis Research UK, and reflects NICE clinical guideline 79.

There are three separate BPTs applicable where care meets the standards set out in Table 4A-10 below. These BPTs apply to the first year of care only.

Table 4A-10: Early inflammatory arthritis BPTs

Diagnosis and discharge BPT	For those patients with suspected EIA who are: – seen within three weeks of referral; – diagnosed as not having EIA and discharged within 6 weeks of referral[19]. The BPT includes the costs of plain radiology, ultrasounds, all blood tests, and clinical consultations with doctors / nurses.
DMARD Therapy BPT	For those patients with suspected EIA who: – are seen within three weeks of referral; – have DMARD treatment initiated within 6 weeks of referral[20]; – receive regular follow up[21] and monitoring over first year of treatment with evidence of appropriate titration of therapy. The BPT price includes the annual costs of all blood tests, non-biologic prescriptions, clinical consultations with doctors/nurses, annual review. The price excludes physiotherapy, psychology, podiatry, occupational therapy, telephone emergency advice line, inpatient admissions, biologics and associated drug costs.

[19] In exceptional circumstances where a patient is referred twice in-year then only the initial referral is eligible for the BPT. The second referral must 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.

[20] 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.

[21] 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.

Biological therapy BPT	For patients with suspected EIA who: – are seen within three weeks of referral; – have disease modifying antirheumatic drugs (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. The BPT price includes the annual costs of all blood tests, non-biologic prescriptions, clinical consultations with doctors/nurses, annual review. The price excludes physiotherapy, psychology, podiatry, occupational therapy, telephone emergency advice line, inpatient admissions, biologics, drug infusion and associated costs.

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.

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 of joint inflammation by the time DMARD initiation is suggested.

There are substantial proven benefits 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.

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.

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".

The BPT covers the first year of care only. Treatment for patients diagnosed more than 12 months previous will continue to be paid for using the rheumatology TFC 410. Each of the BPT prices is an annual payment. Patients are only eligible for one of the payments in year, subject to meeting all criteria.

The structure of the BPT aims to remove any first and follow up ratios in operation locally that may have prevented providers from receiving full payment for delivering a best practice service.

For the purposes of this BPT, the costs of diagnostic imaging are included in the price.

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.

Activity meeting the best practice characteristics 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 conventional price will not be applied.

If a provider is not meeting the best practice specification they will continue to be paid the outpatient first and follow up attendance national prices for the rheumatology TFC 410.

The pricing approach is designed to adequately reimburse the costs of best practice. Prior to 2013/14, providers were paid on a first and follow up attendance basis as part of a generic TFC for rheumatology, which did not in all circumstances adequately reflect the actual costs of a best practice service.

The pricing of the DMARD therapy BPT is reflective 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 BPT price will adequately fund, on average, providers with a regular mix of patients.

The price of the TFC for rheumatology has not been affected by the introduction of the BPT.

4.7 Endoscopy procedures

The aim of this BPT is to provide a financial incentive for engagement to promote improved and consistent standards across endoscopy services.

Joint Advisory Group (JAG) accreditation provides formal recognition that an endoscopy service meets the competence to deliver against the measures in the endoscopy Global Rating Scheme (GRS).

The BPT applies to adults only for elective endoscopic procedures in all NHS providers (including community organisations) and independent sector providers. It comprises a single price per HRG with provision for commissioners to withhold 5% of the price 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.

The status of providers are defined by JAG, available on the JAG website, and updated on a monthly basis. Table 4A-11 sets out whether the BPT price applies or whether 5% of the BPT price is withheld, depending on the status of providers.

Table 4A-11: Status of providers – engaged / not engaged

Engaged – full price applies	**Not engaged – 5% to be withheld**
Assessed: accreditation awarded	*Assessed: accreditation not awarded*
Engaged: improvements required	*Not engaged*

SUS PbR will automate payment of the endoscopy BPT by applying the full BPT price to the HRG. Commissioners will need to reclaim any overpayments from providers not engaged in the accreditation scheme. Commissioners must ensure that they reflect changes to status of providers in-year.

Information on the JAG website is at site level rather than organisation level. Where a provider has sites of mixed status, commissioners must apply the BPT 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.

Where providers do not achieve best practice, commissioner expenditure will reduce. It is expected that commissioners will engage with providers to improve services.

The pricing approach is designed to reimburse the cost of achieving best practice. Only spells that meet best practice will attract the full conventional price – otherwise, 95% of the price 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.

4.8 Fragility hip fracture

For patients with a fragility hip fracture, care needs to be quickly and carefully organised to prepare them for surgery. By quickly stabilising patients and ensuring that expert clinical teams respond to their frail conditions and complex needs, the most positive outcomes can be achieved. Equally, the care that these patients receive following surgery is just as important, as it is in the initial days following surgery that the greatest gains can be made in patient outcomes.

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).

The BPT is made up of two components: a base price and a conditional payment. The base price 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:

- 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;
- admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon[22];
- admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia[23];
- assessed by a geriatrician[24] in the perioperative period (within 72 hours of admission);
- postoperative geriatrician-directed multi-professional rehabilitation team;
- fracture prevention assessments (falls and bone health); and
- 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; 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.

This design provides additional per patient funding to meet the anticipated costs of delivering best practice, and creates an incentive for providers to deliver best practice care.

The base price 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:

- patient aged 60 or over (on admission);

[22] 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.

[23] We recommend that providers issue their commissioners with a copy of the agreed joint assessment protocol. Examples are available.

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

- 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);
- a diagnosis and procedure code (in any position) from the list in Annex 5A; and
- HRG from the list in Annex 5A.

SUS PbR will apply the base price to spells with the BPT flag in HRGs from the list in Annex 5A.

SUS PbR will not apply the additional payment. Commissioners determine compliance with best practice using reports compiled from data submitted by providers to the NHFD. The report is available quarterly in line with the SUS PbR reporting timetable[25], i.e. 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 price paid as normal. Payment arrangements for NHFD records entered or completed outside the agreed timeframe must be negotiated locally.

Providers already have access to the NHFD through a lead clinician who is responsible for ensuring the quality and integrity of the data. Commissioners must nominate a data representative with an NHS email account, who will register for access at www.nhfd.co.uk .

Due to changes in information governance, commissioners will no longer be able to link NHFD data to SUS. Instead NHFD reports will now show the total number of patients meeting the best practice payment criteria by CCG.

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:

- improving clinical care and secondary prevention;
- service organisation; and

[25] 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 Health & Social Care 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.

