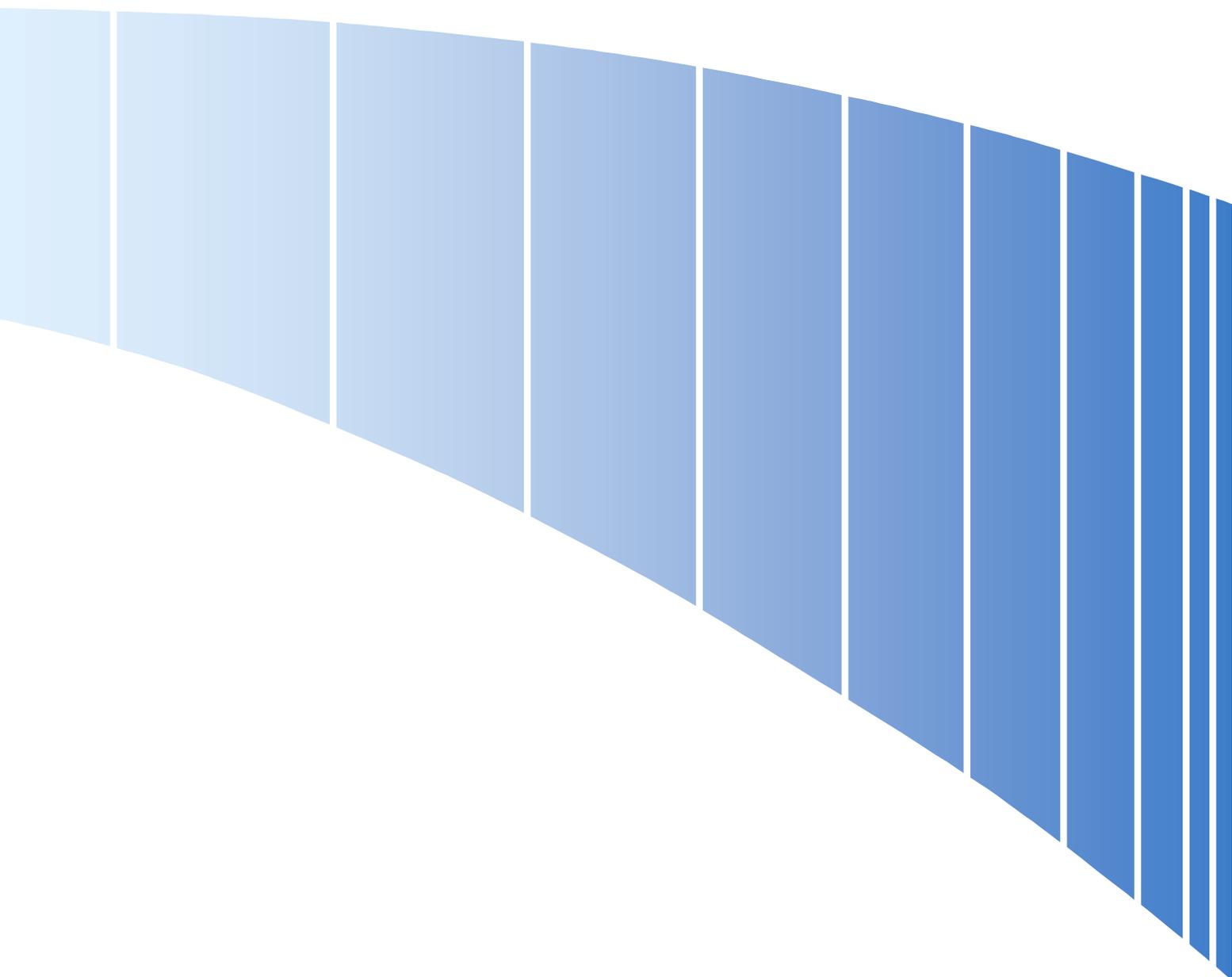


Payment by Results Guidance for 2011-12



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List of tables.....	7
List of figures	8
List of abbreviations	9
Section 1: Introduction	11
Purpose.....	11
Main changes in 2011-12	11
Incentivising quality and better outcomes for patients	12
Embedding efficiency and value for money within the tariff	12
Promoting integration and patient responsiveness	13
Expanding the scope of the tariff	13
Other changes	13
Scope of the national mandatory tariff.....	14
Uplift and efficiency	14
Queries and feedback	15
Section 2: Classification, currency and grouping	16
Currency.....	16
Classification	16
Grouping	16
Data stages	17
PbR pre-processing stage	17
Grouping stage	18
PbR post-grouping stage	18
PbR adjustments stage.....	19
Section 3: Admitted patient care	20
Structure.....	20
Elective care.....	20
Emergency readmissions	21
Re-ablement and post discharge support.....	24
Marginal rate emergency tariff.....	26
Purpose	26
Application	26
Defining emergency	26
Setting the baseline	27
SHA risk pool	28
Short stay emergency adjustment.....	29
Long stay payments	29
Specialised service top-up payments	31
Alteplase adjustment.....	32
Pricing adjustments.....	32
Home births.....	33
Antenatal admissions	33
Zero price	33
No tariff price.....	34
Section 4: Outpatient care	35
Structure.....	35
Outpatient procedures.....	35
Outpatient attendances	36
Expanding the scope	36
Eligibility.....	37

Consultant led and non-consultant led.....	37
First and follow-up attendances.....	38
Multi-professional and multi-disciplinary.....	39
Rebundling of diagnostic imaging.....	41
Pre-operative assessments.....	41
Zero price.....	41
Section 5: Urgent care.....	42
Accident and emergency services.....	42
Major trauma.....	42
Section 6: Best practice tariffs.....	43
Introduction.....	43
Adult renal dialysis.....	44
Characteristics of best practice.....	44
Tariff structure and prices.....	45
Implementation.....	48
Cataracts.....	50
Cholecystectomy.....	51
Day cases.....	51
Characteristics of best practice.....	51
Tariff structure and prices.....	52
Implementation.....	53
Fragility hip fracture.....	54
Interventional radiology.....	56
Characteristics of best practice.....	56
Tariff structure and prices.....	57
Implementation.....	58
Paediatric diabetes.....	58
Primary total hip and knee replacements.....	59
Characteristics of best practice.....	59
Tariff structure and prices.....	60
Implementation.....	60
Stroke care.....	61
Immediate post-acute phase of rehabilitation.....	61
Tariff structure and prices.....	63
Transient ischaemic attack.....	65
Characteristics of best practice.....	65
Tariff structure and prices.....	67
Implementation.....	68
Section 7: Exclusions.....	69
Introduction.....	69
Excluded services.....	71
Excluded procedures.....	71
Soft tissue sarcoma surgery.....	71
PETCT.....	72
SPECTCT.....	72
Cardiovascular magnetic resonance imaging.....	72
Pelvic reconstructions.....	72
Head and neck reconstructive surgery.....	72
Intracranial telemetry.....	72

Excluded HRGs.....	73
Excluded TFCs.....	73
Excluded drugs	73
Excluded devices	74
Chemotherapy.....	75
Section 8: Non-mandatory prices.....	78
Introduction	78
Acute phase of rehabilitation	79
Adult hearing services	79
Airflow studies	79
Direct access diagnostic imaging	79
Direct access echocardiograms	80
Home haemodialysis	80
Neurology and neurosurgery	81
Non face-to-face outpatient attendances.....	81
Section 9: Mental health currencies	82
Introduction	82
Mental health clustering tool.....	82
Care clusters	83
Cluster payment periods	84
Initial assessment.....	85
What is an initial assessment?	85
Duration of initial assessments	86
Funding initial assessments.....	87
Existing service users	87
Pricing assessments.....	87
Clusters as contract currency.....	88
Quality and outcomes.....	89
Clusters and IAPT	89
Non-contract activity.....	90
Interaction between care cluster and acute HRGs	91
Other known issues.....	91
Section 10: Other currencies	92
Introduction	92
Ambulance services	92
Critical care	92
Cystic fibrosis	94
Smoking cessation	97
Currencies and tariffs in future years	98
Section 11: Flexibilities	99
Introduction	99
Additional outpatient procedure HRGs	100
Antenatal admissions	100
Bundling for pathways.....	100
Complex diagnostic imaging	100
Infectious disease isolation units.....	100
Innovation payments	101
Service redesign	101
SHA flexibilities	102

Specialised cardiac services	102
Variations to tariff	102
Unbundling	103
Section 12: Other operational issues	104
Market forces factor.....	104
Monthly reporting	104
Non-contract activity.....	105
Devolved administrations	106
Dehosting	106
Never events	107
NHS number	108
Annex A Figure 1: Admitted patients	109
Annex A Figure 1a: Emergency readmissions rule	110
Annex A Figure 1b: Emergency readmissions rule and transfers	111
Annex A Figure 1c: Emergency readmissions rule and exclusions.....	112
Annex A Figure 1d: Short stay emergency adjustment.....	113
Annex A Figure 1e: Long stay payments	114
Annex A Figure 1f: Specialised services top-ups.....	115
Annex A Figure 1g: Alteplase adjustment.....	116
Annex A Figure 1h: Home births.....	117
Annex A Figure 2a: Outpatient attendances	118
Annex A Figure 2b: Outpatient procedures (and determining appropriate attendance)	119
Annex A Figure 3: A&E	120
Annex A Figure 4a: Cataracts best practice tariff.....	121
Annex A Figure 4b: Day case best practice tariffs	122
Annex A Figure 4c: Fragility hip fracture best practice tariff.....	123
Annex A Figure 4d: Primary total hip and knee replacement best practice tariff.....	124
Annex A Figure 4e: Stroke best practice tariff.....	125
Annex A Figure 4f: TIA best practice tariff	126
Annex B: Identification flags.....	127
Annex C: NHFD reports for the fragility hip fracture best practice tariff	129
Annex D: Coding guidance to generate BPTs for EVAR and UFE	131
Annex E: Best practice characteristics for primary total hip and knee replacements	133

List of tables

Table 1: 2011-12 uplift	14
Table 2: Applying PbR rules to patient data	17
Table 3: Tariff type and CDS	17
Table 4: Setting the baseline	27
Table 5: Short stay emergency adjustment percentages	29
Table 6: Long stay payments by HRG chapter	30
Table 7: Specialised service top-ups	31
Table 8: Apportioning CNST costs to HRGs	32
Table 9: Zero price HRGs	33
Table 10: Zero price outpatient TFCs	41
Table 11: Application of tariff adjustments to best practice tariffs	44
Table 12: Haemodialysis tariff prices	46
Table 13: Peritoneal dialysis tariff prices	47
Table 14: National Renal Dataset fields	49
Table 15: Cataracts pathway	50
Table 16: Day case BPTs	51
Table 17: Breast surgery	52
Table 18: General surgery	53
Table 19: Gynaecology/urology	53
Table 20: Orthopaedic	53
Table 21: Urology	53
Table 22: Fragility hip fracture best practice tariff HRGs	55
Table 23: EVAR and UFE prices	57
Table 24: Primary hip and knee replacement BPT prices	60
Table 25: Total tariff for high and lower risk TIA patients	67
Table 26: Changes to the exclusions list	70
Table 27: Definition of soft tissue sarcoma surgery procedure exclusion	72
Table 28: Changes to the 2010-11 device exclusion list	75
Table 29: Summary of payment arrangement for chemotherapy HRGs	76
Table 30: Hormonal treatments and supportive drugs	77
Table 31: Non-mandatory prices for home haemodialysis	80
Table 32: Mental health clusters	84
Table 33: Progress on services excluded from the clusters	90
Table 34: Adult critical care benchmark data	93
Table 35: Neonatal critical care benchmark data	94
Table 36: Cystic fibrosis banding matrix	95
Table 37: Indicative prices for smoking cessation	98
Table 38: Monthly reporting dates	105
Table 39: Fragility hip fracture activity	127
Table 40: BPT flags	128

List of figures

Figure 1: Emergency readmissions	23
Figure 2: Setting the differential for renal dialysis HRGs	46
Figure 3: Transition to mandatory tariff for adult renal dialysis.....	50
Figure 4: Quality markers from the National Stroke Strategy.....	65
Figure 5: Initial assessment classifications	86
Figure 6: Costing matrix.....	87
Figure 7: Worked example for cystic fibrosis banding.....	95
Figure 8: Mean yearly cystic fibrosis treatment costs by band.....	97

List of abbreviations

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

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

Section 1: Introduction

Purpose

1. This guidance provides information to support the operation of Payment by Results (PbR) in 2011-12. It should be used alongside the following¹:
 - (a) *2011-12 tariff spreadsheet*, which includes:
 - i) 2011-12 national mandatory tariffs – for admitted patient care, outpatient procedures and attendances, accident and emergency (A&E), and best practice tariffs
 - ii) 2011-12 non-mandatory prices – for specified services
 - iii) specialised service top-ups – percentages, eligible providers, ICD-10 and OPCS-4 trigger codes
 - iv) best practice tariffs – identification flags, ICD-10 and OPCS-4 trigger codes
 - v) PbR exclusions – showing services, procedures, admitted patient care Healthcare Resource Groups (HRGs), outpatient attendance Treatment Function Codes (TFCs), drugs and devices excluded from the scope of PbR
 - vi) 2011-12 market forces factor (MFF) payment index and underlying index values
 - vii) unbundled HRGs – indicating whether they have a separate tariff, have had their costs rebundled, or are excluded from PbR
 - viii) worked examples for the rules governing payment for emergency activity
 - (b) *Code of Conduct for PbR 2011-12* – establishes the principles that should govern organisational behaviour under PbR and sets expectations as to how the system should operate
 - (c) *Step-by-step guide: calculating the 2011-12 national tariff* - where this guidance raises questions about the calculation of the tariff we recommend readers consult the step-by-step guide
 - (d) *PbR and the market forces factor in 2011-12* – comprehensive guidance on the application of the MFF in PbR
 - (e) *PbR Q&A for 2011-12* – questions and answers to complement the issues covered in this guidance
 - (f) *Guidance for the implementation of SUS PbR from April 2011*².
2. Newcomers to PbR might like to begin with *A simple guide to Payment by Results*.

Main changes in 2011-12

3. The *revision to the operating framework for 2010-11*³ and the health white paper *Equity and Excellence: Liberating the NHS*⁴ set out priorities for the development of the payment system. The design and structure of the national tariff for 2011-12 signals the

¹ www.dh.gov.uk/pbr. The documents at (c), (e) and (f) will be available shortly.

² Available at www.connectingforhealth.nhs.uk/systemsandservices/sus/supports/pbr/pbr-guidance/index.html in due course.

³ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

⁴ www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

start of a series of changes to be made over the coming years, and has been informed by a number of priorities:

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

Incentivising quality and better outcomes for patients

4. We are expanding best practice tariffs into the following service areas (paragraph 162):
 - (a) **adult renal dialysis** – mandated transition to national prices which will incentivise optimal form of vascular access for patients undergoing haemodialysis, together with reimbursement on an activity rather than fixed contract basis using data items defined in the national renal dataset (NRD)
 - (b) a range of **day case procedures** - as we did in 2010-11 with cholecystectomy, we have set prices to incentivise providers to increase their day case rates whilst ensuring that overall best practice does not cost commissioners more
 - (c) **interventional radiology** – incentivises use of the minimally invasive techniques of endovascular aortic repair and uterine fibroid embolisation
 - (d) **primary total hip and knee replacements** – sets prices for a number of HRGs to encourage best clinical management of patients and minimal lengths of stay
 - (e) **transient ischaemic attack** (or mini-stroke) – a tariff for timely and effective outpatient systems for treating patients with TIA to complement the existing acute stroke best practice tariff
 - (f) **paediatric diabetes** – a non-mandatory payment to encourage the running of high quality paediatric diabetes clinics.
5. We are rolling forward existing best practice tariffs, but with revisions to **fragility hip fracture** (paragraph 211) and **acute stroke** (paragraph 242) that increase the payment differential between best and standard practice.

Embedding efficiency and value for money within the tariff

6. We are embedding efficiency and value for money within the tariff by:
 - (a) **setting all tariffs 1% below the mean average of reported costs**
 - (b) better targeting of **long stay payments** by introducing a minimum trim point of 5 days, so that relatively short stays do not attract a payment (paragraph 90)
 - (c) incentivising the provision of care in less acute settings where clinically appropriate by
 - i) **setting prices for a small number of HRGs which are the same across all settings, or across day case and outpatient procedures** (paragraph 49)
 - ii) **increasing the number of mandatory outpatient procedure HRG tariffs** (paragraph 118).

Promoting integration and patient responsiveness

7. **Hospitals will not receive payment for emergency readmissions within 30 days of discharge following an elective admission, and all other readmissions within 30 days of discharge will be subject to locally agreed thresholds** (paragraph 55). This is to ensure that, wherever possible, hospitals have good discharge arrangements in place to avoid readmissions. Primary care trusts (PCTs) must work with providers, GPs and local authorities to reinvest the savings in **re-ablement and post discharge support** (paragraph 64).

Expanding the scope of the tariff

8. We are making some small increases to the scope of the mandatory tariff by including some **admitted patient care HRGs** (paragraph 294) and **outpatient attendance TFCs** (paragraph 295) previously excluded on the grounds of low volume.
9. We are preparing the ground for a more substantial expansion of the tariff in future years by:
 - (a) mandating the allocation of service users to **mental health care clusters** (paragraph 347)
 - (b) mandating currencies for contracting for **adult and neonatal critical care** (paragraph 398)
 - (c) introducing non-mandatory currencies for **ambulance services** (paragraph 396)
 - (d) introducing mandatory currencies for **cystic fibrosis** (paragraph 405)
 - (e) introducing non-mandatory currencies for **smoking cessation** (paragraph 416).

Other changes

10. We are introducing a **flexibility which will allow commissioners and providers, in exceptional circumstances, to seek approval to operate an agreed variation to price which is lower, but not higher, than the published tariff** (paragraph 444).
11. We have also taken the opportunity to address some other issues with the tariff by:
 - (a) moving **A&E from HRGv3.2 to HRG4** (paragraph 153), in line with the rest of the tariff, with five price bands
 - (b) implementing a new pricing structure in HRG sub-chapter VA for **multiple trauma** to better reflect and reward the complexity of multiple diagnoses and procedures and provide support for the new major trauma centres (paragraph 158)
 - (c) carrying out a fundamental and independent review of **specialised service top-ups** (paragraph 94) as a result of which we are:
 - i) introducing new top-ups for **neurosciences** and **spinal surgery**
 - ii) revising the existing top-ups for **orthopaedic** and **children's services**
 - iii) relaxing the rule which previously excluded some HRGs from top-ups on the grounds that they were already heavily weighted to specialised activity
 - iv) updating eligibility lists for these top-ups
 - (d) updating the **market forces factor (MFF) payment index** (paragraph 455) using the latest available data.

Scope of the national mandatory tariff

12. The national mandatory tariff plus an adjustment for MFF is payable by commissioners for day cases, ordinary elective and non-elective admitted patient care, attendances and some procedures in outpatients, and A&E services. It is payable to NHS trusts, NHS foundation trusts, independent sector extended choice network (ECN) and independent sector free choice network (FCN) providers.
13. The national mandatory tariff does not apply to procedures undertaken in wave one and phase two independent sector treatment centres (ISTCs). ISTCs are paid for services according to the terms and conditions of their contracts. Future contracts to provide services from ISTCs will be paid at tariff.
14. We introduced HRG4 as the currency underpinning the admitted patient care tariff in 2009-10. Not all services covered by HRG4 have a national tariff, for a number of reasons, including the quality of available costing and activity data.
15. The 2011-12 tariff is based on 2008-09 NHS reference costs⁵. The costs of services that are currently outside the scope of reference costs⁶ are, by default, not included within the tariff. Some activity remains outside the scope of PbR ([Section 7](#)) and subject to local price negotiation.

Uplift and efficiency

16. Table 1 sets out the uplift and efficiency assumptions for 2011-12. Pay and price inflation is assessed at 2.5%. The national requirement for efficiency in 2011-12 is 4%, 2% of which is embedded in tariff prices next year by setting tariffs below the mean, setting a trim point floor of 5 days for long stay payments, and expanding best practice tariffs. This gives a net price reduction of -1.5% which will apply to both tariff and non-tariff services.

Table 1: 2011-12 uplift

	%
Pay and price inflation	+2.5
Embedded efficiency: tariffs below the mean	-1.0
Embedded efficiency: trim points and best practice tariffs	-1.0
Remaining efficiency	-2.0
Total national efficiency requirement	-4.0
Net price adjustment	-1.5

17. The net price adjustment excludes the cost of the increase in payments by providers to the Clinical Negligence Scheme for Trusts (CNST)⁷. We have recognised these

⁵ www.dh.gov.uk/nhscosting

⁶ Listed in section 16 (services excluded from reference costs) of 2008-09 reference costs guidance (March 2009) at http://collections.europarchive.org/tna/20100509080731/http://dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095859

⁷ www.nhs.uk/Claims/Schemes/CNST/

payments, which represent an additional cost pressure of 0.3% (£68.6 million), through targeted adjustments to tariff prices (paragraph 103).

Queries and feedback

18. It is neither desirable nor possible for this guidance to provide advice for every situation that arises locally, and in these circumstances, we ask commissioners and providers to exercise judgement in interpreting the guidance and come to a local agreement. Commissioners will wish to specify in contracts, and within PbR rules, what they will and will not pay for. For their part, providers will wish to ensure that the way they cost and charge for activity is consistent.
19. With the above in mind, queries about PbR that remain unanswered after referring to this guidance should be directed as follows:
 - (a) PCTs and NHS trusts should contact their SHA PbR leads⁸
 - (b) NHS foundation trusts, SHAs and other organisations should contact the PbR team via pbrcomms@dh.gsi.gov.uk.
20. Other queries should be directed as follows:
 - (a) HRG4 and Grouper software to enquiries@ic.nhs.uk
 - (b) clinical coding and the NHS Data Model and Dictionary to datastandards@nhs.net
 - (c) SUS PbR to bt.sus.helpdesk@bt.com.
21. We would also welcome feedback on any aspect of this guidance, but in particular:
 - (a) improving the operation of PbR
 - (b) use of flexibilities, particularly innovation payments
 - (c) expanding the best practice tariff programme
 - (d) developing new currencies and tariffs.
22. Please contact us at pbrcomms@dh.gsi.gov.uk.

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

Section 2: Classification, currency and grouping

Currency

23. A currency is the unit of healthcare for which a payment is made and can take a variety of forms. HRGs are the currency for admitted patient care, outpatient procedures and A&E. We introduced the latest version, HRG4, as the payment currency for the tariff in 2009-10.
24. HRG4 design remains under constant review for changes in clinical practice and the 2011-12 Local Payment Grouper includes over 130 new HRGs that improve differentiation of care. The main areas relate to the enhanced identification of activity relating to children for both surgical and medical treatments, as well as HRGs specifically created to support best practice tariffs and other policies.
25. More information about HRGs is available on the NHS Information Centre website⁹.

Classification

26. Clinical classification systems describe information from the patient records using standardised definitions and nomenclature. PbR relies on two standard classifications to process clinical data on acute care:
 - (a) International Classification of Diseases tenth revision (ICD-10) for diagnoses¹⁰
 - (b) Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions¹¹. The latest upgrade, OPCS-4.6, will be implemented from April 2011.

Grouping

27. Grouping is the process by which diagnosis and procedure codes on patient records map to an HRG using software produced by the NHS Information Centre¹². The relevant Grouper is the HRG4 2011-12 Local Payment Grouper. The NHS Information Centre also publish comprehensive documentation alongside the Grouper, including a Code to Group workbook that enables users of the Grouper to see how HRGs are derived and to understand the logic used, and full details of HRG changes at sub-chapter level.
28. In general, providers use the Grouper to plan, benchmark and send the results to commissioners as part of their request for payment. Commissioners use the Grouper to assess and validate claims for payment from providers, using the SUS PbR data available to them.

⁹ www.ic.nhs.uk/casemix

¹⁰ As signalled in *Equity and Excellence: Equity and Excellence: Liberating the NHS*, we expect to introduce the latest version of ICD-10 in 2012-13.

¹¹ www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4

¹² www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment

29. The Grouper groups data to HRGs, but does not apply exclusions or tariff adjustments. This needs to be done by users or a third party. Secondary Uses Service Payment by Results (SUS PbR) however groups the data and applies exclusions and tariff adjustments. SUS PbR houses the HRG4 grouping logic and, given the same input as the Grouper, produces the same results.
30. This guidance assumes that where users are locally grouping data, that they are making use of the 2011-12 Local Payment Grouper. Where users are using different grouping methods or software then this guidance may need to be adapted locally to fit. This guidance is consistent with the 2011-12 SUS PbR algorithm.

Data stages

31. Grouping is one of several broad stages in the application of PbR rules to patient data. Table 2 shows each stage.

Table 2: Applying PbR rules to patient data

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

32. These stages apply to the tariff types shown in Table 3 with their corresponding Commissioning Data Set (CDS).

Table 3: Tariff type and CDS

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

PbR pre-processing stage

33. PbR pre-processing describes the preliminary processing of episode level data before it is fed through the Grouper.
34. Prior to applying exclusions, it is important that the full dataset is used to flag potential emergency readmissions. This is because under the new rules governing payment of emergency readmissions (paragraph 53) an initial admission preceding an emergency readmission does not necessarily have to be in the scope of PbR.
35. Certain episodes are excluded because they are outside the scope of PbR, e.g. mental health services or private patients in NHS hospitals. The majority of pre-processing exclusions are identified at TFC level. Under HRG4, HRG exclusions are applied at the

post-processing spell level stage and not the pre-processing episode level stage. The *tariff spreadsheet* includes a full list of exclusions. Only those marked as pre-processing or pre-processing at episode level should be excluded at this stage.

36. Some pre-processing exclusions do not have specific codes listed (e.g. community services). We recommend that where there are no specific codes, commissioners and providers agree these exclusions using previous definitions as a starting point and negotiate payment locally. These episodes can still be excluded from SUS PbR prior to processing by the use of the '=' exclusion.
37. At pre-processing it is important that episode lengths of stay are adjusted to take into account lengths of stay for services outside of PbR, i.e. rehabilitation, critical care and specialist palliative care. The minimum length of stay for an episode is 0. Once the data has been grouped, these adjusted episode lengths of stay will feed into the spell length of stay.
38. From 2011-12, the Grouper will have input fields for lengths of stay for rehabilitation and specialist palliative care as well as critical care. SUS PbR will not be applying length of stay adjustments for rehabilitation or specialist palliative care as the fields do not currently flow into SUS. We are working with the NHS Information Centre to correct this for the next CDS release.
39. Therefore, for the purposes of PbR, a spell's length of stay is the sum of the episode length of stays within it, less any pre-processing exclusions and length of stay adjustments.
40. Once the relevant excluded episodes have been removed and any relevant adjustments have been made for length of stays, the data is ready to be grouped.
41. SUS PbR is able to perform the pre-processing stage, which it applies to data submitted by providers in CDS records.

Grouping stage

42. Users should refer to the manuals on the NHS Information Centre website¹³.

PbR post-grouping stage

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

¹³ www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment

PbR adjustments stage

44. The final stage is the application of any relevant PbR tariff adjustments (paragraph 47 lists these for admitted patient care). The MFF (paragraph 453) is applied to the tariff after any adjustments.