- how to make a case for the posts and resources necessary for the delivery of high-quality, cost-effective care.

The pricing approach is designed to incentivise a change in practice and provide additional funding per patient to adequately fund the costs of best practice.

4.9 Interventional radiology

Interventional radiology (IR) can offer gains in clinical outcome, productivity, patient experience and length of stay when compared with other procedures. The National Imaging Board's publication, *Interventional radiology: Guidance for service delivery*, 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.

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 reimburse 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, provision of IR services will improve.

The IR procedures included in the BPT programme are set out in Table 4A-12.

Table 4A-12: 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)

The procedures covered by the BPT are supported by:

- NICE TA167: Abdominal aortic aneurysm – endovascular stent-grafts;
- NICE IPG367: Uterine artery embolization for fibroids;
- NICE IPG127: Endovascular stent-graft placement in thoracic aortic aneurysms and dissections;
- NICE IPG156: Image guided vacuum assisted excision biopsy of benign breast lesions; and
- The National Imaging Board's publication: Interventional radiology: Guidance for service delivery.

In addition to those procedures covered, The National Imaging Board's publication, Interventional Radiology: Guidance for service delivery, provides evidence for other IR procedures including:

- percutaneous nephrostomy;
- fistuloplasty;
- embolisation for gastro-intestinal bleed; and
- embolisation for trauma.

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.

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.

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.

Annex 5A details the prices, whether they apply at HRG or BPT flag level and the relevant OPCS and ICD-10 codes.

Certain high cost devices are not covered by the BPTs, the cost of which are payable separately. A full list of specified devices which are not reimbursed through national prices can be found in Annex 7B.

4.9.1 Additional coding guidance for interventional radiology BPTs

The information below is provided to assist organisations implement the interventional radiology BPTs.

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

Classification codes for EVAR[26] (OPCS-4 codes):

- L271 Endovascular insertion of stent graft for infrarenal abdominal aortic aneurysm
- L272 Endovascular insertion of stent graft for suprarenal aortic aneurysm
- L273 Endovascular insertion of stent graft for thoracic aortic aneurysm
- L274 Endovascular insertion of stent graft for aortic dissection in any position
- L275 Endovascular insertion of stent graft for aortic aneurysm of bifurcation NEC
- L276 Endovascular insertion of stent graft for aorto-uniiliac aneurysm
- L278 Other specified transluminal insertion of stent graft for aneurysmal segment of aorta
- L279 Unspecified transluminal insertion of stent graft for aneurysmal segment of aorta
- 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:

[26] 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.

- 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

Worked 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).

4.10 Major trauma

The aim of the best practice tariff for major trauma 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.

As described in Section 4 of this consultation notice, the best practice payment criteria are changing in 2014/15.

The BPT is made up of two levels of payment differentiated by the Injury Severity Score (ISS) of the patient and conditional on achieving the criteria set out below.

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

- the patient is treated in an MTC;
- Trauma Audit and Research Network (TARN) data is completed and submitted within 25 days of discharge;
- rehabilitation prescription is completed for each patient and recorded on TARN;

- any coroners' cases are flagged within TARN as being subject to delay to allow later payment;
- tranexamic acid must be administered for those patients receiving blood products within three hours of injury;
- if the patient is transferred as a non-emergency they must be admitted to the major trauma centre within two calendar days of referral from Trauma Unit (TU)27. **This is a new Level 1 criterion for 2014/15**.

A Level 2 BPT is payable for all patients with an ISS of 16 or more providing Level 1 criteria are met and that the following additional criteria are also met:

- 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, but must be present within five minutes (**this is new for 2014/15, the criteria for 2013/14 was 30 minutes**); or
- if the patient is transferred as a non-emergency they must be admitted to the major trauma centre within two calendar days of referral from Trauma Unit (TU)28; and
- Patients directly admitted to a MTC with a head injury (AIS 1+) and a GCS<13 (or intubated pre-hospital), and who do not require emergency surgery or interventional radiology within one hour of admission, receive a head CT scan within 60 minutes of arrival. **This criterion is new for 2014/15**.

We will continue to review these payment criteria in future years to ensure care is of the highest possible standard. While not currently a condition of Level 1 payments, patients with severe injuries being admitted directly to the MTC or transferred as an emergency should be received by a consultant led trauma team as soon as possible (ideally within 30 minutes).

The BPT is not conditional upon the patient's HRG being in the VA chapter (multiple injuries) and applies to both adults and children. Any patients eligible for the major trauma BPT are excluded from the 30% marginal rate emergency admissions threshold. This must be agreed by providers and commissioners.

[27] If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution.

[28] If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution.

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

The BPT will not be applied through SUS PbR and organisations will need to use the TARN database to support payment.

4.11 Outpatient procedures

Performing procedures in an outpatient setting, where clinically appropriate, 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.

As in 2013/14, the BPT covers three procedures:

- Diagnostic cystoscopy;
- Diagnostic hysteroscopy; and
- Hysteroscopic sterilisation.

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 price as a barrier to greater use of hysteroscopic over laparoscopic sterilisation where clinically appropriate and chosen by patients. It is not clear why the reported costs do not accurately reflect the true cost of hysteroscopic sterilisation, but evidence suggests that the device related costs may not be fully apportioned to the HRG.

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 outpatient rate used for BPT calculation, the achievable rate and an estimate of the current rate are detailed in Table 4A-13.

Table 4A-13: Achievable and estimated outpatient rates for diagnostic hysteroscopy and cystoscopy

Procedure	Achievable outpatient rate[29]	Rate for 2014-15 BPT calculation	Estimated[30] outpatient rate
Diagnostic hysteroscopy	80%	60%	43%
Diagnostic cystoscopy	50%	50%	16%

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. By paying a relatively higher price for procedures performed in the outpatient setting, the BPT creates a financial incentive for providers to treat patients in this setting without costing commissioners any more money.

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 national price for MA10Z.

With the advent of new technologies, diagnostic hysteroscopy and therapeutic hysteroscopy can now be safely and effectively carried out in outpatient treatment suites as a combined ‘See & Treat’ service without any need for anaesthesia. Current coding rules do not allow for this activity to be captured in the same visit, and as a consequence providers and commissioners will need to put plans in place locally to capture and pay for this combined activity.

The BPT for all three outpatient procedures apply at the HRG level. SUS PbR will automate payment by applying the relevant prices to the HRG. Annex 5A of this consultation notice details the prices, relevant HRGs, and the relevant OPCS codes.

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[29] 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.

[30] Estimates based on 2011/12 Reference cost activity data. Note HRG design changes for diagnostic cystoscopy mean the rate is based on LB72A.

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.

4.12 Paediatric epilepsy

There are continuing concerns regarding quality of and variance in care for patients with epilepsy in the UK compared to that recommended in NICE clinical guidance 137. This includes misdiagnosis, misclassification, inappropriate drug choices, under referral of epilepsy surgery candidates, inadequate communication, inadequate comorbidity management and school support.

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. The aim of the BPT is to enable access to consistent high quality management of children's epilepsy services.

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

- paediatric consultants[31] with expertise in epilepsies lead the service with ESNs performing an integral role;
- patients 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 ESN. This must cover lifestyle issues as well as medical issues;

[31] 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.

- the follow-up appointments provide sufficient time with both the paediatric consultant (or associate specialist) with expertise in epilepsies and the ESN 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 must be able to be reviewed when clinically required. Outpatient booking systems must be able to guarantee these follow up appointments; and
- 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 the Epilepsy12 national audit.

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. Activity meeting the best practice criteria must be coded against the TFC 223 Paediatric Epilepsy.

Commissioners and providers must 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 price for TFC 420 Paediatrics applies.

The BPT does not include costs related to:

- acute inpatient care;
- new patient assessment;
- epilepsy investigation and treatment costs (e.g. 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; or
- costs of assessment and treatment for other health problems.

SUS PbR will automate payment by applying the BPT to activity coded to TFC 223 paediatric epilepsy. Activity must only be coded to this TFC if it meets the characteristics of best practice.

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 best practice.

4.13 Paediatric diabetes

The aim of the paediatric diabetes BPT is to enable access to consistent high quality management of diabetes. 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.

From April 2014, the BPT will also include inpatient admissions for management of diabetes for these young people and so providers will no longer be reimbursed separately for these admissions. They will continue to be reimbursed for admissions for these young people that are not related to diabetes.

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), i.e. a paediatric diabetes specialist nurse, dietitian and doctor. The doctor must 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 must 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 must be available and recorded at each MDT clinic appointment;

h) all eligible patients must be offered annual screening as recommended by current NICE guidance.[32] Retinopathy screening must 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 must be provided by the regional screening programme;

i) each patient must 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;

[32] CG15 Diagnosis and management of type 1 diabetes in children, young people and adults (July 2004), and TA151 Diabetes - insulin pump therapy (July 2008).

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. They should also participate in peer review;

l) each provider unit must provide patients and their families with 24 hour access to advice and support. This should also include 24 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 must be fully trained and experienced in managing paediatric diabetes emergencies;

m) each provider unit must have a clear policy for transition to adult services; and

n) each unit will have an operational policy, which must 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.

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.

The cost of insulin pumps and associated consumables are not covered by the BPT. Patient education associated with the use of insulin pumps is, however, included in the BPT 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 BPT. Routine prescriptions for insulin, blood glucose testing and ketone monitoring are issued in primary care and so are not part of the BPT.

Where commissioners are satisfied that the standards have been achieved, the BPT must be paid for all the young people attending the clinic.

If a provider admits a young person who is not registered with them, they must invoice the provider with whom the young person is registered. If the young person is not registered with a provider, the admitting provider must invoice the relevant commissioner.

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.

4.14 Parkinson's disease

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).

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

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 only. The BPT excludes the costs of admitted patient care and the cost of any items not covered by national prices.

The criteria for best practice are as follows:

- Referrals from primary care with suspected Parkinson's disease must 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 will continue to be seen within two weeks;
- Each patient must 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 must have a nominated person identified to continue with follow-up and diagnostic review;
- All patients must 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;
- Evidence to demonstrate that the provider is using recognised tools, for example patient feedback, NMS screening tool and cognitive assessment tool; and

- Patients must 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)[33].

Commissioners must 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.

The criteria for the BPT are underpinned by:

- Parkinson's disease: diagnosis and management in primary and secondary care. Clinical guidelines, CG35. National Institute for Health and Clinical Excellence, June 2006;
- National Service Framework (NSF) for long-term neurological conditions. Department of Health, 2005;
- 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 2011; and
- The European Parkinson's disease Standards of Care Consensus Statement. European Parkinson's Disease Association, Volume I, 2011.

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. Therefore, 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 conventional price will not be applied.

One way to identify the activity applicable for consideration against the BPT is to use the non-mandatory diagnosis codes in outpatients (G20X).

[33] There are a small number of circumstances where therapy assessment is not relevant and where providers are able to evidence this, the BPT still applies.

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.

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.

4.15 Pleural effusion

Historically, many patients presenting at A&E with a pleural effusion were 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 aim of this BPT is to incentivise a shift in activity away from non-elective admissions to pleural effusions being performed on a planned elective basis under ultrasound control.

This is achieved by setting the price for elective admissions relatively higher than the non-elective price, therefore creating a financial incentive for the management of patients on an elective basis. 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 effusions. DZ16A has been specifically excluded because patients grouped to this HRG have major complications and co-morbidities.

British Thoracic Society guidelines 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.

The BPT applies to adults only, with undiagnosed unilateral pleural effusions.

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 Annex 5A; and
- An HRG code from the list in Annex 5A.

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.

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.

As with other BPTs designed to incentivise a shift in activity between settings, this BPT is made up of a pair of prices which create a financial incentive, without costing commissioners more. This is achieved by:

- departing from the conventional pricing structure, with the price for the elective care setting set relatively higher than the non-elective price; and
- decreasing the absolute level of prices for both settings to reflect the lower cost of providing a greater proportion of care in the elective setting.

4.16 Primary hip and knee replacement outcomes

Under this new BPT, which is referred to in Section 4, payment of the primary hip and knee replacements outcome BPT is linked to data collected in both Patient Reported Outcome Measures and the National Joint Registry.

The aim of the BPT is to reduce the unexplained variation which exists between providers in terms of patients' own reported outcomes of surgery.