Section 3: Admitted patient care

Structure

45. For admitted patient care, the currency for payment is HRG4. There are different tariffs depending upon the patient's admission type and an HRG may not necessarily have a tariff for each admission type. The tariff is based on spells. This is the period from admission to discharge or death rather than finished consultant episodes (FCEs) of care within a spell. The spell starts when a consultant, nurse or midwife assumes responsibility for care following the decision to admit the patient.
46. For spells that start before and finish in 2011-12, the 2011-12 tariff (and adjustments if applicable) should apply on discharge. For clarity:
 - (a) 2010-11 tariff for patients admitted 30 March 2011 and discharged 31 March 2011
 - (b) 2011-12 tariff for patients admitted 31 March 2011 and discharged 1 April 2011
 - (c) 2011-12 tariff for patients admitted and discharged between 1 April 2011 and 31 March 2012 inclusive.
47. A number of adjustments to the admitted patient tariffs may apply. These are:
 - (a) marginal rate emergency tariff
 - (b) short stay emergency adjustment
 - (c) long stay payment
 - (d) specialised service top-up payment
 - (e) alteplase adjustment
 - (f) adjustments for meeting best practice ([Section 6](#)).
48. The flow diagrams in [Annex A](#) illustrate the application of these adjustments.

Elective care

49. To promote the move to day case settings where appropriate, the majority of HRGs remain set on the average of day case and ordinary elective costs, weighted according to the proportion of activity in each.
50. Having a tariff for procedure based HRGs in an outpatient setting can also help to encourage a move to this more cost efficient setting, where clinically appropriate. We have increased the number of outpatient procedures with mandatory HRG tariffs ([Section 4](#)). For a small number of HRGs we have introduced a single price across outpatient procedures and day cases, or a single price across all settings. We have only done this where there is significant outpatient activity, cost differences are already relatively low, and clinicians agree this is appropriate.
51. Separate day case episodes for the same patient, discharged and readmitted to the same provider on the same day, will not be spelled into the same spell. Instead, each episode will continue to be spelled separately and may attract a separate tariff as part of a pathway agreed with commissioners.

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

Emergency readmissions

53. The *revision to the operating framework for 2010-11* announced “changes to the tariff to cover re-ablement and post-discharge support.” Alongside this, it also announced “an intention to ensure that hospitals are responsible for patients for the 30 days after discharge. If a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment.” This strengthens the long standing flexibility¹⁴, which became a requirement on 1 December 2010, that “emergency readmissions should not attract full reimbursement if the provider did not provide sufficient quality of service or prepare patients adequately for discharge”.
54. The aim is to reduce the actual level of emergency readmission into hospital, which increased by 50% between 1998-99 and 2007-08. Taken together, these changes will give providers a greater incentive to ensure hospitals discharge patients at the right time, and with adequate support, so that numbers of inappropriate readmissions are reduced.
55. In 2011-12, commissioners will not pay for emergency readmissions, with some defined exceptions (paragraph 59), within 30 days of discharge following a day case, ordinary elective, regular day or night admission (around 25% of all readmissions)¹⁵. For clarity, readmissions following outpatient procedures or A&E attendances are excluded from this rule.
56. For emergency readmissions within 30 days of discharge following a non-elective admission:
- (a) commissioners and providers will agree a local threshold rate (i.e. the number of non-elective admissions which are followed by an emergency readmission, as a percentage of the total number of non-elective admissions), based on the last complete 12 months data which are available¹⁶ and adjusted for the exclusions in paragraph 59, above which there will be no payment¹⁷
 - (b) this threshold will be set to deliver at least a 25% reduction in the readmission rate over the previous year (e.g. if the readmission rate for the last complete 12 months is 10% then the readmission rate in 2011-12 will be 7.5% or lower)
 - (c) the only exceptions to a 25% reduction will be where, following clinical audit, a commissioner and provider agree that rates are already in line with best practice, or that only a lesser reduction is achievable (e.g. if the clinical audit suggests that

¹⁴ Paragraph 402 of the *Payment by Results guidance for 2010-11*.

¹⁵ Figure 1 example 1.

¹⁶ To ease implementation, and where commissioner and provider agree, this threshold rate can be set with reference to 2008-09 readmission levels, provided that they are at least as ambitious in reductions achieved as they would have been if set from the most recent 12 months data.

¹⁷ Figure 1 example 2.

for a readmission rate of 5%, 1% of readmissions are avoidable, the readmission rate may be set at 4%).

57. The policy applies to all readmitted patients discharged from 1 April 2011, regardless of when the initial admission occurred. The definition of an emergency readmission in this context is any readmission:
- (a) where the time period between discharge from the initial admission and the readmission is equal to or less than 30 days
 - (b) which has an emergency admission method code¹⁸ of 21-25 or 28
 - (c) which has a national tariff
 - (d) irrespective of whether the initial admission has a national tariff
 - (e) irrespective of whether it is to the same provider
 - (f) irrespective of whether it is non-contract activity (paragraph 461)
 - (g) irrespective of whether the initial admission or readmission occurs in the NHS or independent sector.
58. Where multiple admissions precede a readmission, the admission immediately preceding the readmission should be considered the initial admission. The amount that will not be paid is the total price associated with the continuous inpatient readmission spell¹⁹, including any associated unbundled costs, e.g. critical care or high cost drugs. PCTs will create a post-discharge fund from the savings (paragraph 64).
59. There are a number of exclusions from this policy, which will apply to emergency readmissions following both elective and non-elective admissions:
- (a) any readmission which does not have a national tariff
 - (b) maternity and childbirth - where the initial admission or readmission is in HRG subchapter NZ (obstetric medicine)
 - (c) cancer, chemotherapy and radiotherapy - where the initial admission or readmission includes a spell first mentioned or primary diagnosis of cancer (ICD-10 codes C00-C97 and D37-D48) or an unbundled HRG in subchapter SB (chemotherapy) or SC (radiotherapy). We intend to revisit and limit this exclusion in future years
 - (d) young children – where the patient is under 4 at the time of readmission
 - (e) some multiple trauma – where the root HRG code is VA14 or VA15 in the readmission
 - (f) patients admitted in an emergency due to a transport accident – identified by secondary ICD-10 codes beginning with V in the readmission
 - (g) patients who are readmitted having self-discharged against clinical advice – included in discharge method code 2 in the initial admission

¹⁸ As defined in the NHS Data Model and Dictionary at

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

¹⁹ The definition of a continuous inpatient readmission spell in this context is a continuous period of care from admission to discharge, regardless of any emergency or other transfers which may take place.

- (h) emergency transfers of an admitted patient from another provider, where the admission at the transferring provider was an initial admission and not itself a readmission^{20, 21}
- (i) cross border activity – where the initial admission or readmission is in the devolved administrations (paragraphs 464 to 466).

60. Commissioners should continue to reimburse providers for readmitted patients when any of these exclusions apply. Where commissioners accept that a readmission is clearly unrelated, they may also continue to reimburse providers. [Annex B Figure 1a](#), [Figure 1b](#) and [Figure 1c](#) illustrate the application of this rule.

61. Where a patient is readmitted to a different provider from the one where the initial admission occurred, the second provider must be reimbursed, but the commissioner will deduct the amount from the first provider when reconciling activity for payment as soon as practical, even if this is outside the monthly reporting timetable in paragraph 458. The amount deducted from the first provider is full tariff, regardless of whether the marginal rate emergency tariff was applied to the second provider, and the second provider’s MFF²². The amount the PCT contributes to its post-discharge fund is also the full and not marginal tariff. Emergency transfers of an admitted patient from another provider which form part of a continuous inpatient readmission spell will be deducted from the first provider²³. For emergency readmissions following a non-elective admission where the initial admission is non-contract activity, commissioners will need to decide for themselves whether to recover payment for the readmission²⁴. Figure 1 includes a number of worked examples.

Figure 1: Emergency readmissions

Example 1

Provider	Contract/NCA	Admission method	Admitted	Discharged	Tariff
A	Contract	Elective	20/03/2011	21/03/2011	£500
A	Contract	Emergency	30/03/2011	01/04/2011	£500

PCT withholds payment of £500 from Provider A within SUS PbR reconciliation dates and commits £500 to PCT post-discharge fund.

Example 2

Provider	Contract/NCA	Admission method	Admitted	Discharged	Tariff
A	Contract	Non-elective	31/12/2011	01/01/2012	£500 * 30% = £150
A	Contract	Emergency	31/01/2012	31/03/2012	£500

Provider A is above its emergency readmissions threshold. PCT withholds full tariff for the readmission, committing £500 to PCT post-discharge fund. Note that Provider A is also above its marginal rate emergency admissions baseline, and was paid for the initial admission at the marginal rate of 30%.

²⁰ Emergency transfers of an admitted patient from another provider are included in admission method code 28, which also includes other means of emergency admission. Organisations may wish to adopt additional rules to flag emergency transfers.

²¹ Figure 1 example 3.

²² Figure 1 example 4.

²³ Figure 1 example 5.

²⁴ Figure 1 example 6.

Example 3

Provider	Contract/NCA	Admission method	Admitted	Discharged	Tariff
A	Contract	Elective	01/05/2011	01/05/2011	£500
B	Contract	Emergency transfer	01/05/2011	31/05/2011	£1000

This is identified as an emergency transfer following an initial admission. The readmissions rule does not apply.

Example 4

Provider	Contract/NCA	Admission method	Admitted	Discharged	Tariff
A	NCA	Elective	01/01/2012	07/01/2012	£500
B	Contract	Emergency	31/01/2012	14/02/2012	£1000 * 30% = £300

Provider B is above its marginal rate emergency admissions baseline. PCT pays Provider B a marginal rate of 30% * £1000 = £300, commits 70% * £1000 = £700 to the SHA transformation fund, recovers £1000 from Provider A as soon as practical and commits £1000 to the PCT post-discharge fund.

Example 5

Provider	Contract/NCA	Admission method	Admitted	Discharged	Tariff
A	Contract	Elective	10/04/2011	10/04/2011	£500
A	Contract	Emergency	01/05/2011	01/05/2011	£500
B	Contract	Emergency transfer	01/05/2011	31/05/2011	£1000

Both the emergency readmission and emergency transfer are one continuous inpatient readmission spell. PCT pays £1000 to Provider B, withholds £500 and recovers £1000 from Provider A, and pays £1500 into PCT post-discharge fund.

Example 6

Provider	Contract/NCA	Admission method	Admitted	Discharged	Tariff
A	NCA	Non-elective	01/02/2012	03/02/2012	£500
B	Contract	Emergency	10/02/2012	15/02/2012	£1000

PCT does not have a contract and therefore an agreed emergency readmissions threshold with Provider A. The PCT should decide whether to recover the £1000.

62. It is the responsibility of PCTs to send to each relevant provider a statement showing the value of financial adjustments resulting from this rule. Providers cannot dispute this data on the basis that they are unable to verify activity occurring outside of their own organisation. SUS PbR will, from April 2011, contain a report on readmissions for commissioners produced at reconciliation and post-reconciliation points as part of the managed service extracts. This report will identify both the initial admission and the readmission and include cross provider activity. Although providers will not have a specific report, all readmissions will be flagged by SUS PbR and include the Spell ID and provider organisation code for the initial admission. *Guidance for the implementation of SUS PbR from April 2011* will contain advice on how SUS PbR will support the readmission rules.

Re-ablement and post discharge support

63. In 2010-11, PCTs have received £70 million additional funding for re-ablement and post discharge support linked to hospital discharge. PCTs are required to develop local plans in conjunction with providers, GPs and local authorities to develop seamless care for patients on discharge from hospital and to prevent readmission to hospital, and to use these plans as a basis for co-ordinating activity on post-discharge support from 2011-12. In 2011-12, PCTs will receive £150 million in their recurrent allocations, rising

to £300 million from 2012-13, to develop local re-ablement services in the context of post-discharge support²⁵.

64. From 1 April 2011, the new rules on not paying for emergency readmissions will create additional savings for PCTs. PCTs will be required to work with providers, GPs and local authorities to use these savings, alongside the baseline funding of £150 million in 2011-12 and £300 million in 2012-13, to improve the support available to patients within the 30 days following discharge from hospitals. SHAs will monitor the progress of PCTs in identifying and using these savings. We also encourage the use of locally agreed year of care tariffs for named patients with complex long-term conditions who are frequently readmitted to hospital, while we develop more pathway and year of care tariffs in the future.
65. From 1 April 2012, the responsibility and funding for patients in the 30 days after discharge will move to acute providers and so PCTs will need to work with them and other partners to anticipate and prepare for this change. During 2011, we will work with early implementer organisations to identify increases to tariffs from 2012-13 to cover the cost of re-ablement and post-discharge support. The types of post-discharge support that might be included in hospitals' 30 day responsibility include:
 - (a) homecare re-ablement – primarily social care services to help people with poor physical or mental health accommodate their illness by learning or re-learning the skills necessary for daily living and regaining or maintaining their independence
 - (b) intermediate care - time-limited, residential or community based services, in community hospitals or other settings, designed to help people make a faster and more complete recovery from illness
 - (c) rehabilitation - medical treatment to help restore physical functioning following a hospital admission or procedure. Examples may include physiotherapy following orthopaedic surgery or speech and language therapy following a stroke
 - (d) community health services – provided by district nurses and others
 - (e) follow-up outpatient attendances.
66. We will also consider including:
 - (a) drugs – to give clarity to the supply of drugs to patients on discharge from hospital
 - (b) equipment.
67. We anticipate that the following services will be excluded from hospitals' responsibility for post-discharge support:
 - (a) pre-existing long-term residential and home care provided by local authorities
 - (b) care provided under a GP contract.

²⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_123460

Marginal rate emergency tariff

Purpose

68. A marginal rate of 30% of the relevant published tariff will continue to apply for increases in the value of emergency admissions. The marginal rate provides an added incentive for closer working between providers and commissioners, to support the shift of care out of hospital settings and keep the number of emergency admissions to a minimum.

Application

69. The marginal rate applies to increases, but not decreases, in the value of emergency activity. Where the actual value of emergency activity in 2011-12 remains below or at the baseline, commissioners will continue to pay providers at the full rate of tariff for that activity. The point at which the actual value of emergency activity exceeds the baseline value will trigger the introduction of the 30% marginal rate. For example, if the baseline is £1 million, and the actual value of activity in 2011-12 is £0.9 million, then the payment is also £0.9 million and not £0.93 million (being 30% of the difference between actual and baseline). But if the actual value of activity in 2011-12 is £1.1 million, then the payment is £1.03 million (being 30% of the difference between actual and baseline).
70. The marginal rate should be applied to the tariff after any other national adjustments for short stay emergency spells, long stay payments or specialised service top-ups. For example, a spell to which both the 70% short stay emergency adjustment and 30% marginal rate applied would be paid at 21% of the tariff price.
71. The marginal rate applies at an annual level but commissioners will need to monitor on a cumulative monthly or quarterly basis in line with contractual arrangements. The *tariff spreadsheet* provides examples to illustrate the principles for calculating the difference between the values of actual and baseline activity and making in-year adjustments. Our simplified examples assume an even profile; in reality, emergency activity will probably be monitored using a suitable seasonal profile.

Defining emergency

72. Emergency spells are defined by admission method codes 21-25 and 28²⁶ for the purposes of the marginal rate.
73. While the marginal rate does apply to emergency transfers (included in admission code 28), we recognise that these might have more complex care pathways which are more difficult to demand manage. Therefore, we have allowed for flexibility in how these are treated in the baseline (paragraph 82(c)).
74. Because it is determined solely by admission method code, the marginal rate applies to babies born at home as intended and then subsequently admitted because of clinical need (included in admission method code 28) but not other births (admission codes 82

²⁶ http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1

or 83), and it applies to admission method codes 21-25 and 28 regardless of TFC (e.g. 501 – obstetrics).

75. The marginal rate does not apply to:
- (a) activity outside the scope of PbR
 - (b) non-contract activity
 - (c) activity eligible for best practice tariffs
 - (d) A&E attendances.

Setting the baseline

76. The baseline above which the marginal rate takes effect is determined on the basis of contractual relationships between commissioners and providers. Where there is one provider and several PCTs in the contract, then we would expect arrangements to be agreed locally in line with contractual payment flows. There is no minimum contract value below which the marginal rate does not apply. There will need to be explicit agreement of the baseline for each contractual relationship, which should be included within the 2011-12 contract and concluded as part of the 2011-12 contract negotiations.
77. Where a provider reduces the value of its emergency activity against the baseline value in aggregate, the marginal rate will still apply for those contracts where the value of its emergency activity is above the baseline. Table 4 illustrates this.

Table 4: Setting the baseline

Provider A (figures in £m)					
	Baseline	Actual	Change	Marginal rate	Contract payment
	A	B	C = B - A	D = C (if > 0) * 0.7	E = B - D
PCT A	2	3	1	0.7	2.3
PCT B	3	1	-2	0	1
Sum of contracts ²⁷	5	4	-1	0.7	3.3

78. The 2011-12 baseline will be the actual value of the full 12 months of activity in the financial year 2008-09 priced at the 2011-12 tariff. To calculate the baseline, commissioners will need to group and price 2008-09 activity (on HRGv3.5) to HRG4, and price it using the features of the 2011-12 national tariff structure. This includes the new rules for not paying for emergency readmissions within 30 days of discharge. The value of emergency readmissions following elective admissions, and the value of the agreed reduction in the number of emergency readmissions following non-elective admissions should be removed from the baseline. The *tariff spreadsheet* includes a worked example. Because the baseline is priced using features of the 2011-12 national tariff, 2008-09 features do not apply. As the worked example in the *tariff spreadsheet* makes clear, the baseline operates on the bottom line value and not at individual HRG or any other disaggregated level.

²⁷ Note that the contract payments are £3.3 million even though the aggregate value of activity is £4 million against a baseline of £5 million.

79. The marginal rate does not apply to activity eligible for best practice tariffs. Although the most effective way to do this is to fully adjust the baseline and actual outturn values to reflect activity eligible for best practice tariffs, commissioners and providers may choose one of the following approaches where both parties agree:
- (a) making no adjustment (where there are very low levels of activity)
 - (b) making an estimate of the proportion of growth accounted for by the value of best practice tariff activity
 - (c) removing the value of best practice activity from the actual outturn figures.
80. Where a service opened during 2008-09 then the activity data needs to be annualised, or a later year's activity used. Where a new service is opened or an existing service is significantly reconfigured, then the baseline should be set using 2011-12 plan, annualised part year activity data from 2010-11, or 2009-10 full year activity, depending on when the service is opened or reconfigured.
81. Where a service has transferred between providers since 2008-09, or is to be transferred in 2011-12, the baseline will be derived from the previous provider's 2008-09 activity. This principle also applies to a planned transfer of emergency capacity or activity between providers.
82. The only other circumstances in which an amendment to the value of the baseline may be made are where
- (a) a PCT is able to demonstrate that emergency activity has sustainably reduced
 - (b) there has been a significant service redesign which would make the 2008-09 outturn unrepresentative of future patterns of activity (for example, more emergency admissions to one provider as a result of an A&E department at a second provider moving location)
 - (c) there is evidence of or planned changes to service patterns, for example an increase in emergency transfers of patients to tertiary centres or the establishment of major trauma centres. Commissioners should be monitoring patterns of tertiary referrals to ensure they are appropriate
 - (d) agreed changes in counting and coding have occurred since 2008-09.
83. The marginal rate does not apply to contracts with commissioners in the devolved administrations.

SHA risk pool

84. In recognition that commissioners have a joint responsibility with providers in managing health system risk, SHAs should manage the 70% savings accruing from the triggering of this business rule to create a pool for system risk management and transformation. It is for SHAs to determine how they collect and utilise these savings but we would expect some of them to be invested in emergency admission avoidance. For example, North East SHA has provided £1.1 million in 2010-11 to support the 111 pilot²⁸ which the North East Ambulance Service NHS Trust has been running in County Durham and

²⁸ Further information is available at http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_118861

Darlington. One of the purposes of the scheme is to avoid unnecessary use of A&E services and unplanned admissions to hospital.

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

Short stay emergency adjustment

86. The short stay emergency adjustment is a mechanism for ensuring appropriate reimbursement for lengths of stay of less than two days where the average HRG length of stay is longer. It is illustrated in [Annex B Figure 1d](#).
87. The short stay emergency prices are published in the *tariff spreadsheet*, based on the percentages in Table 5 (which remain unchanged in 2011-12), and do not need to be locally calculated. The level of reduction depends on the national average length of stay of the HRG. For example, the payment is 70% of tariff for an HRG with an average length of stay of 2 days.

Table 5: Short stay emergency adjustment percentages

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

88. The short stay emergency adjustment applies when all of the following criteria are met:
- (a) the patient's length of stay is either zero or one bed day
 - (b) the patient is not for a child, defined as aged under 19 years on the date of admission
 - (c) the admission method code is 21-25 or 28
 - (d) the average length of non-elective stay for the HRG is two or more days
 - (e) the HRG is not defined by length of stay
 - (f) the assignment of the HRG has the potential to be based on a diagnosis code, rather than on a procedure code alone, as indicated in the *tariff spreadsheet*, irrespective of whether a diagnosis or procedure is actually dominant in the HRG derivation.

89. If all of these criteria are met, then the short stay emergency adjustment and not the non-elective tariff applies, regardless of whether the patient is admitted under a medical or a surgical specialty. Any adjustments to the tariff, such as specialised service top-ups, are applied to the reduced tariff.

Long stay payments

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

91. The HRG costs reported in the published 2008-09 reference costs do not include the cost of stays beyond a defined trim point (these are reported separately in reference costs as excess bed days). The trim point is defined in the same way as for reference costs, but is spell-based and there are separate elective and non-elective trim points. The payment will operate after a patient's length of stay exceeds the trim point, when a daily rate will apply.
92. We have completed our review of long stay payments signalled in the *PbR guidance for 2010-11*. As a result, we are:
- introducing a trim point floor of five days²⁹
 - standardising long stay payments by HRG chapter (Table 6).

Table 6: Long stay payments by HRG chapter

HRG chapter	Description	Payment £
A	Nervous system	209
B	Eyes and periorbita	269
C	Mouth, head, neck and ears	248
D	Respiratory system	198
E	Cardiac surgery and primary cardiac conditions	209
F	Digestive system	217
G	Hepatobiliary and pancreatic system	222
H	Musculoskeletal system	232
J	Skin, breast and burns	220
K	Endocrine and metabolic system	200
L	Urinary tract and male reproductive system	214
M	Female reproductive system and assisted reproduction	250
N	Obstetrics	370
P	Diseases of childhood and neonates	280
Q	Vascular system	241
S	Haematology, chemotherapy, radiotherapy and specialist palliative care	240
V	Multiple trauma, emergency medicine and rehabilitation	230
W	Immunology, infectious diseases and other contacts with health services	202

93. If a patient is medically ready for discharge and delayed discharge payments³⁰ have been imposed on local authorities under the provisions of the Community Care (Delayed Discharges etc) Act 2003, then commissioners should not be liable for any further long stay payment. SUS PbR will apply an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the CDS, by removing the number of days between that and actual discharge from any long stay payment. This is the only circumstance in which long stay payments may be adjusted. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that appropriate charging to local authorities is taking place.

²⁹ For simplicity, we have shown a trim point floor of at least five days for all HRGs in the tariff spreadsheet, regardless of whether the HRG includes length of stay logic of less than five days.

³⁰ <http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Delayedischarges/index.htm>

Specialised service top-up payments

94. Specialised service top-up payments are designed to recognise the additional costs of specialised activity compared to non-specialised activity within the same HRG. [Annex B Figure 1f](#) illustrates their application.
95. *The operating framework for 2010-11* announced “a fundamental review of the current methodology” for top-ups. The Centre for Health Economics at the University of York carried out the review and their report³¹ recommended revised top-ups for children’s and orthopaedic services and new top-ups for several services. We have accepted some of the recommendations in the report.
96. Top-ups are a percentage of the relevant HRG tariff and are shown in Table 7 together with the relevant specialised service code (SSC) flag and provider eligibility.

Table 7: Specialised service top-ups

	Top-up	SSC flag	Eligible provider list?
Children	60%	23	Yes
Neurosciences	28%	8	Yes
Orthopaedic	24%	34	No
Spinal surgery	32%	6	Yes

97. To determine which spells are applicable for specialised service top-ups, the Grouper uses lists of ICD-10 and OPCS-4 codes in the *tariff spreadsheet* that are based on the third edition of the Specialised Services National Definition Set (SSNDS) published in 2009³². The Grouper then applies one of the SSC flags in Table 7 to the patient record. OPCS-4 codes can be in any position in the patient record, but ICD-10 codes must be in the primary position. In 2011-12, all HRGs are eligible for top-ups, whereas in previous years any HRG where at least 80% of the activity was specialised was excluded from top-ups.
98. Not all organisations are eligible. Eligibility lists are included in the *tariff spreadsheet* and were agreed by a panel of SCGs, NHS Specialised Services and other NHS organisations in November 2010. Because the Grouper does not apply tariff adjustments, it does not incorporate organisation eligibility and therefore manual intervention is required to ensure that only those top-ups that an organisation is eligible for are applied to any data.
99. A spell may be eligible for more than one top-up, and the Grouper is able to output multiple SSCs (e.g 23 and 34) for one spell, but only the highest is applied.
100. The specialised services top-up is applied after a short stay emergency adjustment or long stay payment, but before an alteplase adjustment or additional best practice tariff payment.

³¹ Available from www.dh.gov.uk/pbr alongside the final tariff package.

³² <http://www.nscg.nhs.uk/index.php/key-documents/specialised-services-national-definitions-set/>

101. Although there is no specialised services top-up for cardiac services, we are introducing a flexibility to enable commissioners to support specific services where the tariff may not provide sufficient reimbursement (paragraph 443).

Alteplase adjustment

102. The use of the drug alteplase for stroke (coding rules dictate that there will only be one reported use in a spell) will continue to receive a targeted adjustment when HRG AA22Z (non-transient stroke or cerebrovascular accident, nervous systems infection or encephalopathy) is coded with unbundled HRG XD07Z (fibrinolytic drugs band 1). XD07Z is an unbundled HRG that contains OPCS-4 code X83.3 (fibrinolytic drugs). [Annex B Figure 1g](#) illustrates.

Pricing adjustments

103. Rather than include the cost pressure arising from NHS contributions to the CNST in the overall tariff uplift, we have made £68.6 million of targeted adjustments to tariff prices, taking into consideration:

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

104. We targeted CNST costs on tariff prices by identifying the relevant HRG chapters or sub-chapters and apportioning the costs across the HRGs in proportion to overall costs. Table 8 shows the adjusted HRG chapters for each of the specialty areas reflected in the CNST.

Table 8: Apportioning CNST costs to HRGs

HRG chapter or sub-chapter	Specialty	% increase in tariff prices
AA	Neurology, neurosurgery	0.37%
B	Ophthalmology	0.18%
CZ	Otolaryngology, plastic surgery	0.02%
D	Respiratory	-0.18%
E	Cardiology, cardiothoracic surgery	0.01%
F	General surgery	0.26%
G	General surgery	0.26%
H	Plastic surgery, trauma and orthopaedics	0.28%
J	General surgery, plastic surgery	0.16%
LA	Renal procedures and disorders	0.02%
LB	Urology	0.07%
N	Obstetrics	2.75%
P	Paediatrics	0.06%
Q	General surgery	0.20%
VA	Trauma and orthopaedics	0.27%
VB ³³	A&E	0.66%

³³ Excluding band 5.

105. We continued to take account of NICE technology appraisals published since April 2008. We also made a number of pricing adjustments following sense check to tariffs which did not seem to be rewarding activity appropriately. These are described in *Step-by-step guide: calculating the 2011-12 national tariff*.

Home births

106. Home births are collected in the admitted patient care other delivery event CDS and reimbursed at the same rate as a normal delivery without complications, as illustrated in [Annex B Figure 1h](#).

Antenatal admissions

107. HRG4 expanded the number of HRGs for non-delivery related antenatal activity from the previous one (N12) to six (NZ04 to NZ09). This was intended to allow differentiation of the types of admission and lead to more accurate costing. In 2011-12, we are introducing a seventh non-delivery HRG, NZ10Z, for diagnostic and therapeutic procedures on fetus.

108. These HRGs continue to be subject to what appears to be inconsistent recording and poor costing. Although we have again adjusted prices by shifting some costs from the non-delivery HRGs to the delivery HRGs, we have not attempted to address this issue further for 2011-12 because in 2012-13 we anticipate introducing pathway tariffs for maternity which support womens' choices³⁴.

109. In the meantime, many commissioners are working with their providers to understand the variation in recording practice, and to facilitate this we published a *simple guide to maternity services and Payment by Results* (July 2010). We strongly recommend that providers review their current recording and delivery practice to ensure that activity is correctly recorded, both clinically and administratively, and correctly costed. We also encourage commissioners to work with providers to benchmark this activity to understand what clinical activity takes place during these contacts. Where the published tariff is clearly over-reimbursing actual local costs as a result of changes made to local recording practices (rather than just inefficient service) commissioners should consider the use of a flexibility (paragraph 430), with review, to manage the situation.

Zero price

110. Table 9 shows HRGs that have a mandatory tariff of zero pounds (£0). There should be no payment for this activity.

Table 9: Zero price HRGs

HRG code	Description	Justification
LA08E	Chronic kidney disease with length of stay 1 day or less associated with renal dialysis	Empty core HRG for renal dialysis for chronic kidney disease
PB03Z	Healthy baby	Costs are included with the mother's care
UZ01Z	Data invalid for grouping	Organisations should not be funded for invalid data

³⁴ The current HRGs and CDSs will continue to be needed for choice and referrals to tertiary providers.

No tariff price

111. Where insufficient costing or activity data was submitted to support the calculation of a tariff for an HRG we have not included that HRG in the national tariff, for example AA01Z Intracranial procedures for trauma with major diagnosis. However, these HRGs can still be used as contract currencies with locally agreed prices.
112. No tariff information (£-) has been supplied in the *tariff spreadsheet* where a tariff is not applicable for that combination of HRG and admission method.

Section 4: Outpatient care

Structure

113. The outpatient attendances tariffs are based on treatment function code (TFC)³⁵. In 2011-12, following a review of exclusions, we are increasing the number of TFCs with outpatient attendance tariffs. We are also increasing the list of outpatient procedure HRGs with a mandatory tariff. We have rebundled the costs and activity for remaining outpatient procedure HRGs not on this list into the relevant outpatient attendance TFCs, as described in *Step-by-step guide: calculating the 2011-12 national tariff*. These will be reimbursed using the relevant outpatient attendance tariff, unless commissioners and providers wish to employ the flexibility at paragraph 429.
114. Commissioners and providers should have regard for the provisions in the *Code of Conduct* around standard notice periods and transition arrangements where the introduction of mandatory tariffs for outpatient procedures and attendances, set on 2008-09 activity, results in increased reporting of activity.
115. Where patient data groups to a non-admitted attendance HRG (HRG4 sub-chapter WF), SUS PbR determines whether the TFC has a mandatory tariff and applies the appropriate outpatient attendance tariff. If the TFC does not have a mandatory tariff, the price is for local negotiation between commissioners and providers. This is illustrated in [Annex B Figure 2a](#).
116. Where patient data groups to an outpatient procedure HRG (i.e. not from HRG4 sub-chapter WF), SUS PbR determines whether the HRG has a mandatory outpatient procedure HRG tariff and applies it. Where it does not, SUS PbR determines whether the relevant mandatory outpatient attendance tariff (HRG4 sub-chapter WF), based on TFC, is applicable. This is illustrated in [Annex B Figure 2b](#).
117. In 2011-12, we are introducing a distinction between HRGs that are excluded across all settings, and HRGs that are excluded for admitted patient care but where the activity may still generate an outpatient attendance tariff. For example, the HRG for lung volume studies (DZ45Z) is excluded from admitted patient care and does not have an outpatient procedure tariff, but may generate an outpatient attendance TFC tariff.

Outpatient procedures

118. We have increased the number of mandatory outpatient procedure HRG tariffs. We selected HRGs with at least 5,000 procedures nationally, at least 20 providers submitting data in 2008-09 reference costs, and amended these following clinical advice. We do not expect every procedure that maps to these HRGs can be appropriately carried out in an outpatient setting.

³⁵ TFCs are defined in the NHS Data Model and Dictionary as codes for “a division of clinical work based on main specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including consultants.”

119. The outpatient procedure HRG tariff is paid instead of the outpatient TFC attendance tariff, regardless of whether or not the activity is consultant led or if the TFC is excluded for outpatient attendances, except where the service as a whole is excluded. If more than one of these procedures is undertaken in a single outpatient attendance, the HRG will be based on the same logic as used in admitted patient care (i.e. based on the procedure that is ranked highest in the grouping hierarchy), and only one outpatient procedure HRG tariff will be chargeable.
120. Commissioners and providers should agree appropriate categorisation of outpatient attendance and day case activity. The NHS Data Model and Dictionary is a source of information on this issue³⁶. Providers should ensure that the way that they charge for activity is consistent with the way that they cost activity in reference costs, and consistent with any conditions for payment that commissioners include within contracts. The Audit Commission are reviewing definitional issues in conjunction with the Department, NHS Connecting for Health and the NHS Information Centre, and will report in 2011.

Outpatient attendances

Expanding the scope

121. We have increased the number of TFCs with outpatient attendance tariffs. As with outpatient procedures, we initially selected HRGs with at least 5,000 first attendances, at least 20 providers submitting data in 2008-09 reference costs, and amended these following clinical advice. The additional TFCs that have a mandatory tariff in 2011-12 are:
- (a) cardiac surgery
 - (b) cardiothoracic surgery
 - (c) dermatology
 - (d) infectious diseases
 - (e) nephrology³⁷
 - (f) paediatric dermatology
 - (g) thoracic surgery.
122. Having a mandatory tariff will support the provision of these services. However, we are aware that some of the services covered, for example dermatology and paediatric dermatology, may cover very different types of activity in different providers. For this reason, the service redesign flexibility (paragraph 439) may be relevant.
123. There will also be new TFCs supporting best practice tariffs for paediatric diabetic medicine (paragraph 230) and TIA (paragraph 262), and new TFCs supporting currencies for adult cystic fibrosis and paediatric cystic fibrosis (paragraph 405).

³⁶ <http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs/cds/admitpat/daycase>

³⁷ These tariffs do not include the costs of erythropoiesis stimulating agents (ESAs) or drugs for mineral bone disorders.

Eligibility

124. The mandatory outpatient attendance tariff remains applicable only to pre-booked, consultant led attendances. We took advice as to whether the requirement for attendances to be pre-booked, that is booked before the patient's arrival at hospital, should be retained, given that reference costs since 2007-08 have been extended to include outpatient attendances that have not been pre-booked. Our advisory groups said this requirement should be retained. The pre-booked requirement is not limited to Choose and Book³⁸, and may include local systems accepting patients based on GP letters or phone calls. Genito-urinary medicine (GUM) services, and other sexual health services providing confidential open access, are an exception to the pre-booked requirement. The tariff applies to these services, whether walk-in or appointment based, and provided by acute trusts or PCTs. Prices for other outpatient attendances that are not pre-booked or consultant-led should be agreed locally.
125. Where an attendance with a consultant from a different main specialty during a patient's admission replaces an attendance which would have taken place regardless of the admission, then provided it meets the relevant conditions (i.e. it is pre-booked and consultant-led) it can attract a tariff.
126. The attendance does not have to take place in trust premises, so consultant led outreach clinics held in a GP practice or a children's centre could be eligible to receive the tariff. For these clinics, it will be important to make sure the data flows into SUS PbR. Home visits are not eligible and should be subject to local pricing. The advice we have received is that home visits should be part of the work to develop currencies and tariffs for community services.
127. As with admitted patient care, not all activity taking place in outpatient clinic settings, even when supported by separate data flows, will attract a separate payment under the national tariff. Data may be required to support other policy initiatives and, where there is doubt about funding, providers should refer to the methodology used to compile their reference cost returns to establish where the funding for a service is expected to be found.
128. SUS PbR will not apply a tariff where the Attended or Did Not Attend field in the outpatient CDS is empty.

Consultant led and non-consultant led

129. The NHS Data Model and Dictionary definition of a consultant led service is a "service where a consultant retains overall clinical responsibility for the service, care professional team or treatment. The consultant will not necessarily be physically present for each consultant led activity but the consultant takes clinical responsibility for each patient's

³⁸ Choose and Book is the national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

care.”³⁹ A consultant led service does not apply to nurse consultants or physiotherapist consultants.

130. There is no national tariff for non-consultant led clinics. The NHS Data Model and Dictionary states that “all non-consultant led activity is identified in the admitted patient care CDS and HES by a pseudo main speciality code of 560 for midwives, 950 for nurses and 960 for allied health professionals.” We encourage health economies to consider setting local prices for this activity.
131. The exception to this approach is for maternity services in an outpatient setting. We have set the same mandatory price for consultant and midwife led activity⁴⁰, reflecting that the majority of pregnant women receive the same care through a midwife, whether or not a consultant is responsible. This tariff applies to both TFCs 501 (obstetrics) and 560 (midwife episode). Providers should code consultant led activity to 501 and midwife led care to 560.

First and follow-up attendances

132. There are separate tariffs for first and follow-up attendances. A first attendance is the first or only attendance in respect of one referral. Follow-up attendances are those that follow first attendances as part of a series in respect of the one referral. The series ends when the consultant does not give the patient a further appointment, or the patient has not attended for six months with no forthcoming appointment. If after discharge the condition deteriorates, a new referral occurs and the patient returns to the clinic run by the same consultant, this is classified as a first attendance.
133. The end of a financial year does not necessarily signify the end of a particular outpatient series. If two outpatient attendances for the same course of treatment are in two different financial years but are less than six months apart, or where the patient attends having been given a further appointment at their last attendance, the follow-up tariff applies.
134. To disincentivise follow-ups where these are not necessary, we have added 10% of the costs of follow-up attendances to first attendances when setting tariffs (with the exceptions of infectious diseases and nephrology, where correct clinical management demands a follow-up regime). The *2011-12 NHS operating framework* suggests “PCTs may identify clinically appropriate follow up ratios for outpatient appointments in certain specialties”.
135. Some clinics are organised so that a patient may be seen by a different consultant team (within the same specialty and for the same course of treatment) on subsequent follow-up visits. Where this is the case, commissioners and providers may wish to discuss an adjustment to funding to recognise that a proportion of appointments being recognised

39

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

⁴⁰ which may include community midwife clinics provided that the principles in paragraphs 10.1.6 and 10.1.7 of the *Code of Conduct* apply.

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

136. There has been some concern about levels of consultant-to-consultant referrals, and when it is appropriate for these to be reimbursed as a first rather than follow-up attendance. Given the variety of circumstances in which these may occur, it is not currently feasible to mandate a national approach to counting and reimbursement. The Audit Commission have found that consultant-to-consultant referrals are not the main driver of increases in outpatient activity. They found that share of referrals for new outpatient attendances has remained more or less the same over the last three years (in 2009-10, 57% from GP referral, 8% from consultant referral, 17% from A&E referral and 18% from other sources)⁴¹.
137. We are again publishing a non-mandatory price for non face-to-face outpatient activity (paragraph 344), which commissioners and providers may wish to use to facilitate changes to outpatient pathways.

Multi-professional and multi-disciplinary

138. There are separate tariffs for multi-professional and single-professional outpatient attendances. The multi-professional tariff is payable for two types of activity, distinguished by the following OPCS-4 codes:
- (a) X62.2 - assessment by multi-professional team NEC - for multi-professional consultations
 - (b) X62.3 - assessment by multi-disciplinary team NEC – for multi-disciplinary consultations.
139. Multi-professional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. The TFC of the consultant clinically responsible for the patient should be applied to a multi professional clinic where two consultants are present. Where there is joint responsibility then this should be discussed and agreed between commissioner and provider.
140. 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.
141. These definitions apply when a patient benefits in terms of care and convenience from accessing the expertise of two or more healthcare professionals at the same time. The clinical input of multi-professional or multi-disciplinary attendances must be evidenced in the relevant clinical notes or other relevant documentation.
142. 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,

⁴¹ *More for less 2009-10 Are efficiency and productivity improving in the NHS?* (December 2010), available at www.audit-commission.gov.uk/moreforless2

operating equipment and passing instruments. They also do not apply where a patient sees single professionals sequentially as part of the same clinic. Such sequential appointments count as two separate attendances, should be recorded as such in line with existing NHS Data Model and Dictionary guidance on joint consultant clinics⁴².

143. The multi-disciplinary attendance definition does not apply to multi-disciplinary meetings, where care professionals meet in the absence of the patient. Multi-disciplinary meetings should not be recorded as multi-disciplinary attendances.
144. We provide below some examples of multi-professional and multi-disciplinary consultations, but the list is not exhaustive, and commissioners and providers should exercise common sense and document in contracts when determining where multi-professional or multi-disciplinary applies.
145. Some examples of multi-professional attendances are where:
 - (a) a patient sees both an obstetric consultant due to concerns about risk factors associated with a previous miscarriage and a midwife to discuss the birth plan
 - (b) an orthopaedic nurse specialist assesses a patient and a physiotherapist provides physiotherapy during the same appointment.
146. Some examples of multi-disciplinary attendances are where:
 - (a) a breast surgeon and an oncologist discuss with the patient options for surgery and treatment of breast cancer
 - (b) a respiratory consultant, a rheumatology consultant and nurse specialist discuss with the patient treatment for a complex multi-systemic condition, e.g. systemic lupus erythematosus
 - (c) a patient sees a paediatrician to discuss their disease and a clinical geneticist to discuss familial risk factors.
147. Some examples of where the multi-professional or multi-disciplinary definitions do not apply are:
 - (a) a consultant and a sonographer, when the sonographer is operating equipment for the consultant to view the results
 - (b) a consultant maxillo-facial consultant and a dental nurse passing examination instruments to the consultant
 - (c) a consultant and a nurse specialist, when the nurse specialist is taking a record of the consultation
 - (d) a consultant and a junior doctor, when the junior doctor is present for training purposes
 - (e) a consultant ophthalmologist and a nurse, where the nurse administers eye drops or gives the sight exam as part of the consultation.

⁴² <http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/help/faqs-07/sharedcare>

Rebundling of diagnostic imaging

148. We have continued to rebundle diagnostic imaging into the outpatient attendance tariffs, except where the diagnostic imaging is accessed directly, e.g. via referral from a GP. The *Step-by-step guide: calculating the 2011-12 national tariff* describes the methodology.
149. Rebundling should not be a barrier to the provision of this service in alternative settings. We have published separate non-mandatory prices for direct access diagnostic imaging (paragraph 334), and a flexibility for more complex diagnostic imaging (paragraph 432).

Pre-operative assessments

150. The *PbR guidance for 2010-11* said that “the direction of travel, signalled by the best practice tariff for cataracts, is that in future pre-operative assessments will not attract a separate outpatient attendance tariff.” Our advisory groups told us that payment for pre-operative assessments should continue to be a matter for local agreement in 2011-12. There is not currently a definition of what constitutes a pre-operative assessment, and therefore a national approach to counting and reimbursement is not currently appropriate or feasible.
151. Where a pre-operative assessment takes place following admission, the costs are reflected in the admitted patient care HRG. Where the assessment takes place prior to admission, and constitutes a pre-booked consultant-led outpatient attendance, it will generally be recorded as a follow-up outpatient attendance and may attract the relevant tariff. The best practice tariffs for cataracts and primary total hip and knee replacements include the pre-operative assessment. In addition, some commissioners have contracts in place preventing separate payments for pre-operative assessments occurring on the same day as an admission.

Zero price

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

Table 10: Zero price outpatient TFCs

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

Section 5: Urgent care

Accident and emergency services

153. In 2011-12 the A&E tariff will move from HRGv3.2 to HRG4. There are five A&E tariffs for services delivered in A&E and minor injury units (MIUs), spread over 11 HRG classifications based on investigation and treatment. It is illustrated in [Annex B Figure 3](#).
154. Non-24 hour A&E units and MIUs remain eligible for the band 5 tariff only regardless of which HRG is triggered from the data.
155. Patients who are dead on arrival (DOA) should always attract the band 4 tariff. These do not have an HRG and are triggered by the A&E Patient Group code 70 (brought in dead). SUS PbR will include a SUS-specific HRG for DOA.
156. Where a patient is admitted following an A&E attendance, both the relevant A&E and non-elective tariffs are payable.
157. In the *PbR guidance for 2010-11* we said that we “were advised by our governance groups to review whether A&E services should be funded on a partly fixed and partly variable funding mechanism from 2011-12”. We have since been advised that this should not happen at this time.

Major trauma

158. Following the establishment of regional networks of trauma care⁴³, we have introduced revised tariffs for the completely redesigned multiple trauma HRGs (sub-chapter VA)⁴⁴ to ensure new major trauma centres are appropriately reimbursed for the casemix complexity of multiply injured patients.
159. The new multiple trauma HRGs use a system of scoring based on the diagnoses and procedures within an episode or spell for each patient. A grid subsequently allocates the patient to a HRG based on the scores generated.
160. We would expect activity in the higher scoring HRGs to be concentrated in the major trauma centres. When the major trauma centres are established, we intend to introduce a business rule to restrict payment of some HRGs to them. In the meantime, SHAs may wish to have similar local arrangements.
161. Providers should meet subscription costs to the Trauma Audit and Research Network (TARN) from their income.

⁴³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119424

⁴⁴ The NHS Information Centre will publish an introduction to sub-chapter VA alongside the 2011-12 Local Payment Grouper documentation at <http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads> in March 2011.

Section 6: Best practice tariffs

Introduction

162. A best practice tariff (BPT) is a national tariff that has been structured and priced to incentivise and adequately reimburse care that is high quality and cost effective. *Equity and Excellence: Liberating the NHS* said that “we will rapidly accelerate the development of BPTs, introducing an increasing number each year, so that providers are paid according to the costs of excellent care, rather than average price.” A specific approach has been developed for each BPT, tailored to the clinical characteristics of best practice and the availability and quality of data.
163. In 2011-12 we are introducing BPTs for the following service areas:
- (a) adult renal dialysis
 - (b) interventional radiology
 - (c) paediatric diabetic medicine
 - (d) primary total hip and knee replacements
 - (e) transient ischaemic attacks (mini-strokes).
164. In addition we are extending the “incentivising day case model” introduced for cholecystectomy to a range of procedures suggested by the British Association of Day Surgery (BADs), covering
- (a) breast surgery
 - (b) hernia repair
 - (c) orthopaedic surgery
 - (d) urology.
165. These service areas were selected using the following criteria:
- (a) high impact (i.e. high volumes, significant variation in practice, or significant impact on outcomes)
 - (b) a strong evidence base and clinical consensus on the characteristics of best practice.
166. For each 2011-12 BPT we describe the clinical characteristics of best practice, the structure and prices, and arrangements for implementation. They apply to patients discharged from 1 April 2011.
167. We are rolling forward the existing BPTs, and unless stated otherwise, the *Payment by Results guidance for 2010-11* continues to apply. For fragility hip fracture and stroke we are increasing the incentive to meet best practice by doubling the additional best practice payments and reducing the base tariffs by the same amount.
168. We have commissioned an external evaluation of the BPTs, using the 2010-11 models as case studies. We have used initial findings in the implementation of the 2011-12

package, and the final report, which we will publish during 2011, will inform future policy from 2012-13.

169. [Annex C](#) summarises how BPTs are identified in SUS PbR or other data sources. BPTs are mandatory and share the same status as the rest of the national tariff, including the application of tariff adjustments (Table 11), and the opportunity to use the flexibilities described in [Section 10](#).

Table 11: Application of tariff adjustments to best practice tariffs

Best practice tariff	Long stay payment	Specialised service top-up	Alteplase adjustment
Adult renal dialysis			
Cataracts	●	●	
Cholecystectomy	●	●	
Day cases	●	●	
Fragility hip fracture	●	●	
Interventional radiology	●	●	
Paediatric diabetes			
Primary total hip and knee replacements	●	●	
Stroke	●	●	●
TIA			

Adult renal dialysis

Characteristics of best practice

170. As part of the BPT programme, we are introducing a mandatory currency with mandatory transition from local prices to national tariff for adult renal dialysis for patients with chronic renal failure. The tariff covers adult haemodialysis and peritoneal dialysis.
171. The tariff excludes all modalities of paediatric dialysis and dialysis for acute kidney injury or renal failure. Funding for dialysis in these patients is for local arrangement. It also excludes home haemodialysis, for which we are publishing non-mandatory prices (paragraph 339), pending further collection and refinement of cost data during 2011-12.
172. Returns to the UK Renal Registry (UKRR) of the Renal Association routinely distinguish between patients starting renal replacement therapy on chronic and acute dialysis for definitional purposes based on local clinical judgement, and this should be adhered to for the tariff.
173. Despite differences in payment mechanisms, fully informed choice of all appropriate treatment modalities should be the rule rather than the exception. This includes care at home and other forms of self-care which offer real benefits for kidney patients and link closely to the vision of an NHS organised around patients, giving them more choice, convenience and control over their care.
174. The BPT aims to encourage the adoption of clinical best practice with respect to vascular access for haemodialysis where there is clear clinical consensus as set out in these guidelines and standards:

- (a) Renal Association guidelines (guidelines 1.1 and 1.2)⁴⁵
- (b) Vascular Society and Renal Association joint guidelines⁴⁶
- (c) NSF for renal services (standard 3)⁴⁷.

175. 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.
176. 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.
177. 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.
178. Renal units will need to collaborate with surgical services to establish processes that facilitate timely referral for formation of vascular access.
179. Whilst not a condition of the BPT, contribution to national clinical audits should be considered a characteristic of best practice for providers of high quality renal dialysis care.

Tariff structure and prices

180. The NHS Information Centre has designed a set of new HRGs for renal dialysis which take account of the key drivers in cost and are split by age, dialysis type, complexity, and setting. The HRGs form sub-chapter LD of chapter L, urinary tract and male reproductive system, replacing the old sub-chapter LC from 1 April 2011. We have set the prices on this new design using 2008-09 reference costs, in line with the rest of the 2011-12 tariff.

Haemodialysis

181. The haemodialysis tariff (Table 12) covers a session of dialysis, defined as each session of dialysis treatment on a given day for each patient.

⁴⁵ <http://www.renal.org/Clinical/GuidelinesSection/VascularAccess.aspx>

⁴⁶ <http://www.vascularsociety.org.uk/library/vascular-society-publications.html>

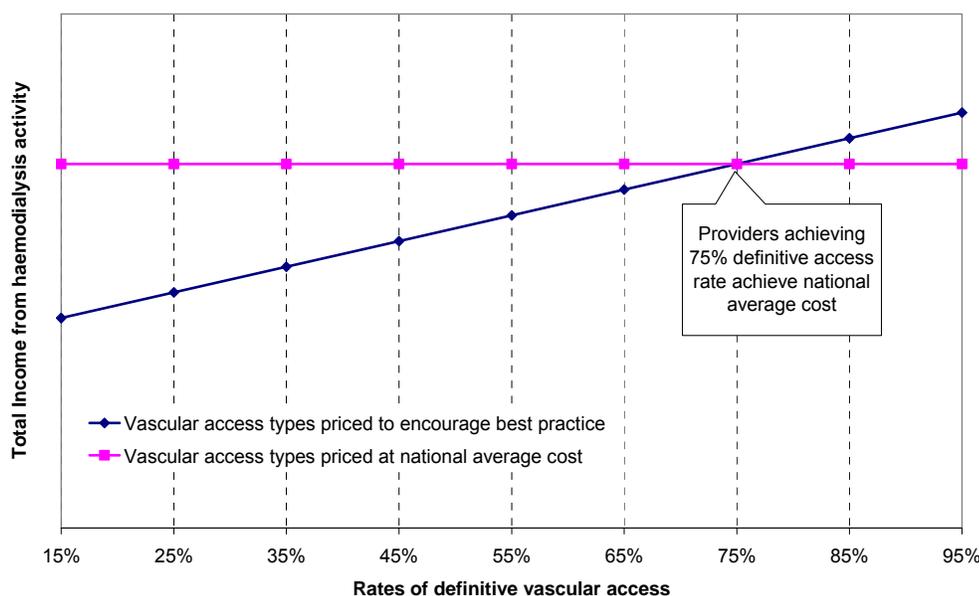
⁴⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4070359

Table 12: Haemodialysis tariff prices

HRG code	Description	Tariff per session £
LD01A	Hospital haemodialysis/filtration with access via haemodialysis catheter 19 years and over	128
LD02A	Hospital haemodialysis/filtration with access via arteriovenous fistula or graft 19 years and over	159
LD03A	Hospital haemodialysis/filtration with access via haemodialysis catheter with blood borne virus 19 years and over	146
LD04A	Hospital haemodialysis/filtration with access via arteriovenous fistula or graft with blood borne virus 19 years and over	182
LD05A	Satellite haemodialysis/filtration with access via haemodialysis catheter 19 years and over	128
LD06A	Satellite haemodialysis/filtration with access via arteriovenous fistula or graft 19 years and over	159
LD07A	Satellite haemodialysis/filtration with access via haemodialysis catheter with blood borne virus 19 years and over	146
LD08A	Satellite haemodialysis/filtration with access via arteriovenous fistula or graft with blood borne virus 19 years and over	182

182. These prices reflect a differential of 25% between dialysis with and without definitive vascular access, designed to encourage the best practice of vascular access via a fistula or graft. The principle applied in setting the price differential is that providers achieving high rates of definitive access receive the same level of income as if there was no BPT and prices were calculated at the national average cost. Its derivation is set out in *Step-by-step guide: calculating the 2011-12 national tariff*. Figure 2 illustrates the impact on provider income.

Figure 2: Setting the differential for renal dialysis HRGs



183. The Renal Association recommends that 85% of prevalent⁴⁸ haemodialysis patients are dialysed via definitive access. We intend to set the BPT to incentivise a movement to this rate over three years:

⁴⁸ Prevalent is defined in Annex B of the 2009 UKRR report at http://www.renalreg.com/Report-Area/Report%202009/Appen-B_Renal09_web.pdf

- (a) 2011-12 75%
- (b) 2012-13 80%
- (c) 2013-14 85%

Peritoneal dialysis

184. The peritoneal dialysis tariff prices (Table 13) cover a day of treatment.

Table 13: Peritoneal dialysis tariff prices

HRG code	Description	Tariff per day £
LD11A	Continuous ambulatory peritoneal dialysis 19 years and over	46
LD12A	Automated peritoneal dialysis 19 years and over	56

185. Currently, assisted peritoneal dialysis groups to the same HRG as automated peritoneal dialysis. This means that the tariff price for LD12A is applicable for assisted peritoneal dialysis. However, because the rates of assisted peritoneal dialysis are low, the current average cost of the HRG will be more reflective of the lower costs associated with automated peritoneal dialysis.

186. Home therapies such as assisted peritoneal dialysis should be encouraged where clinically appropriate. Because the tariff price for LD12A is unlikely to reimburse sufficiently a higher rate of assisted peritoneal dialysis, organisations may need to agree an appropriate increase to the published price using the service redesign flexibility (paragraph 439).

Core and unbundled HRGs

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

Drug costs

188. Due to the variation in funding and prescription practices across the country, the tariff for renal dialysis is not intended to fund the following drugs in 2011-12:

- (a) ESAs
 - i) Darbopoetin alfa
 - ii) Epoetin alfa, beta (including methoxy polyethylene glycol-epoetin beta), theta and zeta
- (b) drugs for mineral bone disorders
 - i) Cinacalcet

- ii) Sevelamer
- iii) Lanthanum.