The criteria for payment of the BPT are:

- The provider not having an average health gain significantly below the national average; and
- The provider adhering to the following data submission standards:
  - i. a minimum PROMS participation rate of 50%

ii. a minimum NJR compliance rate of 75%

iii. an NJR unknown consent rate below 25%

The data necessary to measure adherence to the payment criteria, along with further information relating to both collections is available on their respective websites at the links below:

- PROMs – www.hscic.gov.uk/proms
- NJR – www.njrcentre.org.uk

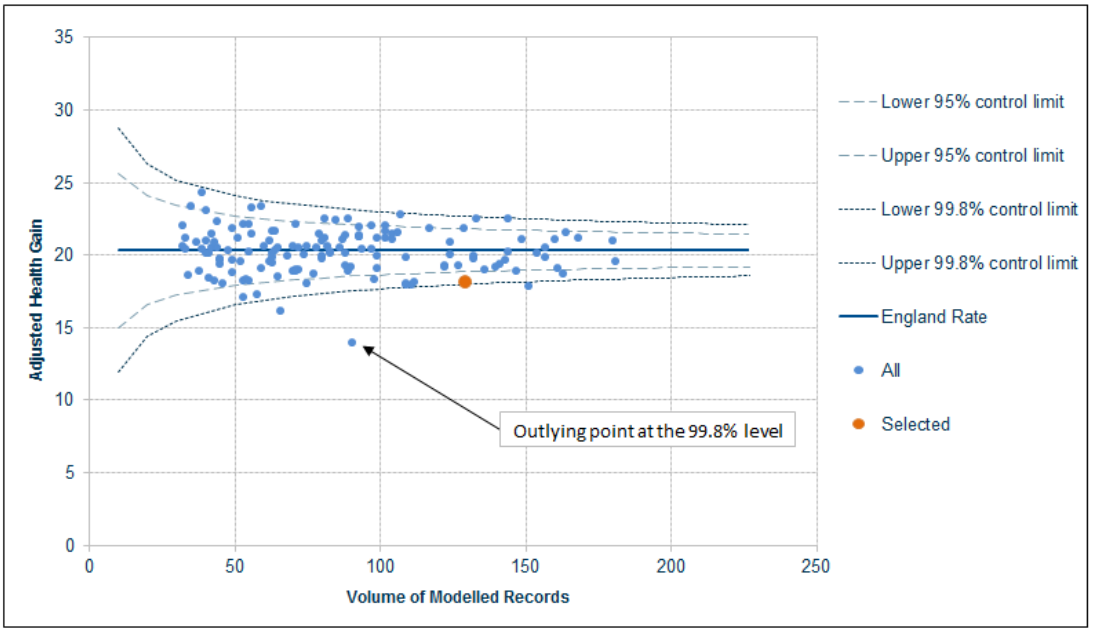
4.16.1 PROMs

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Information is collected about a patient's health status (or health-related quality of life) before surgery and again six months following the procedure, with any change in health state attributed to the intervention. For the purpose of this BPT, changes in health state are assessed using the casemix adjusted condition specific Oxford Hip Score and Oxford Knee Score for primary joint replacements only.

Providers' average health gain is presented in Figure 4A-2 below as a funnel plot and compared to the national average of all providers in England. The funnel plot indicates whether a provider's health gain is statistically significantly different to the national average. For providers below specified significance levels, the PROMs publication identifies providers as outliers, with:

- those below the lower 95% significance level labelled 'alerts'; and
- those below the 99.8% significance level labelled 'alarms'.

Figure 4A-2: PROMs provider score comparison[34]



The proposal for 2014/15 is that providers below the lower 99.8% control limit will not receive the BPT. Whether identified as an outlier or not, all providers should work to achieve the best possible outcomes as outliers are identified relative to the national average, which may change as the data are updated throughout the year.

In order to make the comparisons between providers' outcomes meaningful, a procedure specific casemix adjustment is applied to the PROMs data before inclusion in the funnel plot. These specific adjustments are based on statistical models which predict expected outcomes based on patient characteristics and other factor beyond the control of providers. This allows more accurate comparisons between the average outcomes achieved by different providers. It also means that providers cannot improve their relative position by selecting patients of a particular type as it is the difference between actual and expected health gain that matters, not simply the absolute health gain.

Further information on the casemix adjustment methodology is published by the Department of Health.

[34] Chart adapted from HSCIC's provider score comparison tool, available here.

The method of identifying outliers only works where providers have a minimum of 30 completed questionnaires. Where this is not the case, payment of the BPT is based on providers meeting the data submission requirements of best practice.

The first of these data submission requirements is that providers achieve a minimum participation rate to PROMs. This rate is calculated as the number of pre-operative PROMs questionnaires completed, relative to the number of eligible HES spells.

The PROMs publication also reports a number of other outcome and data submission statistics for primary hip and knee replacements[35]. While not a condition of this BPT, these may be considered as evidence of good practice.

PROMs data are updated on a cumulative basis, meaning the data become more complete over the year. Because the post-operative questionnaire is not administered until 6 months after surgery, compliance to the BPT will need to be assessed against the latest available data at the time of payment. Organisation level data are made available each quarter (typically in February, May, August and November). Data is provisional until a final annual publication is release each year, but for the purpose of the BPT the provisional data shall be used.

In some instances the latest participation figures will relate to a different time period than the outcome measure as post-operative questionnaires are not sent out until six months after surgery and so subject to a greater delay[36].

4.16.2 National Joint Registry

In addition to PROMs outcome and participation, payment of this BPT is conditional on data submitted to the NJR.

[35] These include: EQ5D Index, EQ5D VAS and linkage, issue and response rates.

[36] Although questionnaires are sent out 6 months after surgery, published outcomes will be subject to a further lag while questionnaires are completed, returned and processed.

The NJR is part of the National Clinical Audits and Patient Outcomes Programme and aims to improve patient care by collecting information about joint replacement prostheses and surgical techniques in order to provide an early warning of issues related to patient safety. Providers are required to upload information to the registry after joint replacement, which the NJR use to support quality improvements and best practice through its monitoring and reporting of the outcomes achieved by different prostheses, surgeons and providers. The NJR also supports choice and policy decisions through the data published in its Annual Report. Payment of the BPT is conditional on providers meeting minimum thresholds with regards to two aspects of the NJR data:

1) Compliance – measured as procedures uploaded relative to the number of eligible spells recorded in HES; and

2) Consent – measured as the proportion of uploaded procedures to which patient consent was not requested or is unknown.

As with the PROMs data, there is a short lag between procedure and these being made available through NJR publications. Therefore, commissioners should base compliance on the latest available data at the time of payment.

4.16.3 Data quality

Participation in the data collections is being included to improve the data quality and the accuracy with which outcomes are reported. PROMs participation rates might be improved by distributing the pre-operative questionnaires in a structured and organised way. Integrating the process into the general pre-operative assessment routine is a good way to help ensure high coverage. Providers might also work with their individual supplier who delivers and collects the questionnaires to find a solution that meets their individual needs.

PROMs participation rates for a small number of providers may be greater than 100%. This occurs where the number of PROMs questionnaires returned exceeds the activity recorded in HES. This can occur for a number of reasons, for example where a provider administers the PROMs questionnaire, but the procedure is either carried out at another provider due to subcontracting arrangements, or the procedure is not carried out at all due to unforeseen circumstances. Where this causes issues with assessing adherence to the best practice characteristics, providers and commissioners should reach local agreement as to whether thresholds are met.

While not a condition of this BPT, there are some things which providers can do to improve the accuracy of their reported rates:

- Some providers choose to administer the pre-operative PROMs questionnaire at a pre-assessment clinic prior to admission. This means that questionnaires may be received for cancelled operations for which there is no episode in HES. Administering questionnaires closer to, or actually on the day of admission may reduce the chances of this happening; and
- Clinical coding problems could mean that questionnaires cannot be linked to HES because of poor or incomplete clinical coding. Ensuring that all procedures are fully coded would help this.

NJR Compliance rates reflect the extent to which eligible hip and knee joint replacement procedures recorded in HES correspond to a record in the NJR. These compliance rates may report to be greater than 100% when the number of records uploaded to the Registry exceeds a provider's HES activity recorded in HES. This may reflect inaccuracies in the coding of HES data, or may be where activity is sub-contracted to another provider, such that HES reports activity at the primary provider, but the corresponding NJR record is recorded against the sub-contracted provider.

To improve NJR Compliance, a provider must ensure that both NJR and HES data accurately reflects joint replacement activity undertaken within and on behalf of the organisation. Providers should work with their local NJR Regional Co-ordinator to address any issues in NJR Compliance.

4.16.4 Operational

SUS PbR will automate payment of the BPT for all elective activity coded to the four relevant HRGs (HB12B, HB12C, HB21B and HB21C). Commissioners will need to monitor PROMs and NJR publications to determine whether providers are complying with the payment criteria. Where this is not the case, commissioners should reduce payments to the non-best practice price until an improvement is shown in the published data.

The aim of the BPT is to improve patient outcomes and it should not be seen as a way for commissioners to reduce funding. Therefore, before adjusting payment, it is expected commissioners will discuss the data with providers and support any action to improve outcomes.

As set out in Section 6 of this consultation notice, there are some variations to the BPT whereby commissioners must continue to pay the full BPT, even where providers are not meeting all of the best practice payment criteria. For this to apply providers must satisfy commissioners that one of the following scenarios applies:

- where recent improvements are not yet reflected in the nationally available data; or
- where providers have identified why they are an outlier on PROMs scores and have a credible improvement plan in place, the impact of which is not yet known; or
- where a provider has a particularly complex casemix which is not yet appropriately taken into account in the casemix adjustment in PROMs.

The rationale for each is set out below.

Scenario 1: Recent improvements

Because of the lag between data collection and publication, recent improvements in patient outcomes may not be shown by the latest available data. In these circumstances providers will need to provide evidence to support a claim that outcomes have subsequently improved.

Scenario 2: Planned improvements

To mitigate the risk of outcomes deteriorating for those providers not meeting the payment criteria, commissioners must continue to pay the full BPT if providers have identified shortcomings with their service and can evidence a credible improvement plan.

In both situations, the variation would be a time limited agreement, with improvements needing to materialise in the published data for reimbursement at the BPT level to be maintained.

Scenario 3: Casemix

In addition, providers that have a particularly complex casemix and who cannot demonstrate that they meet the best practice criteria may request that the commissioner continues to pay the full BPT. Although the PROMs results undergo a casemix adjustment, there may be rare instances where providers facing an exceptionally complex casemix are identified as outliers in the PROMs publications. Where this is the case, commissioners will likely already be aware of the issue. We anticipate that any such agreement would only be valid until such time as the casemix adjustment in PROMs better takes into account complexity.

4.16.5 Improving outcomes

There are many factors which affect patient outcomes and the way in which any improvements are achieved is for local determination. However, the following suggestions may be of use in supporting discussions between providers and commissioner when planning improvements.

The headline PROMs scores can be broken down into individual domain scores, and if required providers can request access to individual patient scores through the HSCIC. Providers might look at which questions they perform badly on to identify why they have been identified as an outlier.

Individual patient outcomes might also be compared against patient records to check for complications in surgery or comorbidities which may not be accounted for in the casemix adjustment. It would also be sensible to check whether patients attended rehabilitation sessions once discharged from hospital.

Reviewing the surgical techniques and prosthesis used against clinical guidelines and NJR best practice recommendations is another way in which providers might attempt to address poor outcomes. As well as the surgical procedure itself, outcomes can be improvement by scrutinising the whole of the care pathway to ensure there is not another area that is affecting outcomes.

Providers may also choose to work collaboratively with those identified as having outcomes significantly above average to learn from service design at other organisations. Alternatively, providers can consider conducting a clinical audit, a quality improvement process that seeks to improve patient care and outcomes through a systemic review of care against expected criteria.

4.17 Same day emergency care

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.

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 prices to be developed to encourage further shifts from the admitted setting.

The 19 scenarios have been selected from the NHS Institute's *Directory of AEC in Adults*. 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.

Table 4A-14 shows the current 'same day' rate for each of the 19 clinical scenarios, as well as the 75th percentile same day rate used to calculate the BPT. It is believed that these rates represent a sufficiently challenging, but achievable, rate for most providers. It also means that there is a margin within the BPT prices to accommodate local circumstances where providers have started to implement AEC pathways in the non-admitted setting.

Table 4A-14: Same day emergency care clinical scenarios

Clinical scenario	75th percentile rate (used to calculate BPT prices) (HES 2010-11[37])	Current national average rate (HES 2011-12)
Abdominal pain	40%	35%
Anaemia	16%	14%
Bladder outflow obstruction	30%	24%
Community acquired pneumonia	12%	20%
Low risk pubic rami	13%	10%
Minor head injury	64%	56%
Supraventricular tachycardias (SVT) including atrial	34%	29%
Epileptic seizure	35%	28%
Acute headache	43%	35%
Pulmonary embolism	18%	14%
Asthma	30%	24%
Lower respiratory tract infections without chronic obstructive	49%	43%
Chest pain	50%	46%
Falls including syncope and collapse	41%	36%
Appendicular fractures not requiring immediate fixation	39%	29%
Cellulitis	35%	26%
Renal/ureteric stones	45%	35%
Deep vein thrombosis	75%	53%
Deliberate self harm	56%	47%

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%.