189. Organisations should continue with current funding arrangements for these drugs when used in renal dialysis or outpatient attendances in nephrology (TFC 361). For all other uses, the relevant tariff prices are intended to reimburse the associated costs because they are not on the high cost drugs exclusion list. The policy intention is to reimburse the cost of these drugs through tariff. We will work with the renal community to achieve this in the shortest feasible timeframe.
190. Patients with iron deficiency anaemia of chronic kidney disease will require iron supplementation. For patients on haemodialysis, the tariff prices are intended to cover the costs of intravenous iron. For patients, either on peritoneal dialysis or otherwise, the costs will be reimbursed by a non renal dialysis mandatory tariff, either in outpatients or admitted patient care, depending on the type of drug and method of administration (slow infusion or intravenous).

Acute kidney injury/renal failure

191. The introduction of adult renal dialysis into PbR is for patients with chronic renal failure and not those with acute kidney injury. Principally this is because acute renal failure is excluded from the scope of the NRD for detailed data collection.
192. Previously, where recorded by OPCS codes, dialysis events associated with acute kidney injury would produce an unbundled dialysis HRG from sub-chapter LC. In 2011-12 the grouper will only produce HRGs from the sub-chapter LD and not LC. Organisations will need to put in place local arrangements for capturing and reporting this information for payment purposes. It would be possible for organisations to report such activity using the seven NRD items which generate the LD HRGs but as the tariff prices apply only to chronic renal failure patients, payment for this activity would be for local agreement.

Dialysis away from home

193. It is important that patients can dialyse away from home. The introduction of a mandatory tariff is intended to make it easier to arrange dialysis away from home by providing a consistent basis for financial flows. The tariff prices apply equally for patients at or away from home. Local policies should operate within existing guidance⁴⁹.

Implementation

194. In order to support the policy and be more clinically meaningful, the new HRGs in sub-chapter LD require seven data items defined in the mandatory⁵⁰ NRD and listed in Table 14. Commissioners should include these dataset fields in information schedules of NHS contracts where these services are provided.

⁴⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084218

⁵⁰ ROCR reference ROCR/OR/0192/FT6/001MAND

Table 14: 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
Dialysis [182] type of dialysis access, e.g. fistula [23] dialysis times per week
Organisations will also need to derive: <ul style="list-style-type: none">• a unique patient identifier (need not be NHS number)• patient age (in years derived from date of session – date of birth)

195. The reporting process for renal dialysis will differ from other tariff services. The data items defined in the NRD are not contained in the CDS and do not flow into SUS PbR. We therefore expect organisations to implement local reporting in 2011-12 while we continue to work towards a national solution in 2012-13. The Grouper, by including the new design of LD HRGs for renal dialysis, will allow organisations to generate HRGs from patient data extracted from their own systems.
196. The introduction of adult renal dialysis into PbR may represent a financial cost pressure for some commissioners and providers where locally agreed prices differ significantly from the national average of reference costs on which the national tariff is set. We are therefore setting out how we expect organisations to move to the national tariff.
197. In 2011-12, it will be mandatory for organisations to commission and report on the basis of the chapter LD HRGs. For reimbursement, it will be mandatory for all organisations to move 50% towards the national tariff prices from 2010-11 locally agreed prices or equivalent if commissioning on block contracts (Figure 3 illustrates). In 2012-13, the national tariff price will be mandatory.

Figure 3: Transition to mandatory tariff for adult renal dialysis

LD01A hospital haemodialysis/filtration with access via haemodialysis catheter 19 years and over

Where local price is above national tariff

2010-11 local price	£180
2011-12 national tariff price	£128
2011-12 national price adjusted for provider MFF*	£128 x 1.2188 = £156
Difference	-£24 [£180 - £156]
50% of difference	- £12 [0.5 x -£24]
2011-12 local price (on mandated transition)	£168 [£180 - £12]

Where local price is below national tariff

2010-11 local price	£132
2011-12 national tariff price	£128
2011-12 national price adjusted for provider MFF*	£128 x 1.2188 = £156
Difference	£24 [£156 - £132]
50% of difference	£12 [0.5 x £24]

2011-12 local price (on mandated transition) £144 [£132 + £12]

* The national tariff is net of the unavoidable cost differences of providing healthcare, as captured by the MFF. Local prices will implicitly include these cost differences so account needs to be taken of the MFF. Either local prices need to be divided through by the provider's MFF or the national tariff price needs to be multiplied by the provider's MFF.

Cataracts

198. The 2010-11 cataract treatment BPT will continue in the same form in 2011-12, applying to HRGs BZ02Z and BZ03Z. The tariff applies to the entire elective cataract pathway by covering the sum of the costs of the individual outpatient attendances and the surgical event (with a combined elective and day case price). For each HRG one of two prices will apply, depending on whether a patient has cataract extraction on one or both eyes.

199. The tariff corresponds to the elements of the best practice pathway (Table 15). The first eye tariff covers levels 2-5 of the pathway and the second eye tariff covers levels 6-7. Reimbursement for a patient who follows a pathway covering levels 2-7 is therefore the sum of the two tariffs. Implementation is illustrated in [Annex A Figure 4a](#).

Table 15: 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 inpatient in exceptional circumstances
5	Follow-up	Review by nurse, optometrist, or ophthalmologist ideally at 2 weeks. Listing for second eye where appropriate
6	Cataract removal procedure (2 nd eye)	Most likely to be on a day case basis but could be inpatient in exceptional circumstances
7	Follow-up	Review by nurse, optometrist, or ophthalmologist ideally at 2 weeks

Level	Description	Events
		(pathway tariff includes cost of follow-up outpatient attendance for this). Review at 4 – 6 weeks by local optometrist (pathway price does not include cost of this as it is incurred in primary care).

200. Since April 2010, additional functionality has been available in SUS PbR to help commissioners to implement this pathway tariff. Commissioners and providers can access an extract that links events along a patient pathway using the Patient Pathway ID field⁵¹, returning records in chronological order per patient. More information is available in SUS PbR documentation available on the NHS Connecting for Health website⁵².

Cholecystectomy

201. The 2010-11 cholecystectomy (gall bladder removal) BPT will continue in the same form in 2011-12, applying only to HRGs without complications and co-morbidities (GA10C, GA10D and GA10E). There are no changes to the structure or price, except to reflect 2008-09 reference costs.

Day cases

Characteristics of best practice

202. A day case is a procedure which is both planned to be carried out with no overnight stay, and where no overnight stay results. We are setting BPTs for 12 procedures in five surgical sub-specialties to incentivise day cases (Table 16).

Table 16: Day case BPTs

Surgical sub-specialty	Procedure
Breast surgery	Sentinel node mapping and resection
	Simple mastectomy
General surgery	Repair of umbilical hernia
	Primary repair of inguinal hernia
	Repair of recurrent inguinal hernia
	Primary repair of femoral hernia
Gynaecology/urology	Operations to manage female incontinence
Orthopaedic surgery	Therapeutic arthroscopy of shoulder - subacromial decompression
	Bunion operations with or without internal fixation and soft tissue correction
	Dupuytren's fasciectomy
Urology	Endoscopic resection of prostate (TUR)
	Resection of prostate by laser

203. We used a similar model to cholecystectomy in 2010-11, designed to incentivise surgery on a day case basis, where clinically appropriate. The British Association of Day Surgery (BADS) publishes a directory of procedures that are amenable to day case or short stay

⁵¹ This is one of the 18 weeks (referral to treatment) fields mandated for compliance since January 2010.

⁵² <http://www.connectingforhealth.nhs.uk/systemsandservices/sus>

admissions along with rates that they believe are achievable in most cases⁵³. The rates were obtained following consultation with colleagues recognised as leaders in day and short stay surgery. The procedures we have selected for 2011-12, like cholecystectomy in 2010-11:

- (a) come from the 3rd edition of the directory
- (b) are high volume (greater than 5,000 admissions)
- (c) have day case rates that vary significantly between providers and are nationally below the BADS rates.

204. Performing these procedures as day cases offers advantages to both the patient and provider. BADS argue that patients prefer to recuperate in their familiar home environment, while providers benefit from reduced pressure on inpatient beds. Advances in analgesic and anti-emetic regimens have reduced the need for a prolonged stay in hospital to treat pain and sickness and patients feel more empowered when they are in control of their own pain relief. BADS has no evidence to suggest that a shortened length of stay produces any greater risk in relation to potential post-operative complications or readmission rates.

Tariff structure and prices

205. We have set the prices in Table 17 to Table 21 to incentivise providers to increase their day case rates whilst ensuring that overall best practice does not cost commissioners more. This has been achieved by:

- (a) introducing separate prices with the day case prices relatively higher than the ordinary elective prices
- (b) decreasing the absolute level of day case and ordinary elective prices to reflect the lower cost of providing the BADS day case rate⁵⁴ compared to the national average rate. This means that the day case prices are lower than if we had set them conventionally based on current day case rates.

Table 17: Breast surgery

Procedure	BPT flag	BADS day case rate	Conditional HRG codes	Day case tariff	Elective tariff
Sentinel node mapping and resection	61	80%	JA06Z JA07A JA07B JA07C JA09B JA09D	£1,376	£1,076
Simple mastectomy	62	15%	JA07B JA07C	£2,385	£2,085

⁵³ The BADS Directory of Procedures (3rd edition) suggests day case rates which should be achievable in most cases, but also sets certain caveats which mean that these rates may not be achievable. It is available at: <https://www.daysurgeryuk.net/bads/shop/shopdisplayproducts.asp?id=9&cat=BADS+Publications>

⁵⁴ For certain procedures the rate used for tariff calculation is lower than in the BADS directory. This is footnoted in the tables.

Table 18: General surgery

Procedure	BPT flag ⁵⁵	BADS day case rate	Conditional HRG codes	Day case tariff	Elective tariff
Repair of umbilical hernia	63	85%		£1,118	£818
Primary repair of inguinal hernia	64	95%	FZ18A	£1,126	£826
Repair of recurrent inguinal hernia	65	70%	FZ18B	£1,124	£824
Primary repair of femoral hernia	66	90%	FZ18C		

Table 19: Gynaecology/urology

Procedure	BPT flag	BADS day case rate	Conditional HRG codes	Day case tariff	Elective tariff
Operations to manage female incontinence	67	80%	LB23Z	£995	£695

Table 20: Orthopaedic

Procedure	BPT flag	BADS day case rate ⁵⁶	Conditional HRG codes	Day case tariff	Elective tariff
Therapeutic arthroscopy of shoulder – subacromial decompression	68	80%	HB62C	£2,253	£2,053
Bunion operations, with or without internal fixation and soft tissue correction	69	85%	HB34E	£1,279	£1,079
			HB35B	£1,489	£1,289
			HB35C	£993	£793
Dupuytren's fasciectomy	70	95%	HB53Z	£2,297	£2,097

Table 21: Urology

Procedure	BPT flag	BADS day case rate	Conditional HRG codes	Day case tariff	Elective tariff
Endoscopic resection of prostate (TUR)	71	15%	LB25B	£2,030	£1,880
			LB25C	£1,863	£1,713
Resection of prostate by laser ⁵⁷	72	90%	LB25C	£1,863	£1,563

Implementation

206. With the exception of the hernia repairs BPTs, implementation (illustrated in [Annex A Figure 4b](#)) is different to cholecystectomy in 2010-11, because the tariff prices apply at the procedure rather than the HRG level. To achieve this, the Grouper generates an identification flag (explained in [Annex B](#)) for the relevant OPCS-4 codes.

207. For the hernia repair BPTs, whilst the Grouper still generates identification flags, they are redundant for reimbursement because hernia repair procedures account for the

⁵⁵ These flags are redundant for reimbursement.

⁵⁶ We have not set prices for the orthopaedic procedures on BADS day case rates though they still offer providers a financial incentive to carry out these procedures as day cases without costing commissioners more than a conventional tariff. During 2011-12, we will work with stakeholders, including the British Orthopaedic Association, to agree a best practice day case rate for these procedures.

⁵⁷ We are incentivising a target day case rate of 30% for resection of prostate by laser in 2011-12, due to short term barriers to achieving the BADS rate. We will incentivise a move to the BADS rate for over the course of three years. We also wish to highlight the relevant NICE guidance, available at www.nice.org.uk/CG97, which recommends that this treatment is carried out by holmium laser.

majority of activity in the associated HRGs. The BPT and conventional tariff prices are the same, calculated using a weighted average of the BADS day case rates.

208. An identification flag is generated for these OPCS-4 codes only when the elective spell also has an admission method code of 11, 12 or 13. The day case price applies where the spell has a patient classification code of 2, and the ordinary elective price where it has a patient classification code of 1 or 5.

209. SUS PbR will automate payment by:

- (a) generating the relevant flag
- (b) applying the relevant price for each patient classification type where the flag groups to one of the conditional HRGs.

210. As with top-ups, the Grouper is able to output multiple flags (e.g 61 and 62) for one spell, but only the highest tariff is applied.

Fragility hip fracture

211. The 2010-11 fragility hip fracture BPT will continue in the same form in 2011-12 with the following revisions:

- (a) a sub-set of HRGs from the new multiple trauma sub-chapter VA are now eligible
- (b) a greater differential has been set between the base tariff and the best practice tariff.

212. The fragility hip fracture BPT (illustrated in [Annex A Figure 4c](#)) applies to a subset of patients aged over 60 admitted non-electively within the hip procedure for trauma HRGs and a subset of HRGs in the multiple trauma sub-chapter VA, where all of the following clinical characteristics are met:

- (a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia
- (b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon⁵⁸
- (c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia⁵⁹
- (d) assessed by a geriatrician⁶⁰ in the perioperative period (within 72 hours of admission)
- (e) postoperative geriatrician-directed multi-professional rehabilitation team
- (f) fracture prevention assessments (falls and bone health).

⁵⁸ 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.

⁵⁹ We recommend that providers issue their commissioning PCTs with a copy of the agreed joint assessment protocol. Examples are available at www.nhfd.co.uk

⁶⁰ Geriatrician defined as consultant, non-consultant career grade (NCCG), or specialist trainee ST3+.

213. Table 22 lists the relevant HRGs.

Table 22: Fragility hip fracture best practice tariff HRGs

Hip procedure HRGs		Multiple trauma HRGs	
HRG	Label	HRG	Label
HA11A	Major hip procedures category 2 for trauma with major cc	VA11A	Multiple trauma diagnoses, score <=23 with interventions, score 1 - 8
HA11B	Major hip procedures category 2 for trauma with intermediate cc	VA11B	Multiple trauma diagnoses, score 24 - 32 with interventions, score 1 - 8
HA11C	Major hip procedures category 2 for trauma without cc	VA11C	Multiple trauma diagnoses, score 33 - 50 with interventions, score 1 - 8
HA12B	Major hip procedures category 1 for trauma with cc	VA11D	Multiple trauma diagnoses, score >=51 with interventions, score 1 - 8
HA12C	Major hip procedures category 1 for trauma without cc	VA12A	Multiple trauma diagnoses, score <=23 with interventions, score 9 - 18
HA13A	Intermediate hip procedures for trauma with major cc	VA12B	Multiple trauma diagnoses, score 24 - 32 with interventions, score 9 - 18
HA13B	Intermediate hip procedures for trauma with intermediate cc	VA12C	Multiple trauma diagnoses, score 33 - 50 with interventions, score 9 - 18
HA13C	Intermediate hip procedures for trauma without cc	VA12D	Multiple trauma diagnoses, score >=51 with interventions, score 9 - 18
HA14A	Minor hip procedures for trauma with major cc		
HA14B	Minor hip procedures for trauma with intermediate cc		
HA14C	Minor hip procedures for trauma without cc		

214. These HRGs cover more than hip procedure patients. To target the BPT towards fragility hip fractures the Grouper will flag spells with an identification flag of 88, and SUS PbR will apply the base tariff to spells, where they meet the following criteria:

- (a) patient aged 60 or over (on admission)
- (b) non-elective admission method (excluding maternity)
- (c) a diagnosis and procedure code (in any position) from the list in the *tariff spreadsheet*.

215. We have calculated the base tariffs using reduced national average reference costs to take account of current compliance. An additional payment will apply on top of the appropriate base tariff price if all of the best practice compliance criteria are met. To further incentivise best practice in 2011-12, we have doubled this additional payment to £890 and reduced the base tariff by a corresponding amount.

216. In 2010-11, further guidance on reporting and payment was published on the National Hip Fracture Database (NHFD) website⁶¹ in the *Best practice tariff for fragility hip fracture care user guide*, which is now subsumed and superseded by this guidance. In addition, from April 2011 pbrnhfdregistration@dh.gsi.gov.uk will be disabled and organisations should contact us as usual through pbrcomms@dh.gsi.gov.uk.

217. Commissioners determine compliance with best practice using reports compiled from data submitted by providers to the NHFD. Providers already have access to the NHFD

⁶¹ www.nhfd.co.uk

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

218. [Annex C](#) lists the on-line reports available from the NHFD. Commissioners should link SUS data with NHFD data by using the NHS number. The NHS number is therefore required to enable linkage to the commissioner and, if missing or invalid, the provider should complete or correct it before a commissioner match can be made. The report also contains Date of Admission and Date of Operation, which can be compared with SUS PbR output on the spells that have an SSC of 88 to additionally validate matching. All records, including those for patients aged 60 or over who fail to meet the criteria, are sent to relevant commissioners when available.
219. The report is available quarterly in line with the SUS PbR reporting timetable⁶² (paragraph 458), i.e. the report for the April to June quarter will be available at the final reconciliation point on 1 September 2011. The additional best practice payment is therefore paid quarterly in arrears, with the base tariff paid as normal. Payment arrangements for NHFD records entered or completed outside the agreed timeframe should be negotiated locally.
220. NHFD is currently the only source of data relevant to the BPT criteria collected on a regular basis, with professional clinical oversight. We therefore recommend participation in the NHFD although organisations may implement alternative local solutions. Further information on best practice is available from the NHFD website including advice on:
- (a) improving clinical care and secondary prevention
 - (b) service organisation
 - (c) how to make a case for the posts and resources necessary for the delivery of high-quality, cost-effective care.

Interventional radiology

Characteristics of best practice

221. The interventional radiology BPT applies to two procedures:
- (a) endovascular aortic repair⁶³ (EVAR) – for people with abdominal aortic aneurysms
 - (b) uterine fibroid embolisation⁶⁴ (UFE) – for women with uterine fibroids (benign tumours of the uterus).
222. The benefits of minimally invasive procedures such as those facilitated by interventional radiology include decreased lengths of stay, reduced risk of hospital acquired infections, and faster rehabilitation. These procedures are an alternative to open surgery, but do

⁶² 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. Data will then be matched to PCTs which will take a further two weeks. Once the PCT data is uploaded, providers will be given another two weeks to correct any problems or omissions.

⁶³ Also known as endovascular stenting.

⁶⁴ Also known as uterine artery embolisation (UAE).

not represent best practice in every circumstance because clinical considerations and patient choice may make open surgery alternatives legitimate.

223. NICE guidance⁶⁵ recommends EVAR as a possible treatment for patients diagnosed with abdominal aortic aneurysms that have not ruptured, and a valid alternative to open surgery where clinically appropriate. It is not recommended for patients with aneurysms that have ruptured except in the context of research. NICE guidance⁶⁶ states that UFE as a “first-line treatment can be recommended” where clinically appropriate.

224. Therefore, the aim of these BPTs is to encourage the provision of innovative procedures by making them more visible in the payment system.

Tariff structure and prices

225. The BPTs are structured and priced on HRGs in the new sub-chapter RC⁶⁷ (Table 23).

Table 23: EVAR and UFE prices

HRG code	Description	£
RC12A	Infrarenal or aortio-uniilac endovascular stent-graft for non ruptured abdominal aortic aneurysm, one branched stent-graft	6,667
RC12B	Infrarenal or aortio-uniilac endovascular stent-graft for non ruptured abdominal aortic aneurysm, one fenestrated stent-graft	
RC12C	Infrarenal or aortio-uniilac endovascular stent-graft for non ruptured abdominal aortic aneurysm, one stent-graft	
RC12D	Infrarenal or aortio-uniilac endovascular stent-graft for non ruptured abdominal aortic aneurysm, two stent-grafts	
RC12E	Infrarenal or aortio-uniilac endovascular stent-graft for non ruptured abdominal aortic aneurysm, three stent-grafts	
RC13A	Other endovascular stent-graft for non-ruptured abdominal aortic aneurysm, one branched stent-graft	
RC13B	Other endovascular stent-graft for non-ruptured abdominal aortic aneurysm, one fenestrated stent-graft	
RC13C	Other endovascular stent-graft for non-ruptured abdominal aortic aneurysm, one stent-graft	
RC13D	Other endovascular stent-graft for non-ruptured abdominal aortic aneurysm, two stent-grafts	
RC13E	Other endovascular stent-graft for non-ruptured abdominal aortic aneurysm, three or more stent-grafts	
RC41Z	Interventional radiology – obs & gynae – uterine fibroid embolisation	2,483

226. The design of the EVAR HRGs is based on:

- (a) whether the abdominal aortic aneurysm is ruptured or not
- (b) whether the procedure is infrarenal or aortic-uniilac or otherwise
- (c) the number and type of endovascular stent-graft devices used.

227. There is a single tariff price for EVAR for non-ruptured abdominal aortic aneurysms, excluding the cost of the stent graft device.

⁶⁵ www.nice.org.uk/TA167

⁶⁶ <http://guidance.nice.org.uk/IPG94>

⁶⁷ HRG sub-chapter RC also includes five EVAR HRGs (RC11A, RC11C, RC11D and RC11E) for ruptured abdominal aortic aneurysm.

228. The 2010-11 reference cost collection will include these new HRGs so we will have cost information to inform prices from 2013-14. Until then, we are using alternative sources of costing. We will move towards introducing separate prices, taking into account the costs of the number and type of stent grafts used, for the EVAR prices in future years.

Implementation

229. [Annex D](#) lists which OPCS-4 and ICD-10 codes are required for the Grouper and SUS PbR to generate the relevant HRGs for EVAR and UFE.

Paediatric diabetes

230. Building on the introduction of non-mandatory prices in 2010-11, in 2011-12 we are encouraging best practice in paediatric⁶⁸ diabetes follow-up outpatient attendances as a prelude to introducing a pathway BPT in 2012-13. There will be a new TFC 263 for paediatric diabetic medicine. This will have a mandatory first outpatient attendance tariff of £358 and a follow-up outpatient attendance tariff of £121.

231. To incentivise best practice, the follow-up tariff will attract a non-mandatory additional payment of £148 per follow-up clinic consultation provided the following criteria are met:

- (a) on diagnosis, a young person is to be discussed with a senior member of the paediatric diabetes specialist team within 24 hours and seen by a member of the team on the next working day. A senior member is defined as a doctor or paediatric specialist nurse with appropriate training⁶⁹ in paediatric diabetes
- (b) a minimum of four clinic appointments per young person per year with a multi-disciplinary team should be offered, i.e. a paediatric diabetes specialist nurse, a paediatric dietician with experience in diabetes, and a doctor. The doctor should be a consultant or career grade doctor with experience and training in paediatric diabetes or a specialist registrar training in paediatric diabetes, under the supervision of an appropriately trained consultant
- (c) additional contacts by other members of the paediatric diabetes specialist team for check-ups, telephone contacts, school visits, trouble shooting, advice, e-mail support etc. Eight 15 minute contacts per year are recommended
- (d) haemoglobin A1c (HbA1c) measurements should be performed and available at each clinic attendance. At least four HbA1c measurements should be recorded per year where possible
- (e) annual screening as recommended by current NICE guidance
- (f) retinopathy screening should be performed by regional screening services in line with the national retinopathy screening programme. Where retinopathy is identified, timely and appropriate referral to ophthalmology should be provided
- (g) annual assessment as to whether psychology input is needed and access to psychological support as appropriate.

⁶⁸ Paediatric includes all children and young people up to their 19th birthday.

⁶⁹ Guidance as to what constitutes appropriately trained is available from the British Society for Endocrinology and Diabetes (BSPED) or the Association of Children's Diabetes Clinicians (for doctors) or the Royal College of Nursing (RCN).

232. These criteria were developed in conjunction with national clinical leads and regional clinical networks, and are substantiated by the NSF for children, young people and maternity services⁷⁰, NICE clinical guidelines⁷¹, *Making Every Child and Young Person with Diabetes Matter* (April 2007)⁷², and *Commissioning services for children and young people with diabetes* (February 2010)⁷³.
233. Commissioners will monitor compliance with these criteria via locally negotiated contracts, which may include, evidence of submission to the Paediatric National Diabetes Audit, local records of clinic attendances, clear pathways for did not attend (including was not brought), and active participation by the provider in the regional Paediatric Diabetes Network.

Primary total hip and knee replacements

Characteristics of best practice

234. We have designed the BPTs for elective primary total hip and knee replacements to incentivise best practice in the clinical pathways of patients undergoing these procedures. The pathway includes the pre-operative assessment, care during the hospital admission and immediate post discharge including outreach care. There is an expectation based on a range of publications that utilisation of such pathways should improve the patient experience and satisfaction, reduce lengths of stay and shorten post-operative rehabilitation.
235. There are four key aspects of good clinical pathways ([Annex E](#) gives the sources of evidence):
- (a) pre-operative assessment, planning and preparation before admission
 - (b) a structured approach to peri-operative and immediate post-operative management, including pain relief
 - (c) early supervised mobilisation and safe discharge
 - (d) structured plans for access to clinical advice and support in the period immediately after discharge, including outreach rehabilitation.
236. In 2011-12, we are encouraging providers to optimise pathways without creating an additional administrative burden by basing prices on the conventional tariff for the relevant HRGs less £232, which is the long stay payment for HRG chapter H. The principle behind this approach is that an optimal pathway costs less because of the reduction in length of stay. With the conventional tariff a function of the variation in clinical practice, its level is higher than if all providers were delivering optimal pathways.

⁷⁰

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4094329

⁷¹ CG15 Diagnosis and management of type 1 diabetes in children, young people and adults (July 2004), available at <http://www.nice.org.uk/CG15> and TA151 Diabetes - insulin pump therapy (July 2008), available at <http://www.nice.org.uk/TA151>

⁷² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073674

⁷³ http://www.diabetes.nhs.uk/commissioning_resource/

We expect the nominal figure of £232 is within the range of savings that providers on average can make by optimising pathways.

237. To ensure that a change in practice benefits the patient and service a process of governance must be put in place. Organisations commissioning and providing best practice should monitor outcomes. In addition to the standard measures of mortality and morbidity, readmission rates and safety, patient reported outcome measures (PROMs) are collected for these two procedures. PROMs offer a patient perspective of clinical outcomes and are a good barometer of the actual value of such changes. Providers of these procedures are mandated in the NHS standard acute contract to offer patients PROMs including a pre-operative questionnaire, with a third party organisation administering the post-operative questionnaire.
238. The National Joint Registry (NJR) was established to define, improve and maintain the quality of care of individuals receiving hip and knee joint replacement surgery. Though not mandated, it is highly regarded in the orthopaedic community. Commissioners are encouraged to promote participation in the NJR⁷⁴ and have the flexibility to make part of the tariff contingent on participation. The exact arrangements are for local agreement but the principle should be that the contingent element is proportionate.
239. Pending the outcome of the evaluation of 2010-11 BPTs, our longer term aim is to make a direct link between the tariff, best practice criteria and accepted clinical outcome measures.

Tariff structure and prices

240. The BPT applies to a subset of patients within the major hip and knee replacement HRGs (Table 24).

Table 24: Primary hip and knee replacement BPT prices

Procedure	HRG	Description	£
Primary total hip replacement	HB12B	Major hip procedures for non trauma category 1 with cc	5,365
	HB12C	Major hip procedures for non trauma category 1 without cc	5,227
Primary total knee replacement	HB21B	Major knee procedures for non trauma category 2 with cc	5,902
	HB21C	Major knee procedures for non trauma category 2 without cc	5,224

Implementation

241. Implementation is illustrated in [Annex B Figure 4d](#). These HRGs cover a range of hip and knee procedures and not specifically primary hip and knee replacements. To target the BPT, the Grouper and SUS PbR will attach a flag to spells meeting the following criteria:
- (a) elective admission (i.e. admission method code of 11, 12, or 13)
 - (b) ordinary admission (i.e. patient classification code of 1 or 5)
 - (c) OPCS-4 codes in the *tariff spreadsheet*.