[37] Based on 2010-11 HES as per the 2013/14 national tariff.

The BPT for each clinical scenario listed above 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. By paying a relatively higher price for same day cases, the BPT creates an incentive for providers to manage patients in this way.

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.

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.

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. Therefore, organisations may agree local payment variations that either encourage development of pathways outside of the admitted setting or ensure adequate reimbursement for acute providers that have already established such pathways.

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 PbR[38]. 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);

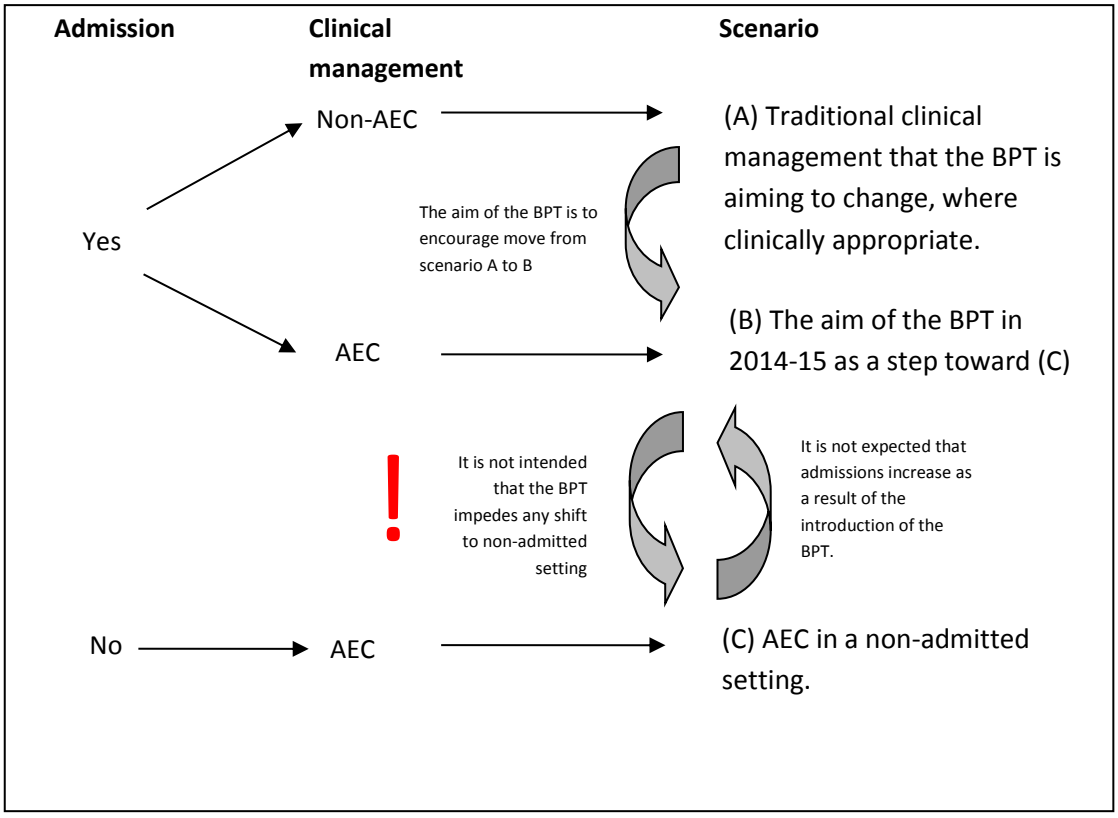
[38] This will only happen for Same Day Emergency Care BPTs because SUS PbR requires a flag to differentiate between currencies on the basis of zero day length of stay and greater than zero days length of stay.

- a primary diagnosis from the list in Annex 5A; and
- an HRG from the list in Annex 5A.

Annex 5A of this consultation notice details the prices, whether they apply at HRG or sub-HRG level and the relevant ICD-10 codes.

Figure 4A-3 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 4A-3: Model of managing patients suitable for ambulatory emergency care



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 Scenario C) for example where scheduled care in an urgent or routine outpatient setting is most appropriate. It is important that the national price does not constrain local innovation and service redesign.

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.

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.

4.18 Transient ischaemic attack

The BPT is aligned with quality markers 5 and 6 of the National Stroke Strategy.

The BPT is made up of two components: a base price and a conditional payment. Both components are conditional on meeting best practice characteristics, though they are payable separately. The components are described below:

- Base price payable to providers meeting minimum best practice criteria. Providers not meeting these will be paid the alternative TFC price. 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:

  a) all patients are assessed by a specialist stroke practitioner, who has training, skills and competence in the diagnosis and management of TIA. This must be consistent with the UK Forum for Stroke Training;

  b) 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;

  c) clinics are provided seven days a week, even if this is via a service level agreement with another provider;

d) all patients are diagnosed and treated within seven days of first relevant presentation of the patient to any healthcare professional regardless of risk assessment; and

e) 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 must 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 agree the level of re-imbursement locally.

- Additional payment for investigation and treatment of high risk patients[39] within 24 hours. The timeframe is aligned with the vital sign for TIAs and mini-stroke, and is defined as follows:

  a) the clock starts at the time of first relevant presentation[40] of the patient to any health-care professional (e.g. a paramedic, GP, stroke physician, district nurse or A&E staff); and

  b) the clock stops 24 hours after this initial contact, by which time all investigations[41] and treatments[42] should be completed.

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

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[39] 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.

[40] Re-classification of patient risk does not later clock start time.

[41] 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).

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

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

SUS PbR will:

a) apply the base price to activity coded under the appropriate TFC; and

b) prevent generation of an outpatient procedure e.g. where 24 hour ECGs are performed, when reported against the TIA TFC.

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 must supply risk assessment data and compliance to qualify for the additional payment; or

c) apply pricing to follow-up attendances.

5 Maternity pathway payment system

5.1 Introduction

The maternity pathway payment system was mandated in April 2013 following a shadow year.

The new pathway payment approach was introduced to address two main issues arising from the previous episodic payment system. First, there were problems with the way different organisations described and recorded antenatal and postnatal non-delivery activity which persisted despite changes implemented every year to attempt to resolve the problems. Second, under the old system, organisations were paid for each inpatient spell, scan or hospital visit, so that the more clinical interventions, the more a hospital was paid. This is may have been counter to some patients' interests who benefit most from proactive care, closer to home.