⁷⁴ Details on how to submit data to the NJR are available at <http://www.njrcentre.org.uk/njrcentre/Healthcareproviders/Enteringdata/Dataentry/DataEntrySystem/tabid/161/Default.aspx>

Stroke care

242. The 2010-11 acute stroke care BPT will continue in the same form in 2011-12 but with a greater differential between the base tariff and the best practice tariff. The BPT (illustrated in [Annex B Figure 4e](#)) applies to non-elective admissions for two HRGs:

- (a) AA22Z Non-transient stroke or cerebrovascular accident, nervous system infections or encephalopathy
- (b) AA23Z Haemorrhagic cerebrovascular disorders.

243. A shortened version of the 2010-11 BPT guidance is provided in this section for convenience in operating the tariff in 2011-12 as well as to highlight the alignment between the characteristics of best practice and the new NICE quality standard on stroke care. We also provide supplementary information about funding for the immediate post-acute phase of rehabilitation.

Immediate post-acute phase of rehabilitation

244. The tariff is a function of the service models in place when it is calculated. In a single service model, AA22Z and AA23Z will capture the costs of the whole pathway and therefore the tariff should adequately fund the associated costs of both the acute phase of care as well as the immediate post-acute phase of rehabilitation. As we move from a single service model to more varied patterns of stroke care delivery, a tariff based on 2008-09 costs and activity will not reflect this diversity.

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

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

246. *Payment by Results for stroke and TIA services (2007)*⁷⁵ included recommendations on unbundling the tariff into an indicative acute stroke and post acute elements and was designed to help those affected by PbR understand better how it was intended to work. Since 2007, the way much of stroke care is delivered has changed significantly, in particular the time people spend in various phases of the care pathway. The National Audit Office (NAO) report *Department of Health: Progress in improving stroke care*

⁷⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077130

(2010)⁷⁶ recognised a need for improved access to specialist community stroke care and early supported discharge (ESD).

247. Because the tariff prices for AA22Z and AA23Z reflect a historic single service model of care, there is consensus that there is resource within the stroke tariff prices to provide high quality care beyond the hyper-acute part of the pathway. To reflect these changes appropriately the NHS has sought assistance to ensure that resources follow patients into the later, rehabilitation focused, elements of the stroke pathway. Work, involving stroke clinicians, is ongoing to produce this, including case studies from health economies which are working to develop solutions to these issues. This support will be available on the NHS Stroke Improvement Programme website⁷⁷ in 2011.
248. The SSNDS for specialised rehabilitation services for brain injury and complex disability categorises the rehabilitation needs of patients and the level of service provision required to meet those needs. For stroke patients, in the majority of cases, the rehabilitation needs will be classed as Category C and require Level 3 service. It is for patients with this category of needs that the NHS Stroke Improvement Programme will be developing solutions to unbundling of the tariff prices for AA22Z and AA23Z. More complex stroke patients, for example with category A or B needs, or those with sub-arachnoid haemorrhage, will have their needs best met in level 1 or 2 specialist rehabilitation settings. Funding for these service levels are currently outside of the scope of tariff. The rehabilitation ERP is currently developing costing and payment models for specialist rehabilitation under the VC chapter of HRGs for rehabilitation.
249. The current tariff structure is based on an average length of stay of 21 days in 2008-09 (decreased from 34 days in 2001). The trim point is set at 54 for AA22Z and 47 for AA23Z days but these, by definition, apply only to outlier⁷⁸ patients and should not be a reason for not developing evidence based alternatives to extended lengths of stay in hospital, for example ESD, for those patients who can benefit. Patients with complex rehabilitation needs, however, who require in-patient rehabilitation and are predicted to require longer lengths of stay in order to reach the level where their needs can be appropriately met in the community should be considered for early referral to specialist rehabilitation.
250. Stays in newer hyper-acute units may be as low as 3 days, with up to 40% of patients moving on to stroke rehabilitation units at that time, and in many stroke pathways patients are moving to different specialist care providers after 7 days in an acute unit. A better shared understanding of the financial implications of these changes is needed to ensure that the money follows the patient appropriately and to reflect the strengthening evidence base for community specialist stroke rehabilitation and ESD. Local discussions about unbundling the tariff to foster implementation of these evidence based interventions in stroke should take place.

⁷⁶ <http://www.nao.org.uk/publications/0910/stroke.aspx>

⁷⁷ www.improvement.nhs.uk/stroke

⁷⁸ Trim points are set to identify unusually long lengths of stay and represent statistical outliers. Trim point is defined as upper quartile + (1.5 x inter quartile range).

Tariff structure and prices

251. 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.
252. Evidence based best practice shows that outcomes are greatly improved if patients are admitted directly to a high quality stroke unit. These patients should not be admitted to a Medical Assessment Unit, but to the acute stroke unit either directly by the ambulance service, from A&E or via brain imaging.
253. Patients with acute stroke should be admitted directly to a stroke unit and assessed for thrombolysis (including receiving brain imaging within 1 hour of arrival at the hospital to identify the type of stroke), receiving it if clinically indicated (NICE quality standard). The scan should not only be done in these timescales but immediately interpreted and acted upon by a suitably experienced physician or radiologist.
254. The stroke BPT is designed to generate improvements in clinical quality in the acute part of the patient pathway. It incentivises key components of clinical practice set out in the National Stroke Strategy⁷⁹, NICE clinical guideline CG68 (July 2008)⁸⁰ and the NICE quality standard for stroke⁸¹. Whilst not a condition of best practice, contribution to national clinical audits should be considered a characteristic of best practice for providers of high quality stroke care.
255. The tariff structure consists of a base tariff and two additional payments for
- (a) care provided on an acute stroke unit
 - (b) timely delivery of initial brain imaging.
256. We are doubling the additional payment for care provided on an acute stroke unit of £684. This should be made for all patients admitted directly^{82, 83} to an acute stroke unit⁸⁴ following initial assessment from either the community, an A&E department or the ambulance service, and treated on a stroke unit with high quality, multi-disciplinary stroke specialist care for the majority⁸⁵ of their stay. Acute stroke units should meet all the markers of a quality service set out in the National Stroke Strategy quality marker 9 which are that:

⁷⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

⁸⁰ <http://www.nice.org.uk/CG68>

⁸¹ <http://www.nice.org.uk/guidance/qualitystandards/stroke/strokequalitystandard.jsp>

⁸² In line with recommendation 17 in NICE clinical guideline CG68

⁸³ Due to the variety of routes into the stroke unit, we define direct admission as intending to be within 4 hours of arrival in hospital.

⁸⁴ Or similar facility where the patient can expect to receive the service set out in quality marker 9 of the National Stroke Strategy.

⁸⁵ Defined as greater than or equal to 90% of the patient's stay within the spell that groups to either AA22Z or AA23Z.

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

257. The additional payment for the initial brain imaging has doubled to £266 and should be made if the scan is delivered in accordance with best practice guidelines as set out in *Implementing the National Stroke Strategy – An Imaging Guide*⁸⁶.

258. Commissioners will be aware that there are a number of different models for delivering high quality stroke care. In places where, for example, a small number of hyper-acute units have been identified to admit all acute stroke patients, there will be other units providing high quality stroke care but not qualifying for the element in this BPT for timely scanning (nor the additional payment for thrombolysis) because they admit patients who are further along the stroke care pathway. However, all acute providers of stroke care should have systems to qualify for the incentive payment for direct admission to a stroke unit.

259. Where patients are thrombolysed using alteplase in accordance with the NICE technology appraisal guidance⁸⁷, they will continue to receive the targeted adjustment of £828 in addition to best practice payments. This adjustment covers the drugs themselves, and the additional cost of nurse input and the follow-on brain scan.

260. To target the tariff specifically to patients diagnosed with a stroke, the Grouper will flag spells with a SSC of 55 for patients whose primary diagnosis is either I61, I63 or I64 (including the various subsets of coding for each of these main codes).

261. Commissioners are required to monitor and adjust payment in accordance with provider compliance with the standards of care defined above. SUS PbR will apply the base tariff to spells with an SSC 55 flag but is unable to apply the best practice additional payments because there is currently no national database recording compliance with the best practice characteristics.

⁸⁶ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085146

⁸⁷ www.nice.org.uk/TA122

Transient ischaemic attack

Characteristics of best practice

262. As signalled in 2010-11, we are introducing a mandatory BPT for non-admitted services for suspected TIA (mini-stroke), aligned with quality markers 5 and 6 of the National Stroke Strategy (Figure 4).

Figure 4: Quality markers from the National Stroke Strategy

QM5. Assessment – referral to specialist

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

QM6. Treatment

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

263. It is widely accepted that current tariffs (primarily the geriatric medicine outpatient attendance tariff) are insufficient to cover the costs of running higher quality, specialised TIA clinics, but that where these have been set up both patient experience and outcomes have improved. We have designed the tariff to correct this, and to release savings through prevention of major stroke and improved outcomes. It consists of a base tariff for providers meeting minimum best practice criteria, and additional payments for high risk patients and use of MRI.

264. The base tariff rewards providers already meeting minimum best practice whilst acting as an incentive for provision of best practice where it does not currently exist. For providers to be eligible they must ensure that:

- (a) all patients are assessed by a specialist stroke practitioner, who has training, skills and competence in the diagnosis and management of TIA. This should be consistent with the UK Forum for Stroke Training⁸⁸
- (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
- (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

⁸⁸ <http://www.ukstrokeforum.org/>

are not subject to this criterion. The nature of the follow-up should be agreed locally and it is not expected that this will necessarily be delivered in the same setting as the initial diagnosis and treatment.

265. Providers failing to meet these criteria will continue to be paid the appropriate conventional tariff but we would expect commissioners to negotiate provision of best practice at the earliest opportunity.
266. An additional payment is made for treatment of high risk patients within 24 hours. Patient risk is defined by the ABCD2 score and is completed by the healthcare professional referring the patient. High risk patients are classified as those with an ABCD2 score greater than or equal to 4. It is accepted that there are some additional factors which are not picked up by the ABCD2 score and may justify a high risk classification. Where a patient presents with other factors, the assessing stroke consultant may legitimately re-classify the patient as high risk regardless of the ABCD2 score of the referrer.
267. This score will be used for assessment of meeting best practice markers as set out below, as well as for vital sign monitoring. Re-classification of patient risk does not alter the clock start time for diagnosis and treatment of patients. Clearly, re-classification will influence the payment providers receive. We recommend commissioners monitor this to ensure that it stays within acceptable parameters.
268. The timeframe for treatment of patients (particularly those assessed as high risk) is key to the delivery of best practice. The BPT is aligned with the vital sign for TIAs and mini-stroke, for which the timeframe is currently defined as follows:
- (a) the clock starts at the time of first relevant presentation of the patient to any health-care professional (e.g. a paramedic, GP, stroke physician, district nurse or A&E staff)
 - (b) the clock stops 24 hours after this initial contact, by which time all investigations and treatments should be completed.
269. The following investigations for high risk TIA cases should be completed within the 24-hour time window:
- (a) blood tests (all patients)
 - (b) ECG (all patients)
 - (c) brain scan (if vascular territory or pathology uncertain. Diffusion-weighted MRI is preferred, except where contraindicated, when CT should be used)
 - (d) completion of carotid imaging (where indicated) and referral for timely carotid surgical intervention (where indicated).
270. The following treatments for high risk TIA cases should be commenced within the 24-hour time window:
- (a) aspirin (where needed or alternative if contraindicated)
 - (b) statin (where needed or alternative if contraindicated)
 - (c) control of blood pressure (where needed unless contraindicated).

Tariff structure and prices

271. The tariff has the following elements:

- (a) base tariff price of £450 (for providers meeting minimum best practice criteria)

The base tariff is payable for all patients presenting at a specialist TIA clinic (both high and lower risk, and regardless of final diagnosis) and covers both initial and follow-up attendances, including brain imaging, carotid imaging, ECGs and echocardiograms, as appropriate. This price assumes that the brain imaging is delivered using CT rather than MRI. This reflects the fact that, for a number of reasons, it may not always be possible to perform an MRI. However, it is still strongly recommended that MRI is the primary modality used.

- (b) additional payment of £92 for treatment of high risk patients within 24 hours

This payment applies to all high risk patients investigated and treated within 24 hours⁸⁹. It is designed to incentivise providers to meet the ambition set out in QM5 of the Stroke Strategy⁹⁰, and has been set as a further 20% of the base tariff.

- (c) additional payment of £92 for use of MRI

The base tariff payment is based upon all patients receiving CT brain imaging. However, unless the patient has a contraindication, diffusion weighted MRI should be the primary technique used for brain imaging. This payment reflects the difference in costs between the two modalities (i.e. the additional cost of providing an MRI scan over a CT scan) and applies regardless of the risk assessment of the patient.

- (d) total tariff for high and lower risk patients

The only difference in tariff available to high and lower risk patients is the quality marker for 24 hour investigation for treatment of high-risk patients. The maximum tariff price for achieving best practice is shown in Table 25.

Table 25: Total tariff for high and lower risk TIA patients

Patient risk assessment (ABCD2)	Base tariff	High risk treated within 24 hours	Brain imaging using MRI	Maximum tariff payable
High (>=4)	£450	£92	£92	£634
Lower (<4)	£450	N/A	£92	£542

- (e) specialist TIA follow-up

⁸⁹ as defined by the Stroke Vital Sign

⁹⁰ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

No price has been set for follow-up attendances because the mandatory follow-up for patients with confirmed TIAs is covered within the price for the first attendance. However, where multiple follow-ups are necessary, commissioners and providers should agree the level of re-imburement locally.

It is recognised that specialist follow-ups may not be delivered in the same setting as the initial diagnosis and treatment. Given this, commissioners and providers may want to agree locally to unbundle the follow-up element of the payment. The base tariff is based upon a follow price of £133 (mandatory tariff for geriatric medicine follow-up), and this could be used as a starting point for negotiation over unbundling this specific element.

(f) non-best practice

For comparison, the equivalent prices for an outpatient attendance in geriatric medicine are £281 (first) and £133 (follow-up). Therefore, providers not meeting best practice criteria would receive £414, assuming a follow-up is provided, which is £36 less than the base best practice tariff price.

Implementation

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

273. SUS PbR will:

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

274. SUS PbR will not:

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

275. Implementation is illustrated in [Annex B Figure 4f](#).

Section 7: Exclusions

Introduction

276. The national tariff is mandatory for activity within the scope of PbR. Some services, procedures, HRGs, TFCs, drugs and devices are outside the scope of PbR and therefore subject to locally agreed payments. The *tariff spreadsheet* includes a full exclusions list and further information, determined after wide-ranging consultation with stakeholders. In addition, the costs of services that are currently outside the scope of reference costs are, by default, also outside the scope of PbR though will not necessarily be listed on the exclusions list.
277. There are various reasons why some activity should be subject to local payment rather than a mandatory tariff. Some excluded services have not had currencies developed for them. Excluded high cost drugs are typically specialist, and their use concentrated in a relatively small number of centres rather than evenly across all providers that carry out activity in the relevant HRGs. These drugs would not be fairly reimbursed if funded through the tariff. Excluded medical devices represent a high and disproportionate cost relative to the cost covered under the relevant HRG. Since we largely base the tariff on historic cost data submitted to us by the NHS, it may not reflect new medical devices introduced after the base year.
278. For all excluded activity, commissioners and providers should agree local prices, and local arrangements for monitoring activity. Non-mandatory prices are provided in [Section 8](#) for a few services to help inform commissioning. Local prices should be paid in addition to the relevant tariff. For example, if a patient is admitted to hospital for a procedure involving an aneurysm coil, the normal HRG based tariff should be paid for the admitted patient spell, with an additional payment to cover the additional cost of the aneurysm coil itself. This additional payment is the only part of the total price subject to local determination.
279. In most cases, the additional payment should cover only the cost of the excluded drug, product or device and associated consumables and preparation. However, some procedures may entail additional direct costs which should also be taken into consideration in determining the appropriate additional payment.
280. In all cases, commissioners and providers will need to determine whether they wish to agree volumes and prices as part of contract agreements, or to operate on a case-by-case basis. For some excluded items, such as spinal cord stimulators or insulin pumps, it may be appropriate to agree volumes and prices in advance within a contract, while for others a case-by-case approach may be preferred. Commissioners and providers will also need to ensure that usage of any drugs or devices is in keeping with NICE and other clinical guidance.
281. There is some overlap between excluded high cost drugs and excluded services. The intention is that where services are excluded, the service as a whole is excluded. Certain service exclusions have flexibility for the method of exclusion to be determined locally (e.g. cystic fibrosis) whereas others are defined by set codes or variables. To avoid

ambiguity, the list of excluded drugs therefore includes some drugs that may be used solely in services excluded from PbR.

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

283. Table 26 summarises the main changes to the exclusions list in 2011-12.

Table 26: Changes to the exclusions list

No longer excluded in 2011-12	Newly excluded in 2011-12
Services	
Renal dialysis	
Procedures	
	Intracranial telemetry
Admitted patient care HRGs	
CZ20Z Complex Major Maxillo-facial Procedures with restoration DZ15A Asthma with Major CC with Intubation DZ21D Chronic Obstructive Pulmonary Disease or Bronchitis with Intubation without CC DZ27C Respiratory Failure with Intubation without CC DZ31Z Complex Lung Function Exercise Testing DZ32Z Simple Lung Function Exercise Testing DZ39Z Complex Gas Exchange Studies DZ40Z Simple Gas Exchange Studies DZ44Z Simple Airflow Studies HA84A Traumatic Amputations with Major CC HD35A Other Wounds or Injuries with Major CC HD35B Other Wounds or Injuries with CC HD35C Other Wounds or Injuries without CC JC13Z Photo Tests LB45Z Retroperitoneal Lymph Node Dissection SA06D Myelodysplastic Syndrome with CC SA16Z Plasma Exchanges 20 or more WA13Y Convalescent or other relief care without CC	
Outpatient TFCs	
170 Cardiothoracic surgery 172 Cardiac surgery 173 Thoracic surgery 257 Paediatric dermatology 330 Dermatology 350 Infectious diseases	
Drugs	
Amprenavir Daclizumab Sitaxentan Zalcitabine	Alitretinoin Amifampridine Boceprevir Decitabine Dexamethasone intravitreal implant Everolimus Fampridine Fingolimod Flebogammadif Gammaplex Gefitinib

No longer excluded in 2011-12	Newly excluded in 2011-12
	Pirfenidone Rilpivirine Riociguat Telaprevir Vicriviroc
Devices	
Atherectomy devices Video capsule for endoscopy	3 dimensional mapping and linear ablation catheters used for complex cardiac ablation procedures (includes 2 dimensional navigation system mapping catheters) ⁹¹ Circular external fixator frame (includes Ilizarov frames) Laser sheaths Radiofrequency ablation probes (when used for treating tumours and complex cardiac ablation procedures)

Excluded services

284. We are mostly carrying forward exclusions from 2010-11, although adult and neonatal critical care, ambulance services and cystic fibrosis will have currencies in 2011-12 (paragraph 395), and adult renal dialysis will have tariffs (paragraph 170). Patient transport services (PTS)⁹² and healthcare travel costs scheme (HTCS)⁹³ costs remain excluded from the tariff.

Excluded procedures

285. We are continuing to exclude the following six procedures:

- (a) soft tissue sarcoma surgery
- (b) positron emission tomography computed tomography (PETCT)
- (c) single photon emission computed tomography (SPECTCT)
- (d) cardiovascular magnetic resonance imaging
- (e) pelvic reconstructions
- (f) head and neck reconstructive surgery.

286. We are also excluding intracranial telemetry in 2011-12.

Soft tissue sarcoma surgery

287. This surgery is only delivered in a very small number of units and is defined in Table 27 (conditions in both columns to be satisfied).

⁹¹ This device exclusion covers all complex cardiac ablation procedures and does not necessarily have to be paired with HRG EA29Z - Percutaneous complex ablation (includes atrial fibrillation or ventricular tachycardia)

⁹² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373

⁹³ http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/DH_075759

Table 27: Definition of soft tissue sarcoma surgery procedure exclusion

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

PETCT

288. PETCT scans only had dedicated codes created for them in OPCS-4 in 2009-10 and are therefore not yet included in reference costs.

SPECTCT

289. SPECTCT scans are excluded for the same reason as PETCT.

Cardiovascular magnetic resonance imaging

290. There is ongoing development work with the British Society of Cardiovascular Magnetic Resonance on the coding and classification of this activity.

Pelvic reconstructions

291. Pelvic reconstructions are defined as “a pelvic/acetabular fracture requiring open reduction and internal fixation covering any significantly displaced acetabular fracture and all complex pelvic ring fractures (except those that are minimally displaced in the over 65s)” and represent a disproportionate cost in relation to other activity within the same HRGs.

Head and neck reconstructive surgery

292. Head and neck reconstructive surgery for the excision and reconstruction of upper aerodigestive tract, skull base, salivary, thyroid gland malignancies, is significantly more expensive than either excision or reconstruction alone. From 2011-12 this exclusion will also cover head and neck reconstructive surgery for non-malignancies, as we are advised that the resource implications are the same as for malignancies.

Intracranial telemetry

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

Excluded HRGs

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

Excluded TFCs

295. We exclude TFCs mostly because the service is excluded from PbR (e.g. rehabilitation), but have also excluded others due to low volumes of activity. As noted in paragraph 121, we reviewed these for 2011-12.

Excluded drugs

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

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

297. The exclusions list contains details of the individual high cost drugs excluded from PbR at the time of writing. Excluded drugs will also create unbundled HRGs where they are coded. To avoid obsolescence in our annual guidance, where possible we link high cost drug exclusions to British National Formulary (BNF)⁹⁴ categories and use generic names of medicines. The general principle is that the exclusion applies to both mandatory tariffs and published non-mandatory prices.

298. If a section or sub-section is listed then all drugs in that section or sub-section are excluded, e.g. under AIDS/HIV antiretrovirals it states “5.3.1”, in this instance all drugs under BNF section 5.3.1 are excluded.

299. If a specific drug is excluded then it is listed by name, e.g. under drugs affecting bone metabolism it states “6.6.1 > teriparatide”, in this instance only teriparatide is excluded.

300. The exclusions list is not necessarily an exhaustive list of all drugs excluded from PbR. The BNF is updated regularly but we will not be updating our list in-year. If in-year a new drug is added to a BNF section or sub-section that is wholly excluded then the new drug is also excluded. For example, if a new drug is added into BNF section 5.3.1 then it will be excluded from the tariff as the whole section is excluded, whereas if a new drug is added into BNF section 6.6.1 then it will not be excluded as currently only teriparatide is excluded in this section.

⁹⁴ www.bnf.org.uk

301. Most drugs are excluded for any purpose irrespective of their BNF section. However, BNF sections should be used as a broad guide to the usage and purpose of the drug. Commissioners and providers should agree locally for which indications an excluded drug will be funded. Drugs can also be stated exclusions for a specific use or purpose. For example, in 2011-12 Sildenafil is only excluded (as part of BNF section 2.5.1/7.4.5) when used for pulmonary arterial hypertension.
302. Some drugs may be excluded from PbR prior to the drugs having the appropriate licensing or NICE guidance. This does not negate their exclusion from PbR. In addition, if a drug that is excluded from PbR is prepared as an unlicensed preparation it is still excluded from PbR. When a drug is excluded from PbR it is not an indication that the drug must necessarily be funded separately, but that the drugs costs have not been included in the published tariffs. We fully expect that commissioners and providers would discuss the usage and any associated payment for the drug through normal, established commissioning routes.
303. Where a new drug is released in-year and it is not excluded from PbR, but it is causing an issue for service delivery, commissioners and providers should agree local arrangements, using flexibilities as appropriate.
304. All home care drugs, where there is no associated admitted patient or outpatient activity at the provider, continue to be excluded from PbR. This includes the actual drug, transportation, delivery and any other associated costs. As in previous years, all blood products are excluded from PbR regardless of whether or not they are listed in the BNF.
305. *PbR Q&A for 2011-12* includes comprehensive questions and answers on high cost drugs in PbR.

Excluded devices

306. The High Cost Devices Steering Group has reviewed existing exclusions and devices which are:
 - (a) new to the NHS since 2008-09 and likely to be in use up to and including 2011-12
 - (b) high cost and represent a disproportionate cost relative to the relevant HRG
 - (c) used in a subset of cases within an HRG
 - (d) used in a subset of providers delivering services under a specific HRG.
307. Table 28 summarises changes to the device exclusion list between 2010-11 and 2011-12. It does not include the new additions to the list in 2011-12 from Table 26.

Table 28: Changes to the 2010-11 device exclusion list

Name of device in 2010-11	Change in 2011-12
3 dimensional navigation system mapping catheters	Now covered under the heading of 3 dimensional mapping and linear ablation catheters used for complex cardiac ablation procedures
Atherectomy devices	Not a 2011-12 exclusion – Now covered by relevant HRG
Endovascular stent graft	As in 2010-11, includes aortic stent grafts
Ilizarov frames	Now covered under the heading of circular external fixator frame
Radiofrequency ablation – probes and catheters	Now covered under the heading of radiofrequency ablation probes (when used for treating tumours and complex cardiac ablation procedures)
Video capsule for endoscopy	Not a 2011-12 exclusion – now covered under relevant HRG

308. The costs of services that are currently outside the scope of reference costs are, by default, not included within the mandatory or non-mandatory tariffs. We expect that commissioners and providers will negotiate locally for these services and devices in the same way as for other services and devices excluded from mandatory tariff. For example, continuous positive airway pressure (CPAP) and bi-level positive airways pressure (BiPAP) machines should be covered under local commissioning arrangements for equipment in hospital and home equipment loans.
309. As in 2010-11, commissioners and providers should agree an additional payment to cover the additional cost of a bespoke prosthesis, over and above the cost of a standard prosthesis. Commissioners and providers should also agree a local price for the programming and maintenance of cochlear implants and bone anchored hearing aids because the tariffs only cover the costs associated with the admitted patient spell in which the device is implanted. For bilateral procedures, the additional cost of the procedure and implant should be subject to local negotiation.
310. When using complex cardiac ablation procedures, only one of the following exclusions can be sought for reimbursement purposes at any one time: 3 dimensional mapping and linear ablation catheters used for complex cardiac ablation procedures, or radiofrequency ablation probes (when used for treating tumours and complex cardiac ablation procedures).
311. Where we have removed devices from the exclusions list, commissioners and providers may wish to consider the use of innovation payments (paragraph 434) to support funding.

Chemotherapy

312. Chemotherapy remains excluded from PbR, but is complicated by the presence in HRG4 of a core HRG (the care related to the primary diagnosis or surgical procedure) and unbundled HRGs (for the chemotherapy). The core HRGs are in the scope of tariff, but the unbundled elements related to the chemotherapy service are out of scope and subject to local prices.