The new approach aimed to resolve these issues and to encourage a more proactive and woman-focused approach to the delivery of maternity care. In conjunction with patient choice and local contracts that focus on quality, this payment approach frees providers to develop services that promote their patients best interests.

The new payment approach also included some services that were previously part of local contracts and not covered by mandatory national prices, such as community antenatal and postnatal care. The cost of these services is now covered by the pathway payments instead.

5.2 How was the pathway payment system developed?

The project to develop the pathway payment system began in September 2010 and involved a wide range of key stakeholders from the outset.

NICE guidance provided the initial foundation for the pathways, while clinical and commissioning experts developed the approach to allocating women to different pathway levels on the basis of their characteristics. Midwives across the country tested the system for two months, looking at the characteristics and factors affecting nearly 7,000 pregnant women.

In addition, several NHS providers undertook detailed costing work to ensure that the groupings created on the basis of service user characteristics really did bring together women that would consume similar levels of resources.

Using the information from the testing phases, price levels were calculated to distribute the same level of total funding that has been spent on maternity services in the past (approximately £2.5bn). The new pathway payment system changes the way money flows within maternity services but has no effect on the overall level of funding (except if there is a change in the birth rate).

5.3 Key features of the pathway payment system

For payment purposes, the pathway is split into three stages. Women choose their lead provider for each stage of the pathway: antenatal care; delivery; and postnatal care. Commissioners pay once for each of these stages per woman.

This could mean three separate payments to the same lead provider or three payments to different lead providers.

At its core, the system is simple. And for most cases, it will provide a simple and easy to administer mechanism. However, it also needs to cope with non-standard events such as:

- How to deal with choice or referrals where a different provider undertakes some elements of care.
- How to deal with a change in lead pathway provider and/or commissioner.

These rules are particularly important given that all providers of maternity care should be working within a local network that ensures all choices are available to women throughout the maternity pathway.

Under the system, a commissioner will pay a provider for all the pregnancy-related care a woman may need for the duration of her pregnancy, birth and postnatal care. In general there will be no further payments for individual elements of activity, although there are a small number of clearly identified exceptions.

Each lead provider retains full responsibility for how they deliver care for their women, while commissioners will judge providers solely on how well they have delivered their overall service. The clear aim is to encourage proactive care and prevention, rather than reaction.

This responsibility remains even where a woman chooses to use a different provider, or is referred elsewhere, for an element of their care. In these circumstances, the lead provider, who has received the pathway payment for this woman, will be required to pay the second provider.

Payments for the delivery itself will continue to be triggered by the specific codes attached to the birth/intrapartum spell. Providers must continue to code these in exactly the same way as they code them now.

However, the differently coded spells will be grouped to one of just two payment categories – "with complications or comorbidities" and "without complications or comorbidities"[43].

There will be no difference in payment for different methods of delivery - normal, assisted or caesarean section.

In the absence of clinical indications to the contrary, normal deliveries are seen as having advantages for mothers and babies. The payment system aims to promote a culture based around normality and should support providers in developing an environment that encourages women to choose normality rather than intervention.

5.3.1 How the system works

Table 4A-15 below sets out what is included and excluded from all three stages of the payment system; antenatal care, delivery and postnatal care.

Table 4A-15: Maternity pathway payments

Area	Included	Excluded
Admitted patient care	All activity against NZ* HRGs (regardless of TFC) (includes fetal medicine[44])	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 (except with a TFC of 501 or 560) An attendance TFC other than 501 (obstetrics) or 560 (midwife

[43] The DH's website shows the list of complications and co-morbidities.

[44] The position with regard to specialist medicine is under review and may change in future years.

Area	Included	Excluded
	(includes fetal medicine)	episode) Emergency gynaecology and early pregnancy activity will normally code to TFC502 or non NZ* HRGs and will therefore be excluded
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[45][46].	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	Pathways for unwell/unhealthy

[45] Universal screening includes routine infectious diseases and fetal anomaly screening and for the neonate, routine examination of the newborn, blood spot and newborn hearing screening.

[46] For further advice, for example on payments for confirmatory screening, please refer to the Public Health Lead at your local NHS England Area Team

Area	Included	Excluded
	during the delivery module and pathway checks/screening during the postnatal module	babies. Babies requiring admitted patient care treatment will have their own admission record
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 (e.g. 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 specified high cost drugs and devices not covered by national prices

The next three sections set out guidance and business rules for each of the three pathway modules.

5.4 The antenatal pathway

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 will regard the organisation that first submits this information as the lead provider, and therefore that organisation will receive the payment.

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 described below and set out in more detail in Annex 4B (maternity data requirements and definitions).

- If a woman has one or more of the “intensive resource” characteristics, she is allocated to the intensive pathway, irrespective of any other factors;
- 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; and
- If a woman does not have any of the listed characteristics, she is allocated to the “standard resource” pathway.

The national proportions of women in each antenatal category, based on findings from the development project, are:

- Standard: 65.5%
- Intermediate: 27.3%
- Intensive: 7.1%

The antenatal pathway is derived by using data items from the new Maternity Data Set as well as some other local information.

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. Other than diabetes, 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.

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. The information will be used to assign each woman to the correct pathway.

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.

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.

5.4.1 Arrangements between providers

Where a woman chooses to use a provider other than the lead provider for part of her care (e.g. 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.

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.

Non-mandatory prices are provided in the national tariff information workbook, and may be used as a guide to determining invoice levels. Where there are no published prices, prices must be agreed between the two organisations.

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.

Providers must 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 must invoice the lead provider.

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 4A-16. 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 4A-16: Proportion of pathway price 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%

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 must be based on the value of the higher resources pathway.

When a woman changes both commissioner and provider (e.g. if she moves house) any refunds to the original commissioner are on the basis of the original categorisation at the antenatal assessment appointment, i.e. if the original pathway was “standard”, the proportion of refund is based on the standard payment price. 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.

Examples are provided below to aid understanding of this issue.

Example 1

Woman categorised as Standard based on antenatal assessment appointment information	Payment of e.g. £1,200[47] 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 price (e.g. £3,000 * 33% = £1000) to Lead Provider B

Example 2

Woman categorised as standard based on antenatal assessment visit information	Payment of e.g. £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 (e.g. £3,000 * 33% = £1000) from commissioner B to provider B

[47] Not actual price.

Pregnancies that end early

The antenatal payment is payable for all pregnancies where an antenatal assessment is undertaken, regardless of when they end.