313. The unbundled chemotherapy HRGs are intended to cover both the delivery costs and the chemotherapy drug costs, inclusive of any pharmacy dispensing on costs and the range of associated drugs to deal with the symptoms or side effects of the chemotherapy drugs themselves.
314. Under HRG4, the unbundled chemotherapy HRGs are split between chemotherapy drug procurement (regimen) HRGs and delivery HRGs. Each patient is allocated one HRG for the regimen procured and one HRG for delivery. The chemotherapy procurement HRGs are for the procurement of drugs for regimens according to band. There are 11 regimen bands, including a new HRG in 2011-12 for drugs not included on the national regimen list (SB16Z). The updated chemotherapy regimens list with mappings to OPCS-4.6 codes (including paediatric regimens) will be published in April 2011.
315. There will be costs associated with procurement for admitted patients and outpatients. The costs of each of the procurement HRGs contain all costs associated with procuring each drug cycle, including pharmacy costs (indirect costs and overheads). HRG SB17Z is introduced in 2011-12 to take account of the delivery of regimens not on the national list.
316. The chemotherapy delivery HRGs are assigned for each attendance for treatment to reflect the complexity of treatment and hence resource usage. An example of a delivery HRG is SB12Z for delivery of simple parenteral chemotherapy at first attendance.
317. The delivery HRGs can be generated for day cases, outpatients, and regular day and night admissions (which are excluded from PbR). Delivery HRGs should not be generated for ordinary admissions, because OPCS-4 delivery codes are not recorded for these, and the delivery costs are included within the core HRG.
318. Due to the structure of HRG4, a core HRG will always be generated even when a day case, outpatient or regular day admission, or regular night admission attends solely for the purpose of delivery of chemotherapy. This will need to be taken into account when agreeing the local price for the chemotherapy service to avoid over-payment, as shown in Table 29.

Table 29: Summary of payment arrangement for chemotherapy HRGs

	Core	Unbundled chemotherapy procurement HRG	Unbundled chemotherapy delivery HRG
Ordinary admission	Within scope of tariff - includes costs for delivery	HRG generated, agree payment locally	No HRG generated
Day case and outpatient	HRG generated, within scope of tariff if appropriate	HRG generated, agree payment locally but check if core payment justified	HRG generated, agree payment locally but check if core payment justified
Regular day and regular night admissions	HRG generated, but the activity is outside the scope of PbR		

319. Nationally we are working to simplify this situation. To avoid over-payment, we introduced a core HRG for 2009-10 reference costs - Sameday chemotherapy admission/attendance (SB97Z) - which is generated by Grouper logic if:

- (a) chemotherapy has taken place and

- (b) the activity has length of stay less than 1 (regular admissions/day case/outpatients/short stay ordinary admissions) and
- (c) the core HRGs which would otherwise be generated are diagnosis driven HRGs (no major procedures have taken place).

320. Our expectation is that this core HRG would in future attract a zero (£0) tariff because it is designed to ensure appropriate overall reimbursement where a patient attends solely for the purpose of delivery of chemotherapy and no additional admission or outpatient attendance has taken place.

321. Drugs which are excluded from the tariff when used for chemotherapy may also have other purposes. When used for non-chemotherapy purposes they may or may not continue to be excluded, e.g. Rituximab will always be excluded because it is excluded as a high cost drug and not just when used as a chemotherapy drug. Work is ongoing to resolve and clarify issues regarding the treatment of hormonal therapies and high cost supportive drugs. Table 30 shows the current treatment of such drugs.

Table 30: Hormonal treatments and supportive drugs

Method of delivery	Hormone treatments	Supportive drugs
As part of a regimen	If included within a regimen no further action	If included within a regimen ignore
By itself	Code to an outpatient attendance/delivery (non chemotherapy)	Excluded under chemotherapy exclusion therefore local prices apply, apportioned over procurement bands
As part of supportive drug	Include costs within supportive drug reimbursement	N/A

322. Therefore, if a hormone treatment is not used as an intrinsic part of a regimen, or as a supportive drug to a regimen, it is only excluded from PbR when the drug is explicitly listed on the exclusion list, or if it is included in a BNF section or sub-section that is wholly excluded from PbR.

Section 8: Non-mandatory prices

Introduction

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

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

324. There will be new non-mandatory prices in 2011-12 for:

- (a) home haemodialysis
- (b) neurology and neurosurgery outpatient attendances
- (c) simple bronchodilator studies.

325. The following services will continue to have non-mandatory prices in 2011-12 as they did in 2010-11 :

- (a) acute phase of rehabilitation
- (b) adult hearing services
- (c) direct access diagnostic imaging
- (d) direct access echocardiograms
- (e) direct access spirometry
- (f) non face-to-face outpatient attendances.

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

327. The following services will no longer have non-mandatory prices in 2011-12:

- (a) adult renal dialysis (paragraph 170)
- (b) dermatology outpatient attendances (paragraph 121)
- (c) paediatric diabetic medicine (paragraph 230).

Acute phase of rehabilitation

328. HRG4 introduced unbundled HRGs for rehabilitation. As in 2010-11, we are not setting a mandatory tariff for these, because clarity is needed in defining where a patient's acute spell ends and where discrete rehabilitation begins. We are therefore continuing to publish non-mandatory prices for the acute phase of care for pneumonia, hip replacement and fragility hip fracture, based on the typical length of the acute phase for the HRGs. These do not relate to discrete rehabilitation.
329. The rehabilitation ERP is reviewing the current approach to developing a tariff for rehabilitation services. The panel will also review the latest reference costs for rehabilitation to help address options for the coding of rehabilitation services, and link into the best practice tariff development for stroke (with emphasis on rehabilitation) and fragility hip fracture services.

Adult hearing services

330. We are again publishing non-mandatory prices for direct access adult hearing services based on pathways developed by the Department's Audiology Board.

Airflow studies

331. The non-mandatory tariff for direct access spirometry is unchanged. This activity maps to HRG DZ44Z (Simple airflow studies).
332. For 2011-12 we are introducing a new non-mandatory tariff for direct access simple bronchodilator studies. This activity maps to HRG DZ35Z (Simple bronchodilator studies).
333. These two HRGs should not be used as the driver for payment, except where they have been accessed directly.

Direct access diagnostic imaging

334. We are continuing to publish non-mandatory prices for diagnostic imaging accessed directly (e.g. when requested by a GP). The costs of reporting are included in the published prices, but are also shown separately so that they can be used if an organisation provides a report, but does not carry out the scan.
335. These prices can be used by commissioners to:
- (a) reduce the attendance tariff for patients who have had directly accessed diagnostic imaging and subsequently have a related outpatient attendance, where the direct access imaging removes the need for a further diagnostic resulting from the outpatient attendance. The *PbR guidance for 2010-11* provided a case study from Leicestershire County and Rutland PCT
 - (b) support the commitment in *Equity and Excellence: Liberating the NHS* to introduce choice for diagnostic testing during 2011-12.

336. SUS PbR does not identify diagnostic imaging services which have been accessed directly. We suggest that commissioners and providers use local data flows to identify services accessed directly.

337. Non-direct access plain film x-rays continue to be included within the tariff. Direct access plain film x-rays do not have non-mandatory prices and will need to be priced locally.

Direct access echocardiograms

338. In 2010-11, a new, unbundled HRG for simple echocardiograms (RA60Z) replaced the core HRG of EA46Z used in 2009-10. As with other imaging, we have rebundled the costs of this activity, except for direct access where we are publishing a non-mandatory price. The unbundled HRG should not attract any additional payment for non-direct access activity. Where direct access activity is processed through the Grouper both a core outpatient attendance HRG and the unbundled HRG will be created. In these circumstances when the activity is direct access, the core HRG should not attract any payment and the unbundled HRG should attract a payment.

Home haemodialysis

339. In 2011-12 we are introducing a BPT for adult haemodialysis and peritoneal dialysis (paragraph 170). We are publishing non-mandatory prices (Table 31) for home haemodialysis, whilst continuing to collect and refine cost data with a view to incorporating it into the mandatory tariff in the future.

Table 31: Non-mandatory prices for home haemodialysis

HRG code	HRG name	Per session £
LD09A	Home haemodialysis/filtration with access via haemodialysis catheter 19 years and over	128
LD10A	Home haemodialysis/filtration with access via arteriovenous fistula or graft 19 years and over	159

340. The price and structure of these non-mandatory home haemodialysis HRGs reflect the general principle that tariff prices should ordinarily apply independently of setting, but also provides scope for locally agreed prices, particularly where patients are receiving more than three sessions per week. As a rule of thumb, it is recommended that the costs of a week of home haemodialysis should not exceed the cost of three sessions of hospital or satellite haemodialysis.

341. We recommend applying the prices per haemodialysis session to each session of home haemodialysis, while acknowledging that patients dialysing at home may wish to have four or five sessions of dialysis a week, as opposed to the three sessions a week in a hospital or clinic that are recommended as minimum practice by the Renal Association. This recommendation is intended to incentivise an increase in the provision of home dialysis options for patients. We encourage commissioners in areas where there are currently low levels of home dialysis provision to work with their providers to create effective choices for patients.

342. Commissioners and providers should always encourage increased sessions of home haemodialysis where these are more appropriate and beneficial for the patient. When home haemodialysis exceeds three sessions per week, the non-mandatory prices may not be appropriate and organisations may wish to agree a more appropriate price. There should be no cap on the number of patients having access to home haemodialysis or the total number of sessions that can be prescribed. These discussions should however help balance any financial risk between commissioner and provider.

Neurology and neurosurgery

343. We are publishing non-mandatory prices for neurology (TFC 400), neurosurgery (TFC 150) and paediatric neurology (TFC 421) consultant-led outpatient attendances, with the intention of introducing mandatory tariffs for 2012-13. We calculated these in the same way as other outpatient attendance tariffs, i.e. with diagnostic imaging rebundled. However, we are investigating the amount and distribution of diagnostic imaging used during these outpatient attendances, and commissioners and providers may wish to take account of local scanning rates where possible when agreeing prices. We also understand that some neurology and neurosurgery outpatient clinics are run on a satellite basis, with variable contracts in place for this model. The delay in introducing mandatory tariffs gives an opportunity for such contracts to be revisited in order to put providers and commissioners in a position to use mandatory tariffs from 2012-13.

Non face-to-face outpatient attendances

344. The non-mandatory price for non face-to-face outpatient attendances is unchanged, and is designed to support the use of convenient communication for patients.
345. The definition of a non face-to-face consultation is one which must directly entail contact with a patient or with a proxy for the patient such as a parent of a young child. A non face-to-face contact should replace a face-to-face consultation which would have attracted the relevant mandatory outpatient attendance tariff.
346. The price may be applied to TFCs that have a mandatory tariff for face-to-face activity, and to consultant led or non-consultant led activity, where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the implications of test results to a patient would warrant its use, but a telephone call, text or e-mail to report a result would not. It does not apply to telemonitoring. The funding for this activity is no longer in the outpatient attendance tariff as an overhead.

Section 9: Mental health currencies

Introduction

347. Mental health currencies – the care clusters⁹⁵ – were made available for local use in 2010-11. *Equity and Excellence: Liberating the NHS* commits us to mandating these currencies for 2012-13 with local prices.
348. 2011-12 is therefore a crucial preparatory year. We expect that by the 31 December 2011 all service users accessing mental health care (post GP or other referral) that have traditionally been labelled working age (including early intervention services from age 14) and older people's services, should be allocated to a cluster.
349. A second crucial task for 2011-12 will be for commissioners and providers to agree the prices to be used in 2012-13. This will require understanding of local costs per cluster. We are developing *Guidance on Establishing Local Prices for Mental Health* and this will be available in the summer of 2011.
350. The development of a mental health currency is a joint piece of work between the Department and the NHS. Much of the development work is done by local projects and then recommended for national use at the mental health PbR product review group.
351. The implementation of PbR in mental health needs to support delivery on the outcomes set out in the new mental health outcomes strategy *No health without mental health: a cross government mental health outcomes strategy for people of all ages*⁹⁶.

Mental health clustering tool

352. Mental health PbR does not use the ICD-10 or OPCS-4 classification systems. Instead, mental health professionals rate service users using the Mental Health Clustering Tool (MHCT)⁹⁷. This tool has 18 scales (e.g. depressed mood, problems with activities of daily living), the first 12 of which are the Health of the Nation Outcome Scales (HoNOS). Each scale is given a rating from 0 (no problem) to 4 (severe to very severe problem).
353. Based on ratings, mental health professionals should be able to identify a cluster whose profile matches that of the service user they are assessing. If no match is possible then a variance cluster (cluster 0) can be used and the reasons for doing so recorded. Our goal is to continually reduce the use of this variance cluster over time e.g. by adding new clusters or by adjusting the boundaries of existing clusters.
354. The final decision on which cluster to allocate a service user rests with the mental health professional. Because clustering is linked to payment the Department is exploring options for review, audit and validation. The Department has also commissioned work to

⁹⁵ The care cluster currency was developed by the Care Pathways and Packages Project (CPPP), a consortium of commissioners and providers from NHS Yorkshire and NHS North East.

⁹⁶ <http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm>

⁹⁷ The complete Mental Health Clustering Tool and the Care Clusters can be found in the *Mental Health Clustering Booklet 2011-12*.

develop a national algorithm to support clustering. This will take MHCT scores and suggest the most likely cluster(s) to inform the mental health professional's clustering decision. Development work will take time and so this will not be ready until mid-2011. In the interim, for provider organisations just getting started on clustering we suggest focusing on using the *Mental Health Clustering Booklet 2011-12* to inform clustering decisions.

355. A number of providers have dispensation to use HoNOS65+ (a variant of HoNOS designed to capture the specific needs of older people) as part of the MHCT, to help with an evaluation to see if this affects MHCT scoring and, ultimately, cluster allocation.
356. MHCT assessments will occur at three points:
- (a) initial assessment
 - (b) scheduled reassessment
 - (c) unplanned reassessment following a significant change in need that cannot be met by the continuation of the current cluster care package⁹⁸.
357. When re-assessing a service user who has already been allocated to a cluster, we acknowledge that they may score lower on the MHCT precisely because they are receiving effective treatment. However, if this treatment is stopped because they are moved to a lower cluster or discharged, their needs would increase again. Therefore, to avoid such perversities, the *Mental Health Clustering Booklet 2011-12* includes straightforward guidance on things to consider in re-assessment (known as care transition protocols) as well as the MHCT and the care cluster profiles.

Care clusters

358. The care clusters as a currency unit are therefore based primarily on the characteristics of a service user, rather than their diagnosis. Expected diagnoses are given for each cluster, but the same diagnosis could lead to multiple clusters e.g. a service user with depression could fit into a number of clusters, dependent on the severity of their symptoms and other clustering scores.
359. The care clusters are numbered 0-21, although cluster 9 is a blank cluster, following the decision not to include it.⁹⁹ We need to future proof the cluster numbering, so that new clusters and subdivisions of clusters can be added in a logical fashion. However, people are also familiar with the existing clustering numbering. We are therefore planning to implement a system for allocating numbers to the clusters in 2012-13.
360. The clusters do not define the appropriate interventions and treatments to meet an individual's characteristics. The exact format of the care packages to meet the needs of each cluster will be decided locally, although obviously taking into account NICE

⁹⁸ Unplanned reassessments should be on an exception basis and agreed with commissioners. Development work should help to identify what percentage of re-assessments will normally be unplanned.

⁹⁹ Cluster 9 related to substance misuse and identified service users who did not have a significant mental health need. They would be treated by substance misuse services, which have different commissioning routes and information systems from mainstream mental health services.

guidance and national policy documents. Determining the care packages locally gives providers the flexibility to develop innovative approaches to care, rather than simply being paid for what they have always done. It also allows the tailoring of care packages to individual's requirements as part of the care planning process. By starting from the perspective of individuals, rather than organisations, they fit with and can be used to support the personalisation agenda set out in *Putting People First*.¹⁰⁰

361. The clusters are mutually exclusive in that a service user can only be allocated to one cluster at a time – if they transfer to a new cluster, the previous cluster episode ends.
362. The clusters are designed to be setting independent, on the premise that people should be treated in the least restrictive care setting possible. Further development work will be checking that this does not create perverse incentives with regard to the minority of mental health service users who do require inpatient care.

Cluster payment periods

363. The clusters differ from the currencies used in acute physical PbR in that they cover extended time periods which may contain multiple different care interactions. For instance, whilst in cluster 3 – non-psychotic (moderate severity) – a service user might have several sessions of psychological therapies, contacts with a care coordinator and other interventions.
364. The appropriate duration for a service user to be in a cluster is likely to be a matter for local agreement between commissioners and providers. However, for comparable contracting purposes, it is important to define payment periods for the clusters. These are linked to scheduled reviews.
365. Table 32 sets out for each of the clusters the expected review interval. They vary considerably from cluster to cluster as some clusters relate to short episodes of mental illness, and others to mental health as a long-term condition. The maximum review interval is annual, in line with the Care Programme Approach (CPA) guidance that reviews should take place at least once a year.

Table 32: Mental health clusters

Cluster no.	Cluster label	Cluster review interval (maximum)
0	Variance	Not applicable
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	6 months
6	Non-psychotic disorders of overvalued Ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual

¹⁰⁰ *Putting People First, A shared vision and commitment to the transformation of Adult Social Care* (December 2007) available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

Cluster no.	Cluster label	Cluster review interval (maximum)
9	Blank cluster	Not applicable
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	6 months
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical or engagement)	6 months

Initial assessment

366. Development of the mental health care clusters has brought into focus the issue of how the initial assessment of an individual, whether or not they are allocated to a cluster, should be reported, costed and reimbursed. This section relates to new referrals and 'one-off' assessment services, rather than to assessments of existing service users (paragraph 372).

What is an initial assessment?

367. The initial assessment can be initiated either as part of the GP or mental health practitioner referral, or in response to a specific request by an organisation. Initial assessments can be classified in three ways, according to how the assessment was initiated, or whether or not an individual is allocated to a care cluster:

(a) **Assessed, not clustered**

In this classification, an individual may be referred by their GP to a mental health provider for an initial assessment. The assessing mental health professional establishes that it is not appropriate for the individual to be allocated to a care cluster. The individual may be referred back to the GP by the mental health professional for other diagnosis or treatment, or signposted to other services. An example of this may include referral for non-care cluster treatment, such as non-mental health related substance misuse.

(b) **Assessed, clustered**

As before, an individual may be referred by their GP to the mental health provider for an initial assessment. The practitioner establishes that the individual needs to be allocated to a care cluster. The individual then comes under the care of the mental health service provider, and a package of care is discussed and agreed with the service user.

(c) **Assessment 'service'**

This classification of service differs from the previous two in that it tends to be more intermittent, covering one-off provision of mental health services, for example,

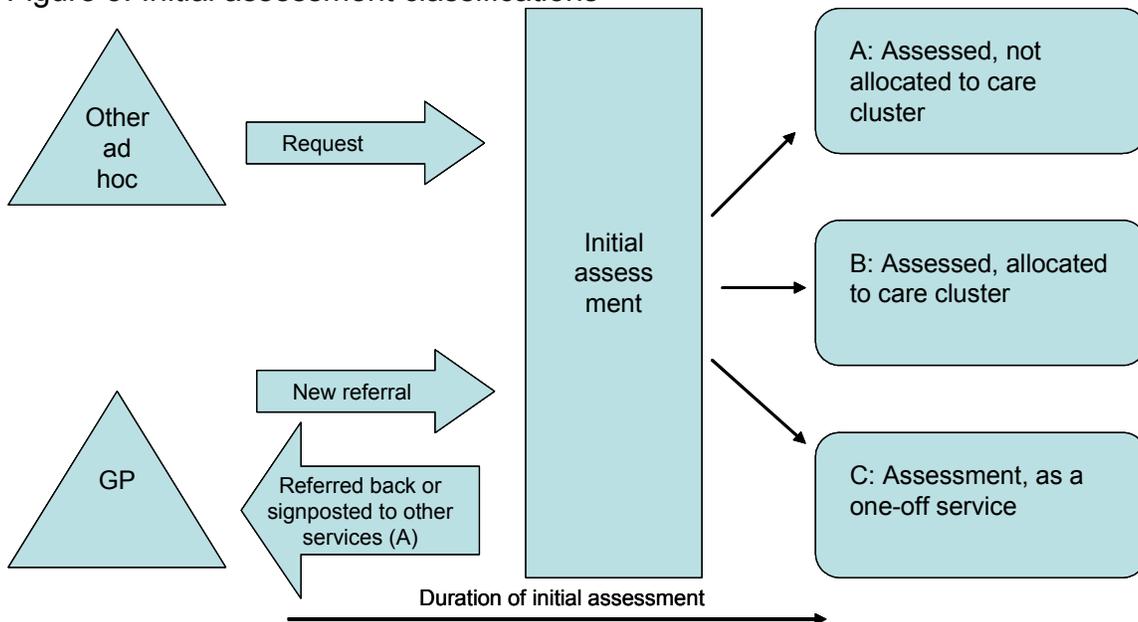
providing clarification to a GP on the mental health of an individual, or mental health liaison services.

Liaison services in both A&E and acute settings offer similar roles. In A&E, services would involve responding to requests for assessments or management advice specific to mental health issues arising from patients presenting at A&E departments, while in acute, these may involve assessing and recognising mental health issues such as dementia or depression in older people. Their findings and advice on treatment and care are shared with the ward staff, allowing for an improved monitoring of the person’s needs. Further work to define an initial assessment is ongoing and will be completed in 2011.

As it is difficult to specify the frequency with which the assessment ‘service’ will be utilised, the details of the circumstances in which it will apply will need to be agreed with commissioners. The risk of this service becoming an uncontrolled activity payment will be minimised if all parties understand what will be, and what will not be, covered by this classification of assessment within service contracts.

368. Figure 5 illustrates the three types of initial assessment.

Figure 5: Initial assessment classifications



Duration of initial assessments

369. The assessment period begins when the mental health provider receives a new referral from a GP or elsewhere. The duration of the initial assessment will be determined by the length of time that it takes the mental health professional to assess the individual using the mental health clustering tool. This will vary dependent upon the nature and complexity of the mental health problems of the individual referred. The assessment is completed when the individual is either allocated, not allocated, or the provision of the one-off service has concluded.

Funding initial assessments

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

371. This does not seem satisfactory and would provide an incentive to reduce thresholds and allocate people to clusters inappropriately. It would also distort care clusters if the costs of initial assessment for people who are allocated are included, when newly clustered service users are compared to people who have been re-clustered. So including the costs of initial assessment in the care cluster payment would undermine the integrity and resource homogeneity of the mental health PbR currency.

Existing service users

372. As indicated above, this section is in respect of new referrals, or the provision of assessment 'services'. Mental health providers will re-assess and re-cluster (where appropriate) existing service users at pre-determined and agreed intervals. To facilitate this, draft transition protocols have been developed which map an individual's progress, and facilitate movement through the care clusters as they respond to the packages of care that they receive. The costs of re-assessment are included in the care cluster as all service users will be reassessed.

Pricing assessments

373. Commissioners and providers will need to negotiate local prices for initial assessments. Some assessments will be more complex than others, requiring more resources including the involvement of several professionals. Figure 6 gives a suggested costing matrix.

Figure 6: Costing matrix

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

(1) The seven care classes are:

- Non-psychotic
 - Mild / moderate / severe (care clusters 1-4)
 - Very severe and complex (care clusters 5-8)
- Psychotic
 - First episode (care cluster 10)
 - Ongoing or recurrent (care clusters 11-13)

- Psychotic crisis (care clusters 14-15)
- Very severe engagement (care clusters 16-17)
- Organic
 - Cognitive impairment (care clusters 18-21)

Clusters as contract currency

374. We envisage the clusters becoming, over time, the primary contract currency used in the standard mental health contract. This means that commissioners will be paying providers on the basis of x people in cluster 1, y people in cluster 2 and so on.

375. In 2011-12, we would encourage commissioners and providers to shadow the clusters alongside their existing contract arrangements. This will be useful in establishing local prices and preparing for cluster payment in 2012-13. Commissioners and providers may also want to consider aligning the service specifications being developed as part of the standard national mental health contract with the clusters – this will enable clear identification of care packages for each cluster.

376. As a contract currency, the clusters may operate in any one of the following ways:

- (a) lead or principal provider basis, i.e. it is expected that a commissioner will contract with one provider who will have overall responsibility for the service user within that cluster. The provider may then sub-contract with other providers to offer particular aspects of care
- (b) lead commissioner model, i.e. it is expected that a commissioner will contract with one or more providers on behalf of other commissioners. Providers will have responsibility for the service users within the clusters commissioned
- (c) joint commissioner model, i.e. it is expected that more than one commissioner will contract with one or more providers for the service users within the clusters commissioned
- (d) in more innovative models the principal provider may not actually provide any treatment themselves – they might be a third sector care co-ordinator, or even, as the potential of personal health budgets is explored, the service user themselves.

377. Unbundling a cluster could be done, to allow direct commissioning of multiple providers, but we would caution that this could lead to paying more on a fee for service basis, that will simply encourage providers to do more activity, rather than provide holistic care over a period of time. A more effective option might be for commissioners to stipulate, within the contracting framework, that specific services are to be provided by stipulated providers. Rather than unbundling, it would be for the provider to negotiate appropriate sub-contract arrangements.

378. It is intended that the clusters should cover care provided by social care staff who are part of integrated mental health teams (e.g. those employed by the mental health provider or as part of Section 75 arrangements). The decision on whether the clusters include other social care interventions will need to be taken locally at this stage – it is subject to further national work.

379. The clusters should, as with PbR more generally, apply regardless of sector, so will also be applicable to the third sector and the independent sector as well as the NHS. We recognise that the independent sector in particular focus on some of the more specialist mental health care, much of which is not covered by the clusters (see paragraph 386).
380. The payment for care clusters will inevitably be an average payment. Commissioners and providers should be cognisant of groups of individuals who will have significant additional costs to the average such as expectant or new mothers requiring perinatal mental health services and mental health service users who are deaf. It is likely to be appropriate to establish additional top-up payments or alternative funding arrangements in addition to the core cluster payment, to ensure the cost of these more specialised services are recognised.
381. We are developing guidance in respect of establishing local prices, which will be available in during 2011.

Quality and outcomes

382. Initially developed as a single joint project between the Department and CPPP, the quality and outcomes work stream is now re-launched as a national sub-group of the mental health PbR national project with a remit to establish outcome measures and quality indicators for the care clusters. The aim is to have recommended outcome measures and quality indicators for the care clusters by the spring of 2011 that would then be ready for mandating and full use in 2013-14. The approach will build upon data and tools now in use, and will be developed further to identify gaps where new indicators are needed.
383. This development process will mean that for the next few years there will be refinements and improvements to the care clusters and the clustering tool. However, changes will build on the existing work, rather than being a significant departure.

Clusters and IAPT

384. *Equity and Excellence: Liberating the NHS* committed the Department to developing “payment systems to support the commissioning of talking therapies.” We want this payment system to align with the care clusters, as the care clusters are designed to capture service user need and help identify an appropriate treatment response, one of which would be a course of psychological therapies. However, we also recognise the good outcome information that is captured by improving access to psychological therapies (IAPT) and want to make use of this in the reimbursement mechanism. We are therefore carrying out a feasibility study with a number of sites in early 2011 to examine issues such as the balance of payment between need and outcome, allocation to clusters using IAPT metrics and the pattern of service users seen by cluster in IAPT services.
385. Once this feasibility study is complete we will communicate its findings and recommend a way forward for the payment for IAPT services.

Exclusions

386. The clusters cover post-GP (or other referral) care for mental health services that have traditionally been labelled working age (including early intervention services from age 14) and older people's services.

387. Table 33 outlines progress on service areas not currently covered by the clusters.

Table 33: Progress on services excluded from the clusters

Service area	Being taken forward by	Work in progress
Child and adolescent mental health services (CAMHS)	CAMHS sub-group of mental health PbR product review group	Testing new allocation
Secure services	Secure service sub-group of mental health PbR product review group	Testing additional MHCT items and cluster refinements in 2011-12
Secondary drug misuse	Drugs recovery from dependency PbR development project	Developing and testing payment mechanisms during 2011
Secondary alcohol misuse ¹⁰¹	Alcohol PbR project	Developing and testing payment mechanisms during 2011
Learning disability services for non-mental health needs.	Proposal under discussion	Proposals from a number of local sites being tested.
Neuropsychiatry, autism and asperger's, tertiary eating disorders, gender dysmorphia (which all services in the specialist definition set for mental health) Liaison psychiatry Acquired brain injury IAPT Mental health services provided under a GP contract	Product review group	Some proposals and discussion on neuropsychiatry and autism. Further development work expected in 2011.

Non-contract activity¹⁰²

388. The longer-term duration of the care clusters means that non-contract activity may require cross-charging. For instance, if a service user is being treated by one mental health provider, but then has an incidence of mental illness elsewhere in the country that leads to them being admitted (e.g. under section 136 of the Mental Health Act) then the provider responsible for the service user's care should reimburse the new provider until the service user is repatriated. If the service user chooses to stay in the new area, then the previous provider should be paid on a pro rata basis for the proportion of the cluster payment period elapsed, and a new cluster duration will then begin (as in an unscheduled transition, although the service user will not necessarily have moved clusters).

¹⁰¹ Both the alcohol and drug work is focussing on people whose main need is their substance misuse. Where substance misuse is a complicating factor for a mental health problem, this is already covered by the care clusters.

¹⁰² This section is in line with *Who pays? Establishing the responsible commissioner* (2007), available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634

Interaction between care cluster and acute HRGs

389. The care clusters are not mutually exclusive with acute physical healthcare HRGs. This is because a mental health service user may well need surgery or other treatment that is not related to their mental health problem and will be provided by an acute trust rather than a mental health service.
390. Many HRGs identify mental health problems as complicating factors in care. For instance, dementia is deemed a complicating factor in orthopaedic procedures. Consequently an HRG is generated which has a higher level of complexity and the acute provider receives a higher payment. For instance an ICD-10 code of F00.1, Dementia in alzheimer's disease with late onset, would result in the generation of HRG HB23B Intermediate knee procedures for non trauma with CC rather than HRG HB23C Intermediate knee procedures for non trauma without CC. HB23B has a tariff price £228 higher than its counterpart without complications or comorbidities.
391. Therefore, identification of mental health problems (e.g. through an assessment of mental state) and any additional costs in treating the primary physical condition, which result from the mental health problem, are included in the tariff price for the HRG. Treatment specifically for the mental health problem, such as that given by liaison mental health services, is not included. Work is ongoing on the reimbursement of liaison mental health services.
392. One area that we are giving further consideration to is who should fund admissions and treatment in acute physical healthcare that are primarily driven by a mental health problem, e.g. self-harm presentations at A&E. Current funding arrangements should continue in the meantime.

Other known issues

393. This is the first year that it is mandatory for the care clusters to be used by mental health providers and they continue to be refined and developed. There are a number of practical issues with regard to the operation of the clusters where we do not yet have a definitive answer:
- (a) how should the issue of transition from CAMHS to adult services be considered?
 - (b) should providers offer a "warranty" on the care they offer and treat people for free or pay another provider's costs, if care is ineffective?
 - (c) should carer support be intrinsic to the clusters or an additional element?
 - (d) how can the cluster operate for people with learning disabilities who have mental health problems given the learning disability will affect the clustering decision?
 - (e) how should local care co-ordination be funded if a service user is in an out of area specialist placement?

Section 10: Other currencies

Introduction

394. *Equity and Excellence: Liberating the NHS* noted that “the absence of an effective payment system in many parts of the NHS severely restricts the ability of commissioners and providers to improve outcomes, increase efficiency and increase patient choice.” It therefore makes a commitment to accelerate the development of currencies and tariffs for new services.

395. In 2011-12 we are providing currencies (but not prices) for the following services:

- (a) ambulance services
- (b) critical care
- (c) cystic fibrosis
- (d) smoking cessation.

Ambulance services

396. Following local work in PbR development sites and national work by the PbR ambulance group we are now in a position to introduce currencies for ambulance services. These are:

- (a) hear and treat – the caller is referred to telephone advice either in-house or elsewhere and no ambulance is dispatched
- (b) see and treat – a vehicle (ambulance or fast response vehicle) is dispatched and the crew treat the patient at the scene, with no transportation to an emergency department or elsewhere
- (c) see and convey – an ambulance is dispatched to the scene, some treatment may be given at the scene but the patient is ultimately transported to an emergency department or elsewhere
- (d) calls - total number of calls received.

397. These currencies will be optional for the 2010-11 reference costs collection, mandatory for 2011-12 reference costs, and mandatory for contracting in 2012-13. Prices will be agreed locally but with the potential to transition to a national tariff from 2013-14.

Critical care

398. We have not yet introduced a tariff for the critical care HRGs because of the large range in costs and contract values, and the wide variation in income that a single national price would produce.

399. As announced in *Equity and Excellence: Liberating the NHS*, we are mandating adult critical care (HRG sub-chapter XC) and neonatal critical care (HRG sub-chapter XA) currencies for contracting in 2011-12. NHS organisations must follow the definitions in the relevant critical care minimum datasets (CCMDS) when contracting, recording and counting activity by the HRG currencies. Prices will remain for local negotiation.

400. This “national currency: local price” model described in *Guidance on NHS commissioning and contracting of adult and neonatal critical care services in 2011-12*¹⁰³ will allow local variations to be taken into account, transitions to be phased and incentives to be implemented without any cliff-edges. All organisations will use the same currency, and basis for deriving the currency, for commissioning, for benchmarking, for consistency, and for developing transferable incentives. All NHS organisations need to develop their contracts using the CCMDS and HRG definitions to ensure consistency across the country.
401. Commissioners of smaller units may prefer a fixed and variable funding model to ensure capacity and availability of beds, whereas commissioners of larger units may prefer a per-patient funding model to incentivise efficiency or movement of beds to meet other strategies (e.g. major trauma). We do not expect any contracts to be agreed on a 100% fixed model (i.e. a block contract).
402. As in previous years, we are publishing comparative activity and pricing information for adult critical care HRGs in Table 34, based on 2008-09 reference costs. The Department has recently published 2009-10 reference costs, which are a more recent source for comparable information.

Table 34: Adult critical care benchmark data

HRG code	Number of organs supported	Average casemix	Days that >80% of patients stay in critical care	Proportion of patients that stay for one night only	Benchmark bed day data (1, 2, 3) (2011-12 prices)
XC01Z	6+	1.0%	NA	NA	£1,541
XC02Z	5	5.3%	NA	NA	£1,541
XC03Z	4	11.3%	13	19%	£1,455
XC04Z	3	20.7%	9	29%	£1,317
XC05Z	2	27.1%	5	33%	£1,117
XC06Z	1	32.9%	3	50%	£821
XC07Z (4)	0	1.6%	2	67%	£250

Sources:

Department of Health critical care project 2007
 Department of Health reference costs 2008-09

Notes:

- (1) includes the total cost of outreach services, as submitted in reference costs
 (2) excludes critical care activity in specialist burn units, spinal cord injury units and specialist hepatic (liver) critical care units; high cost drugs and blood products published as exclusions to PbR; and MFF
 (3) Bed day is defined in the CCMDS; it is not on the basis of a midnight count
 (4) XC07Z price has been suppressed to a hotel cost price, with the costs transferred into the prices for 3 or more organs supported, XC01Z to XC04Z

403. Table 35 provides benchmark bed day costs for the neonatal critical care HRGs, based on 2009-10 reference costs. Commissioners may wish to consider reduced prices for HRGs XA04Z and XA05Z, to take into account that there is a payment made for every

¹⁰³ www.dh.gov.uk/pbr

baby under the core admitted patient care HRG. The core HRG is paid for the explicit purpose of covering the costs of normal care for patients, irrespective of age.

Table 35: Neonatal critical care benchmark data

HRG code	Description	Benchmark bed day costs (1) (2009-10 prices)
XA01Z	Neonatal critical care - intensive care	£997
XA02Z	Neonatal critical care - high dependency care	£726
XA03Z	Neonatal critical care - special care without external carer	£429
XA04Z (2)	Neonatal critical care - special care with external carer	£400
XA05Z (2)	Neonatal critical care - normal care	£400

Source: Department of Health reference costs 2009-10

Notes:

(1) excludes MFF

(2) costs have been equalised to remove relativity issues.

404. Further work is needed to understand the implications for paediatric critical care due to definitional issues and commissioning responsibilities around non-discrete critical care beds. The costs of delivering non-discrete paediatric critical care are included in the prices of admitted patient care HRGs.

Cystic fibrosis

405. Building on several years work by the Cystic Fibrosis Trust as a PbR Development Site, we are introducing a mandatory national currency for cystic fibrosis care with local prices. The currency is a complexity-adjusted yearly banding system with seven bands of increasing complexity. There is no distinction between adults and children.

406. The 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 in the end stage of their illness (requiring intravenous antibiotics in excess of 113 days a year with optimum home or hospital support).

407. Table 36 identifies the characteristics which will lead a patient to be classified into a particular band.

Table 36: Cystic fibrosis banding matrix¹⁰⁴

Banding definitions		Band						
		1	1A	2	2A	3	4	5
Therapies	Maximum number of total days of IV antibiotics	0	14	28	56	84	112	≥113
	Nebulised antibiotics (<i>Pseudomonas</i> infection)		Yes					
	Long-term (>3 months) nebulised antibiotics <u>OR</u> DNase			Yes				
	Long-term (>3 months) nebulised antibiotics <u>AND</u> DNase				Yes			
Hospitalisations	Maximum numbers of days in hospital	0	7	14	14	57	112	≥113
Supplemental feeding	Nasogastric feeds				Yes			
	Gastrostomy					Yes		
Complications	CF Related Diabetes <u>OR</u> ABPA w/o other complications				Yes			
	CF Related Diabetes <u>AND</u> ABPA					Yes and (FEV ₁ ≥60%)	Yes and (FEV ₁ <60%)	
	Massive Haemoptysis <u>OR</u> Pneumothorax					Yes and (FEV ₁ ≥60%)	Yes and (FEV ₁ <60%)	
	CF Related Diabetes <u>AND</u> Gastrostomy					Yes and (FEV ₁ ≥60%)	Yes and (FEV ₁ <60%)	
	Non Tuberculous mycobacterium treated or difficult to treat infections (MRSA)					Yes		

408. Patients are allocated to a banding by extracting data from the Cystic Fibrosis Registry and feeding it into a template that produces the banding. For ease of understanding, Figure 7 provides an example for manually banding a patient.

Figure 7: Worked example for cystic fibrosis banding

Step one: define the value for each criteria

The values for patient A are:

FEV ₁ % predicted lung function	75%
Maximum number of total days of IV antibiotics	12
Nebulised antibiotics (<i>Pseudomonas</i> infection)	Yes
Long-term (>3 months) nebulised antibiotics <u>OR</u> DNase	No
Long-term (>3 months) nebulised antibiotics <u>AND</u> DNase	No
Maximum numbers of days in hospital	7
Nasogastric feeds	Yes
Gastrostomy	No
CF Related Diabetes <u>OR</u> ABPA w/o other complications	Yes
CF Related Diabetes <u>AND</u> ABPA	No
Massive Haemoptysis <u>OR</u> Pneumothorax	No
CF Related Diabetes <u>AND</u> Gastrostomy	No
Non Tuberculous mycobacterium treated or difficult to treat infections (MRSA)	No

¹⁰⁴ The shaded cells support the worked example in Figure 7.

Step two: determine the band for each criteria

This is indicated by the shaded cells in Table 36. It is to be expected that the criteria will fit multiple bands. In our example, patient A is eligible for bands 1, 1A and 2A.

Step three: allocate the patient to their highest band

In our example, patient A is allocated to band 2A. This process is repeated for each patient. The process is automated by extracting data from the Cystic Fibrosis Registry and feeding it into a template that produces the banding.

409. The Cystic Fibrosis Registry produces the bandings based on data returned by cystic fibrosis providers. The 2010 banding is available for commissioners and providers to use for contracting in 2011-12. Updated banding should be included as a contract variation to apply to activity from April 2011. Because cystic fibrosis is a long-term condition there is relatively little movement between bands from one year to another, rather there is a steady progression of disease severity over several years. Commissioners and providers already have 2009 banding data to support this.
410. The bandings cover all cystic fibrosis related care and activity for a patient during the financial year. This includes:
- (a) admitted patient care and outpatient attendances (whether delivered in a specialist centre or at a network clinic under shared care arrangements)
 - (b) home care support
 - (c) nebulised drugs and intravenous antibiotics
 - (d) annual review investigations
 - (e) any overheads associated with treatment
 - (f) all associated staffing costs.
411. Any specific cystic fibrosis admitted patient or outpatient activity should not receive additional activity based tariff payments. To help identify cystic fibrosis activity we are introducing new TFCs for adult cystic fibrosis (TFC 343) and paediatric cystic fibrosis (TFC 264).
412. Unrelated care such as the costs of obstetric care for a pregnant woman with cystic fibrosis is not covered by the annual banded currency and will be subject to other reimbursement mechanism such as the relevant HRG.
413. The costs of nebulised antibiotics are included as we are seeking to develop a nationally consistent approach to purchasing cystic fibrosis drugs that deliver economies of scale. At present our indication is that 90% of these drugs are prescribed through primary care, rather than from specialised centres.
414. The introduction of a national currency with a local price takes account of the variation in prescribing practice around the country as well as acknowledging there have been historically varying levels of spending on cystic fibrosis services. We will work with commissioners and providers to understand these issues during 2011 with the goal of introducing a national tariff for 2012-13.

415. Although prices are subject to local agreement, considerable work on the actual costs underpinning each band has been carried out (Figure 8), and will provide a good starting point for establishing local prices.

Figure 8: Mean yearly cystic fibrosis treatment costs by band

Band	Patients	Mean treatment cost
1	329	£5,792
1a	16	£9,445
2	458	£12,481
2a	479	£18,826
3	361	£27,074
4	109	£45,912
5	33	£56,384

Source: PricewaterhouseCoopers

Notes:

- The table shows the mean treatment costs for the 1,785 patients in the sample.
- The costs are for 2007-08 and have not been inflated to 2011-12 prices.
- MFF is excluded.
- High cost nebulised drugs are included. The cost for each drug is based on the yearly treatment cost from data in the BNF:
 - Colistin (Colomycin) = £3,384
 - Colistin (Promixin) = £5,037
 - Tobramycin (TOBI) = £7,123
 - Pulmozyme (DNase) = £6,161

Smoking cessation

416. Following work by NHS West Midlands who ran a pilot project under the PbR Development Sites Phase 1, we are introducing a non-mandatory currency for smoking cessation.

417. The aim of the project was to increase the supply of stop smoking services by introducing local currencies and tariffs. Accredited providers can recruit and deliver services to eligible patients without referral or authorisation from the PCT. Services are delivered to a detailed service specification.

418. Providers receive payments for both 4 and 12 week quitters, with higher payments available to those providers that support individuals from defined targeted populations such as those from deprived areas, routine and manual workers, people from black and minority ethnic groups, those with mental health issues, communication difficulties and people aged under 25. Higher payments are also paid to providers that incur the costs of stop smoking medications supplied to patients. Separate currencies and tariffs have been developed for stop smoking services delivered to pregnant women.

419. Providers are required to submit monthly invoices and a patient level, minimum dataset. This dataset is used to verify provider payments, enable PCTs to complete their statutory returns for stop smoking services and allow PCTs to audit provider activity. Provider returns are received, validated and processed by Healthcare Commissioning Services, a NHS commissioning and commercial support agency.

420. The Department’s tobacco control policy team is supporting this initiative and has expressions of interest from several local and regional level commissioners to introduce the tariff based payment system in their regions. The database requirements are being supported and provided centrally, reducing the implementation costs to early adopter areas.

421. Indicative prices used in the West Midlands project are included in Table 37 and may be of use for local price setting.

Table 37: Indicative prices for smoking cessation

	Providers that do not incur costs of prescribing		Providers that incur costs of prescribing	
	General population	Targeted populations	General population	Targeted populations
4 week quitter payment	£94	£136	£166	£214
12 week quitter payment	£129	£271	£228	£427

Currencies and tariffs in future years

422. We intend to increase the pace of development of currencies and tariffs for new services in future years. Areas we will be looking at include:

- (a) diabetes - tariffs that improve patient care and outcomes for people with diabetes, including the management and prevention of foot disease in hospitals, and the management of diabetic ketoacidosis and diabetic retinopathy
- (b) HIV outpatient service – we anticipate introducing national currencies for adult HIV outpatient services in 2012-13 to support the delivery of safe and cost effective patient care aligning to British HIV Association guidelines and maintaining the open access nature of sexual health services
- (c) integrated sexual health – covering levels 1, 2 and 3 for sexual reproductive health (SRH) and levels 1 and 2 for sexually transmitted infection (STI) services, and integrated SRH and STI care in a non-GUM setting. We will also be looking at GUM pathways and pricing proposals to cover GUM clinic STI services at levels 1 to 3
- (d) podiatry - which has been identified as lending itself to a reimbursement model for community services that both introduces a currency to community services and supports the introduction of the Any Willing Provider model. It is likely that the currency will be a complexity-adjusted intervention currency, based on a simple treatment episode or package of care
- (e) chemotherapy – we are reviewing options for mandating the existing HRG currencies
- (f) radiotherapy –we are reviewing options for mandating the existing HRG currencies for 2012-13. Brachytherapy currencies will continue to be excluded.

423. Please contact us if you are interested in getting involved in this work.

Section 11: Flexibilities

Introduction

424. A national pricing structure can never reflect the reality of the most innovative care occurring locally. Therefore, there needs to be the opportunity for local discretion, so that PbR is not seen as a barrier to providing the best care for patients. In addition, there is also a need for the national system to accommodate local circumstances in order to retain the benefits of national applicability and transparency. Such accommodation needs to be exercised within clear guidelines. Within PbR, the application of discretion to national currencies or tariffs is referred to as a flexibility.

425. In 2011-12 we are introducing new flexibilities:

- (a) which will allow commissioners and providers, in exceptional circumstances, to seek approval to operate an agreed variation to price which is lower, but not higher, than the published tariff (paragraph 444)
- (b) for specialised cardiac services (paragraph 443).

426. In 2011-12 we are removing the flexibility:

- (a) for SHAs to apply to the Department for permission to temporarily suspend contractual arrangements within a local health economy
- (b) for non-payment of emergency readmissions, following the changes announced in the *revision to the operating framework 2010-11* (paragraph 53).

427. Other flexibilities continue to apply.

428. The following principles for the application of local flexibilities will ensure that we continue to protect the benefit of national tariffs and currencies, whilst allowing for local innovation and material redesign of services:

- (a) **the flexibility supports the provision of care that is better for the patient and the NHS** – obviously, any local flexibility should be supporting better care for patients, whether it is closer to home, more convenient or of higher quality: examples include one-stop shops or see and treat services. A flexibility may also benefit the NHS as a whole, by reducing the costs to the whole health system
- (b) **the flexibility supports material service redesign or more efficient pricing** – local flexibilities can be a means of driving further efficiency as long as quality, choice or competition are not compromised. This should not negate the benefits of national pricing
- (c) **the flexibility is the product of local agreement** – with due regard to the PbR Code of Conduct, flexibilities should be agreed in advance by commissioners and providers and, where appropriate local discussions can be supported by SHAs
- (d) **the flexibility is clearly established and documented** – an audit trail for the agreed flexibility is necessary and it should be documented as part of contract negotiations

- (e) **the flexibility should be time limited and reviewed as appropriate** – flexibilities are not set indefinitely. For instance, innovation payments apply for three years. It may be that a local innovation becomes the national norm and the tariff changes to recognise this.

Additional outpatient procedure HRGs

429. Where commissioners and providers agreed local prices in 2009-10 for outpatient procedures that are not covered by the mandatory list in 2011-12, they may agree to continue using these. In these circumstances we would expect that the local outpatient procedure price would be paid instead of and not in addition to the national outpatient attendance tariff. Commissioners may wish to reduce the prices negotiated in 2009-10 to reflect the national bundling of outpatient procedures (except those with mandatory tariffs) into the outpatient attendance tariffs in 2011-12. We do not expect this flexibility to apply to diagnostic imaging.

Antenatal admissions

430. We know that there is a problem nationally with the classification of maternity non-delivery events (NZ04 to NZ09). Where the published tariffs are clearly over-reimbursing actual local costs, commissioners should consider the use of a payment flexibility to manage the situation until the provider has time to review and adjust coding, recording and costing practices. Where revised categorisation of admission methods leads to a significant change of income, commissioners and providers should consider a time limited transition from one level of payment to the other.

Bundling for pathways

431. We are committed to developing and implementing pathway and year of care tariffs in the future. In the meantime, commissioners and providers may wish to explore options for the local bundling of care into pathways, especially for patients with long term conditions and named patients with frequent admissions. The *PbR guidance for 2010-11* included a suggestion to support hospital at home care for COPD patients¹⁰⁵.

Complex diagnostic imaging

432. Where a specialist provider can demonstrate that it carries out more complex and costly diagnostic imaging than the average, which may particularly be the case for specialist orthopaedic providers, commissioners should consider if there is a case for paying more than the mandatory tariffs for outpatient attendances.

Infectious disease isolation units

433. Commissioners can provide additional funding for infectious disease isolation units. The same arrangements apply as for innovation payments, with the exception of the time limit.

¹⁰⁵ The Department will develop a commissioning pack for COPD during 2011.

Innovation payments

434. Innovation payments allow additional payments for new devices, drugs, treatments and technologies or a new application of existing technologies. They give the commissioner the flexibility to make an additional payment for care that is better than the standard care covered by the national tariff. This additional payment may have longer-term efficiency benefits, e.g. reducing the likelihood of the need to repeat a procedure. We suggest commissioners avoid setting a blanket minimum threshold of cost for consideration of an innovation payment as appropriate thresholds are likely to be widely different for the different categories: drug, device, treatment or technology.

435. It may also be appropriate to use innovation payments if new technology allows procedures, currently done in an admitted patient care setting, to be carried out in an outpatient setting. The innovation payments would cover costs over and above the existing outpatient tariff, for example the cost of a necessary device.

436. The following criteria and conditions apply:

- (a) the payment should be fixed for a maximum period of three years only from the date at which funding first applies (this could be mid-way through a financial year). In exceptional circumstances, commissioner and provider may agree to extend these arrangements
- (b) where appropriate, commissioners should have regard to the existing cost effectiveness evidence or other relevant national guidance, such as the NICE list of interventional procedures¹⁰⁶
- (c) the price should be agreed in advance and should only relate to the additional costs associated directly with the device or technology and its use relative to the cost of the alternative treatment
- (d) commissioners should have due regard to the procurement arrangements for these drugs, devices, technologies or treatments identified as being suitable for funding.

437. The NHS Technology Adoption Centre (NTAC) “How to Why to” guides¹⁰⁷ may help inform discussions between commissioners and providers on implementing and funding specific technologies.

438. Please e-mail us with details of agreed innovation payments, with “innovation payments” as the subject heading, so that we can consider the innovation in the next phase of PbR development.

Service redesign

439. Service redesign creates an opportunity to do some gain sharing and apply joint incentives. We encourage commissioners and providers to think through the balance of incentives and see if there are examples where both can gain. Service redesign can

¹⁰⁶

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

¹⁰⁷

<http://www.technologyadoptionhub.nhs.uk/how-to-why-to-guides.html>

encompass, for example, the concentration of a service at a tertiary level, e.g. specialised coronary interventions.

440. The tariff is based on the average mixture of complexity of services. Where a particular service being delivered is so different from the normal casemix range, perhaps because of contractually agreed patient exclusion criteria, commissioners will be able to pay at less than the tariff price if the difference is so significant that it amounts to a change in service provision.

441. *Equity and Excellence: Liberating the NHS* sets out proposals which envisage a presumption of greater choice. Following conclusion of the consultation process on choice, providers may have more obligations during 2011, including greater choice in diagnostic testing and post-diagnostic testing. We will be considering the implications for the tariff from 2012-13. In the meantime, organisations may use this flexibility in support of new methods of service delivery coming on stream as a result of the expansion in choice.

SHA flexibilities

442. SHAs will retain the flexibility to manage risks and pressures associated with PbR, while converging towards an overall national strategy.

Specialised cardiac services

443. Although there is no specialised services top-up for cardiac services, we are introducing a flexibility to enable commissioners to support specific services where the tariff may not provide sufficient reimbursement. These services are 24 hour PPCI services (primary angioplasty), grown up congenital heart disease (GUCH) services, and management of arrhythmias (catheter ablation and implantation of ICDs).

Variations to tariff

444. Tariff is a fixed price, however in exceptional circumstances, where providers and commissioners agree, they can seek approval to operate a variation to price which is lower, but not higher, than the published tariff, provided that there is no adverse impact on quality, patient choice or competition.

445. This does not mean replacing the national price with a local price, but it does mean agreeing a variation within the tariff rules. Such a reduction could be in the form of a simple unit price reduction or a marginal rate above an agreed threshold but any variation must be operated within the overall framework of the tariff.

446. Providers will continue to be subject to inspection on quality from the Care Quality Commission (CQC) and commissioners will be responsible for ensuring that the quality of services purchased using a variation to the tariff is at least equal to, if not better than, services purchased at full tariff price. All services will remain free at the point of use to patients, and patients must be able to choose between providers regardless of price.

447. Where a commissioner and provider agree on a variation to the published tariff price, the commissioner must seek SHA approval before it can be implemented. Approval for any variation can only be given where a commissioner is able to demonstrate how they will measure quality of service. SHAs must monitor the impact of any agreed variations to tariff.
448. This flexibility does not signal a move to price competition. The flexibility cannot be imposed through a competitive tender process. It is intended to create the opportunity for commissioners and providers to agree together, in exceptional circumstances, a variation to the national price that enables the provision of services to patients which would not otherwise be possible without some flexibility on price.
449. An example of an exceptional circumstance in which a variation might be considered would be when, as part of their contract discussions, a provider and commissioner would like to take steps to incentivise their health economy's desired outcomes. Building on the example of the existing 30% marginal rate for emergency activity over and above a baseline of the value of 2008-09 activity, they agree to apply marginal rates across more areas of PbR activity, using a variety of different baselines.
450. An example of where it would not be appropriate to consider a variation would be a commissioner seeking to secure reduced tariff payments by guaranteeing a provider greater volumes of elective activity if they agree to be paid at a price lower than the published tariff. This arrangement would risk distorting patient choice, and so would not be permitted.

Unbundling

451. Paragraph 145 of the *PbR guidance for 2010-11* set out the following principles for determining whether a service should be unbundled for payment under PbR:
- (a) unbundling should only take place where a substantive case can be made that it is necessary to achieve significant policy objectives
 - (b) the approach to unbundling for payment should be based on the principles set out in *Options for the Future of PbR* that "the acute tariff should be unbundled only for service items that are commissioned directly from primary care. By contrast, where secondary care clinicians are making the decisions on interventions, we propose to expand the use of casemix based funding and to unbundle only high-cost, low-volume items"
 - (c) a further criterion should be added that would allow unbundling of a service where the costs of a particular activity cannot be predicted from standard casemix measures.
452. Commissioners and providers may continue to unbundle services where it is consistent with these principles.

Section 12: Other operational issues

Market forces factor

453. The MFF payment is calculated from the tariff price, and any tariff adjustments, multiplied by the MFF payment index for each unit of activity within the mandatory scope of PbR and paid directly to the provider by the PCT. MFF payments should be itemised separately in the contract value and the monthly reconciliation accounts. SUS PbR includes the final tariff value to facilitate this process.
454. The MFF is also payable for non-mandatory prices and non-contract activity. Commissioners and providers should agree whether the MFF is appropriate for locally agreed prices.
455. Organisations should use the relevant MFF payment index in the *tariff spreadsheet*. Independent sector ECN and FCN providers take the MFF of the NHS trust or NHS foundation trust nearest to the location where the care was delivered. The MFF applies to ISTCs as set out in contracts.
456. The MFF payment index has been routinely updated using latest earnings data and other data updates, following a review by the Advisory Committee on Resource Allocation (ACRA) for 2011-12 PCT allocations. As with previous updates, we are continuing with a 2% capping policy to the MFF underlying index¹⁰⁸. By this we mean that the underlying MFF index value of an organisation will move towards the target value, but by no more than 2% from the 2010-11 value.
457. Organisations merging on 1 April 2011 will have a new MFF payment index from this date. Those that merge during the financial year will have a new MFF from 1 April 2012 and SHAs should put in place arrangements to ensure a neutral impact across the health economy for the remainder of the year. Organisations should notify us of any planned mergers so that we can calculate and confirm the new MFF value.