Contracts must contain local outcomes and quality measures to incentivise reducing the number of avoidable pregnancy losses.

The cost of obstetric/maternity-related healthcare activities (with an NZ HRG or coded to TFC 501 or 560) for pregnant women whose pregnancy ends prior to the antenatal assessment visit must not be separately reimbursed. Activity which is currently coded to TFC 502 (Gynaecology) must be separately reimbursed.

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

Care delivered under the pathway payment system may span more than one financial year. Commissioners and providers may wish to agree on apportioning the payments due appropriately between the two financial years. Alternatively, a simple solution may be that, in future, providers receive payments for all those women who begin their pathway within one financial year.

5.5 The delivery pathway

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 mothers and their babies (unless the babies have identified health problems) until transfer to community postnatal care Additional ‘per day’ payments will apply for patients who stay longer than pre-set durations (known as trim points).

The national average proportions for with and without complications and comorbidities are:

- With CCs: 28.6%
- Without CCs: 71.4%

The following list provides further information on the delivery pathway prices: The prices set already take into account the higher-cost types of births, such as caesarian sections;

- The complications and co-morbidities are based on ICD diagnosis codes and are listed in the HSCIC's grouper documentation;
- 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;
- 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;
- 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;
- A provider must not decline pathway responsibility on the basis that the care or delivery may be expensive;
- 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;
- Where more than one provider shares the care (e.g. 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.

5.6 The postnatal pathway

The postnatal care pathway follows the same format as the antenatal pathway, with three levels of payment based on expected resource usage - *Standard, Intermediate* or *Intensive.* The relevant payment will be determined by a woman's specific health and social care characteristics and factors. These are set out in Annex 4B (maternity data requirements and definitions).

These factors and characteristics will include those collected at the antenatal booking appointment, but supplemented with information gathered throughout the previous stages of the maternity. There will be no need to collect "new" data.

The average proportion of women in each postnatal category, based on findings from the project, are:

- Standard: 64.2%
- Intermediate: 35.0%
- Intensive: 0.8%

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.

Commissioners must be aware that they will need to 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

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.

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 of who provides the postnatal care.

Payment is based on the postnatal lead pathway provider providing information to the commissioner about the relevant characteristics and factors that assign each woman to their relevant pathway after discharge from postnatal care.

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.

Once a pathway level has been assigned to a patient (i.e. usually when being discharged following the intrapartum episode), then the pathway level stays at the original level determined.

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.

There are some specific exceptions. NICE guidance identifies some potential postnatal complications that require immediate urgent acute care, where payment must be claimed from local commissioners. These are listed below:

- Intervention for postpartum haemorrhage;
- Intervention for genital tract sepsis;
- Intervention for venous thromboembolism;
- Intervention for breast mastitis, abscess;
- Postnatal wound infection requiring surgery; and
- Pulmonary embolism.

Payment for the above will be based on the relevant HRGs

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.

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.

There is no defined time period during which community postnatal care is provided by the maternity team.

The pathway continues until responsibility for ongoing maternity health care is transferred to primary care / the health visitor.

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.

Commissioners should introduce local outcome and patient experience indicators to ensure the highest quality care and the timing for handover of responsibility is safe.

5.7 Information flows for the antenatal and postnatal pathways

It is expected that the maternity minimum data set will be available in April 2014. Commissioners and providers will need to agree local information flows for the supplementary data required for the antenatal and postnatal pathway modules. For further information on data definitions and requirements see Annex 4B (maternity data requirements and definitions).

Unlike in SUS, the new system does 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 and the supplementary data from local information flows.

The window between the reporting period for the activity and the deadline is expected to be about four weeks.

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.

Furthermore, 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.

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.

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. Providers must provide information to their commissioners about the number of women for whom HIV status will result in a move from the standard or intermediate pathways to the intensive pathway, so that contract payments can be adjusted.

6 Cystic Fibrosis pathway payment

The cystic fibrosis (CF) pathway currency is a complexity-adjusted yearly banding system with seven bands of increasing patient complexity. There is no distinction between adults and children.

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).

Patients are allocated to a band by the Cystic Fibrosis Trust using data from its national database, the UK CF Registry.

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

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

For any patient admission or outpatient contact in relation to cystic fibrosis, the HRG is included in the Year of Care payment regardless of whether it is one of the CF specific diagnosis driven HRGs or not. All outpatient CF activity must be recorded against TFC 264 and TFC 343.

Some elements of services, included in the CF pathway payments, 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 (e.g. 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 prices paid to the specialist CF centre.

There are a number of specified services which require local negotiation on price:

- High cost CF specific **inhaled/nebulised** drugs: Colistimethate sodium, Tobramycin, Dornase alfa, Aztreonam Lysine, Ivacaftor and Mannitol;
- Insertion of gastrostomy devices (PEG) and insertion of totally implantable venous access devices (TIVADs) are not included in the annual banded prices. These surgical procedures will be reimbursed via the relevant HRG price; and
- Neonates admitted with meconium ileus who are subsequently identified to have cystic fibrosis will not be subject to the CF pathway payment until they have been discharged after their initial surgical procedure. This surgical procedure will be reimbursed via the relevant HRG price. Once discharged after their initial surgical procedure subsequent CF treatment will be covered by the CF pathway payment. Annual banding will not include the period they spent as an admitted patient receiving their initial surgical management.

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

7 Looked After Children Health Assessments

Looked after children are one of the most vulnerable groups in society and data show that they have poorer health outcomes than other children with a corresponding adverse impact on their life opportunities and health in later life. Section 4 of this consultation notice explained that arrangements for commissioning and carrying out health assessments for children placed out-of-area are variable, resulting in concerns over the quality and scope of assessments. To address this, a currency was devised and mandated for use in 2013/14, including a checklist for the components that must be included in the assessment. This checklist is set out below.

Checklist tool

This must 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 competences 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.

Child's Name			
NHS Number			
Date of Health Assessment[48]			
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: • Pre-existing health issues • Any newly identified health issues			
• Recommendations with clear time scales and identified responsible person			
• Evidence that referrals to appropriate services have been made.			
• A chronology or medical history including identified risk factors.			
• An up to date Immunisation summary			
• Summary of Child Health Screening			
• 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 recorded			
Evidence that Carer's concerns/comments have been sought and recorded.			
Evidence that information has been gathered to inform the Assessment from the placing Social Worker and			

[48] This should be within 28 days of the request.

other health professionals providing care e.g. (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, behavioural 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

2) Who pays? Determining responsibility for payment to providers