Monthly reporting

458. The 2011-12 standard NHS contract for acute services sets out the terms for providers to submit national data sets to SUS. The four key stages in the process are as follows:
- (a) inclusion date – means date by which the provider needs to submit data for the month in question for inclusion in the report available for monthly reconciliation.
 - (b) first reconciliation point – means date when the PbR activity is available to the commissioner to facilitate reconciliation between provider and commissioner.
 - (c) post-reconciliation inclusion date – means date by which the provider and the commissioner need to have resolved any issues relating to the data submission for the month in question. The time between the inclusion date and post-reconciliation inclusion date can be used by providers to submit any late or amended data

¹⁰⁸ As the minimum value changes by less than -2.0% capping the underlying index has the same effect as capping the payment index.

- (d) final reconciliation point – means date when the final reconciliation report is available for the month in question.

459. Commissioners should be diligent in checking the completeness of CDS data in submissions to SUS, including the NHS number.

460. Table 38 sets out the timetable for monthly activity reporting and report availability for 2011-12.

Table 38: Monthly reporting dates¹⁰⁹

Month	Inclusion date	First reconciliation point	Post-reconciliation inclusion date	Final reconciliation point
April 2011	Fri 20 May	Tue 31 May	Wed 23 Jun	Fri 01 Jul
May 2011	Thu 23 Jun	Fri 01 Jul	Thu 22 Jul	Mon 01 Aug
June 2011	Fri 22 Jul	Mon 01 Aug	Fri 22 Aug	Wed 31 Aug
July 2011	Mon 22 Aug	Wed 31 Aug	Mon 23 Sep	Mon 03 Oct
August 2011	Fri 23 Sep	Mon 03 Oct	Fri 21 Oct	Mon 31 Oct
September 2011	Fri 21 Oct	Mon 31 Oct	Fri 23 Nov	Thu 01 Dec
October 2011	Wed 23 Nov	Thu 01 Dec	Wed 21 Dec	Tue 03 Jan
November 2011	Wed 21 Dec	Tue 03 Jan	Wed 24 Jan	Wed 01 Feb
December 2011	Tue 24 Jan	Wed 01 Feb	Tue 22 Feb	Thu 01 Mar
January 2012	Wed 22 Feb	Thu 01 Mar	Wed 21 Mar	Thu 29 Mar
February 2012	Wed 21 Mar	Thu 29 Mar	Wed 20 Apr	Mon 30 Apr
March 2012	Fri 20 Apr	Mon 30 Apr	Wed 23 May	Thu 31 May

Non-contract activity

461. *Who pays? Establishing the responsible commissioner* (September 2007)¹¹⁰, in setting arrangements for payment for non-contract activity (NCA), stated “providers should invoice responsible commissioners for NCA quarterly, within 30 days of the quarter end”. This advice is now superseded and from 2011-12 the reporting and payment for NCA activity should be brought into line with monthly reporting dates in the standard NHS contract for acute services as set out in Table 38 above.

462. The prices for NCA in 2011-12 will be as follows:

- (a) the mandatory national tariff (including any adjustments) and MFF
- (b) where there are no mandatory national tariffs, then locally agreed prices, i.e. prices agreed by the provider with their coordinating commissioner
- (c) where there are neither mandatory national tariffs nor locally agreed prices, then 2008-09 national average reference costs¹¹¹.

463. Providers should make every effort to ensure NCA invoices are sent to the correct commissioners. Where an invoice has been inadvertently sent to the incorrect commissioner, the provider is permitted one further re-invoice for this activity inside the standard timescales. Commissioners should make every effort to provide a timely

¹⁰⁹ October to March dates remain provisional.

¹¹⁰ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466

¹¹¹ No uplift is necessary, given the relevant uplifts are 1.7% (2009-10), 0.0% (2010-11) and -1.5% (2011-12).

response. Where part of an invoice is in dispute, then payment should be made for the non-disputed activity.

Devolved administrations

464. The Department is discussing renewal of the *Interim protocol on cross border commissioning between England and Wales* with officials from the Welsh Assembly Government. This process will take into consideration the changes to the NHS in England set out in *Equity and Excellence: Liberating the NHS*. The current protocol applies to patients in Gloucestershire, Herefordshire, Shropshire County and West Cheshire PCTs, and Betsi Cadwaladr University, Powys Teaching and Aneurin Bevan Local Health Boards (LHBs). It states that Welsh Commissioners will commission work from English providers as per (PbR), i.e. tariff plus MFF. Where there is no applicable tariff, Welsh Commissioners are encouraged to follow, as near as reasonably practicable, the provider's pricing arrangements agreed by their English commissioning consortium.
465. The Department also has an agreement with Wales, Scotland and Northern Ireland (the devolved administrations) to cover the treatment of patients who fall ill away from their home country. Under these arrangements, the treating provider invoices the responsible commissioner without the need for pre-treatment agreement. In addition to non-elective treatments, cross-border elective and outpatient referrals outside contracts also occur. Providers in England and the devolved administrations must seek prior approval from the responsible commissioner for these referrals, who may otherwise refuse payment. English providers should charge at mandatory national tariff rates for these patients.
466. These arrangements are further described in *Cross-border emergency treatment: agreement between England, Scotland, Wales and Northern Ireland*¹¹², (September 2006) and *Supporting information for the resolution of outstanding issues relating to the Cross-border emergency treatment: agreement between England, Scotland, Wales and Northern Ireland* (June 2007), which continue to apply for activity commissioned by devolved administrations in 2011-12 and until further notice. The only change to this guidance is the price for this activity which will now be 2008-09 national average reference costs.

Dehosting

467. Dehosting (or cross charging) for services previously provided on an all-comers basis, mainly A&E and GUM services, continues to apply in England in 2011-12. This does not extend to the devolved administrations, which means that a patient registered in the devolved administrations treated in an English A&E department is paid for by the host commissioner in England, and vice versa.
468. Patient confidentiality means it is not always possible to identify the host commissioner. The underlying principle is that identifiable data should not be necessary for

¹¹² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139150

commissioning purposes in relation to any health service. This is particularly so for sexual health services, where the data is sensitive and in some circumstances controlled by additional legislation. The Patient Information Advisory Group (PIAG) support the following process for safeguarding confidentiality whilst facilitating cross charging:

- (a) clinics should collect contact details where patients are willing to provide them, including full postcode. Where patients are unwilling to provide their postcode, they could be asked for the name of their PCT if they know it or record that the patient was unwilling to provide their details
- (b) clinics should use the postcode to look up the PCT
- (c) clinics should provide to the relevant PCTs an accurate indication of numbers of patients seen and whether a first or follow-up appointment
- (d) PCT staff must accept this on trust. Under no circumstance is any postcode data to be disclosed, as in some instances this will be identifiable and will constitute a serious breach of confidentiality.

469. Genito-urinary medicine monthly access monitoring (GUMMAM) collects attendance at GUM clinic by PCT of residence and can be used for dehosting and cross charging purposes. This dataset is based on national rules for collection and SHA auditing arrangements may be undertaken to validate the data. In the rare circumstances where GUMMAM data cannot be used, providers can allocate postcodes using at least the first 3 or 4 digits in the postcode (the district or sector digits). PCTs could provide look up tables to facilitate accurate allocation of PCT.

470. It may not be possible to identify the PCT in all instances. PCTs will wish to agree local arrangements, e.g. the host PCT charges neighbouring PCTs a proportion of the unallocated patients on an annual block basis based on the numbers of allocated patients seen from that PCT. SHAs have a role in ensuring that PCTs comply with these arrangements.

Never events

471. Never events are serious patient safety events that are largely preventable. From April 2011, PCTs should use the expanded list of never events¹¹³ as part of their contract agreements with providers. The focus of this policy remains on promoting clear reporting and discussion mechanisms for never events as part of a programme of commissioning for safety.

472. For 2011-12, commissioners will have the discretion to decide to make no payment for treatment that results in one of the national never events, or for treatment to deal with the consequences of a never event. The final decision to withhold payment will rest with commissioners who will wish to discuss the appropriateness and the level of payment that is withheld with providers.

473. SUS PbR will still generate payments, which should be adjusted locally through contracts. Where a national tariff does not apply for the episode of care in which the

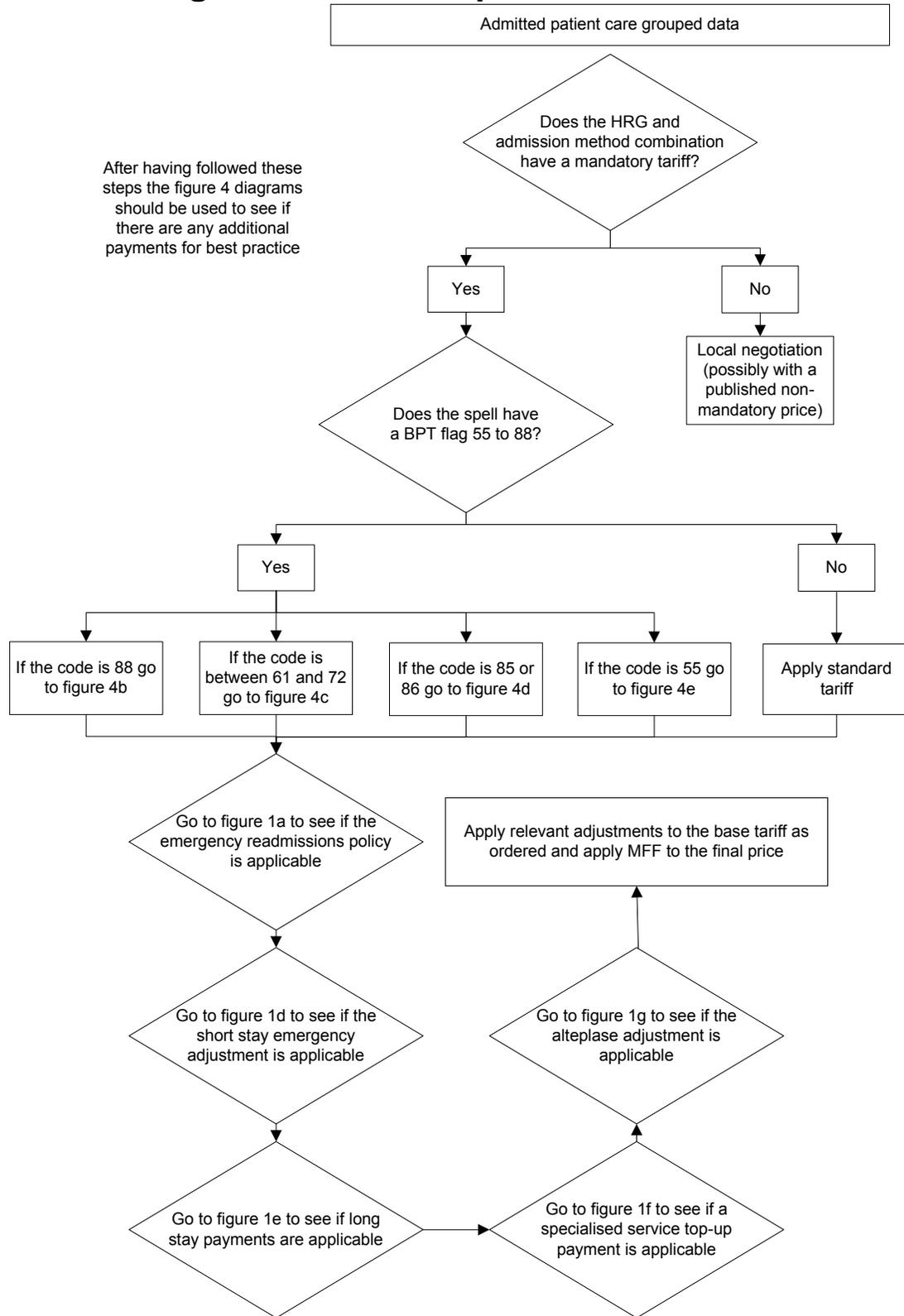
¹¹³ These will be published on the Department of Health website shortly.

never event occurred, commissioners may wish to discuss appropriate alternative cost recovery mechanisms.

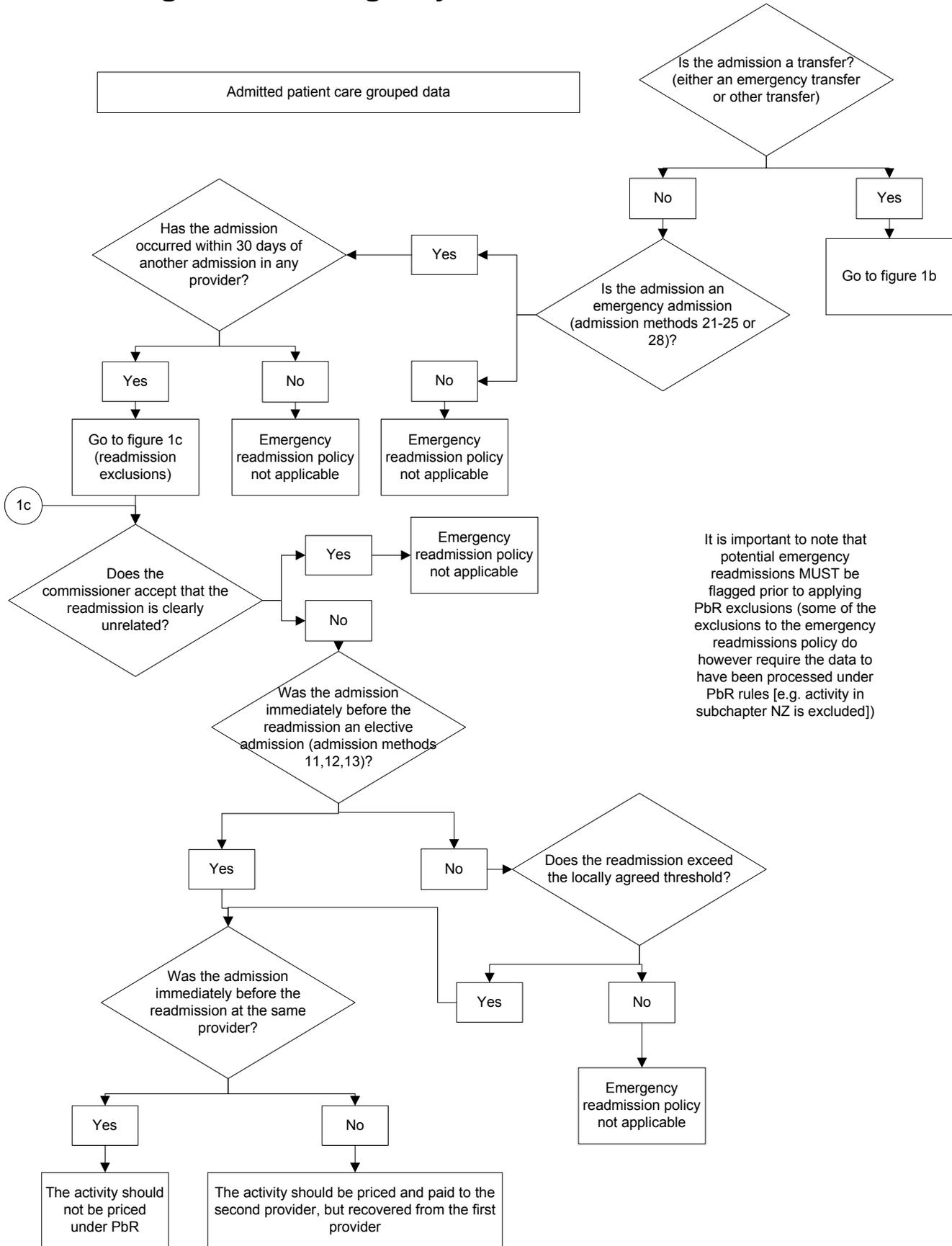
NHS number

474. As noted in the operating framework for 2011-12, consistent and effective use of the NHS number is vital for patient safety. Providers of NHS funded care will use the NHS number as the primary patient identifier for all communications. Organisations should begin preparing for 2012-13, from when commissioners will be able to withhold payment where NHS numbers are missing from CDS records, subject to defined exceptions where it is accepted that it may not be possible or practical to source the NHS number.

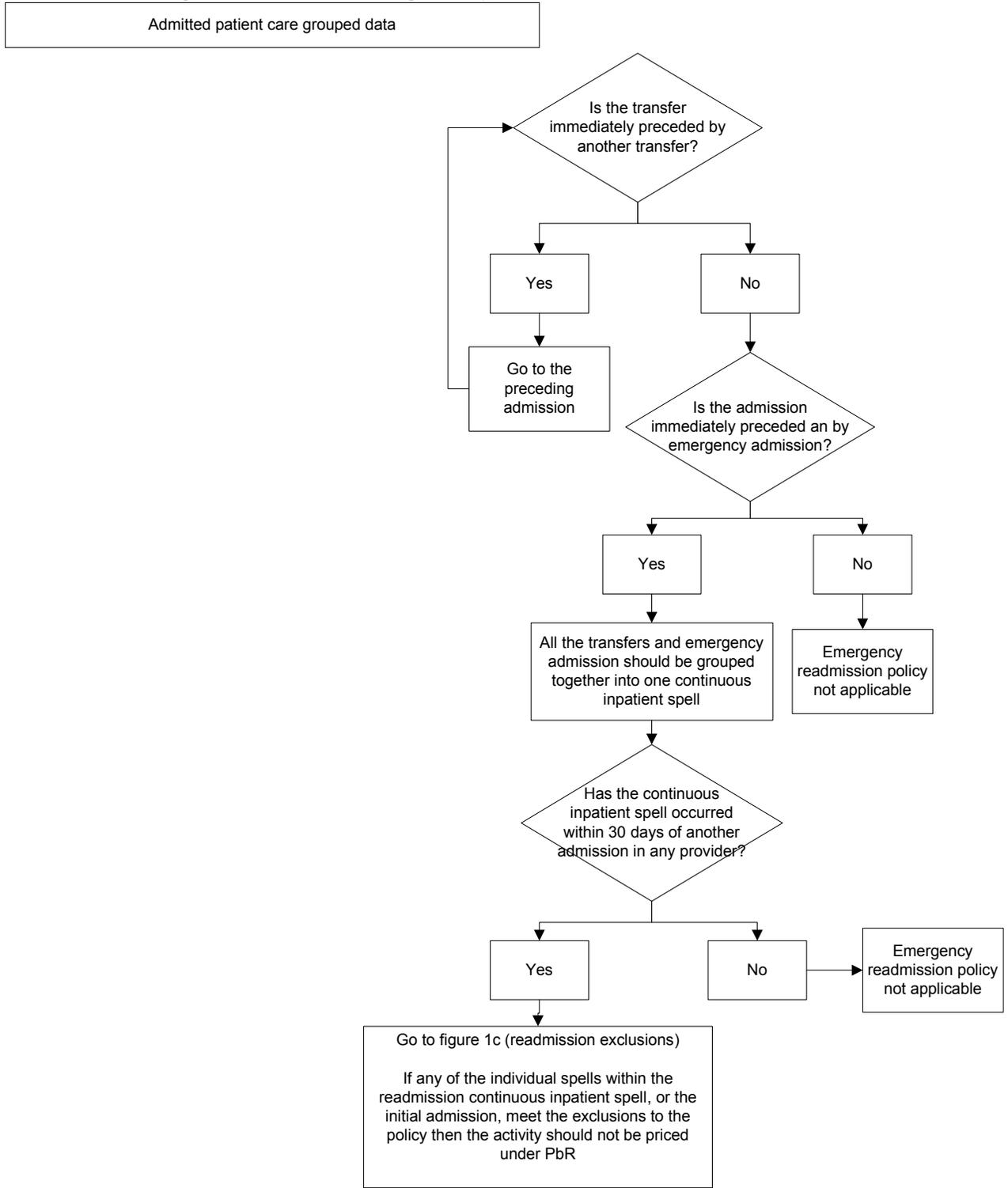
Annex A Figure 1: Admitted patients



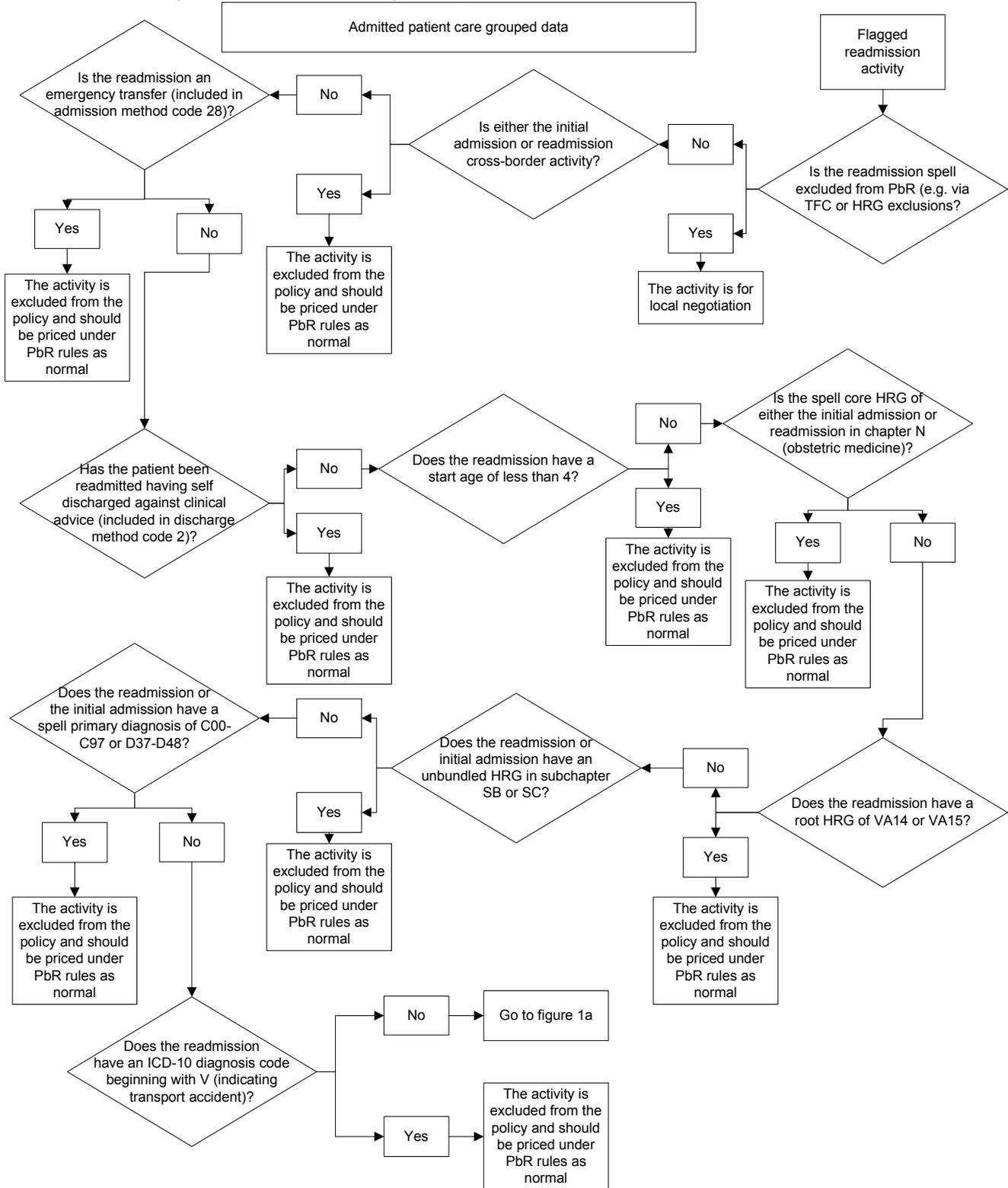
Annex A Figure 1a: Emergency readmissions rule



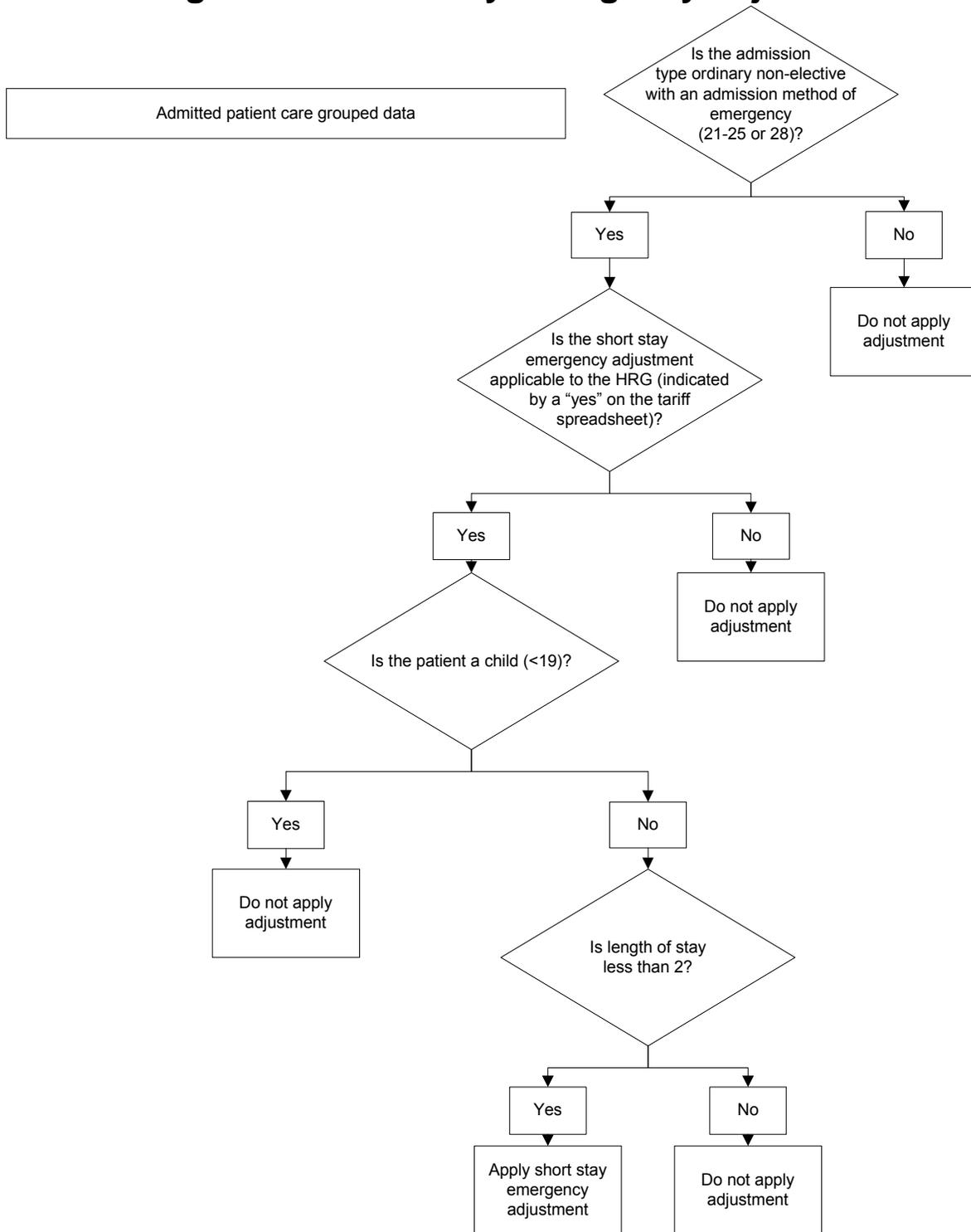
Annex A Figure 1b: Emergency readmissions rule and transfers



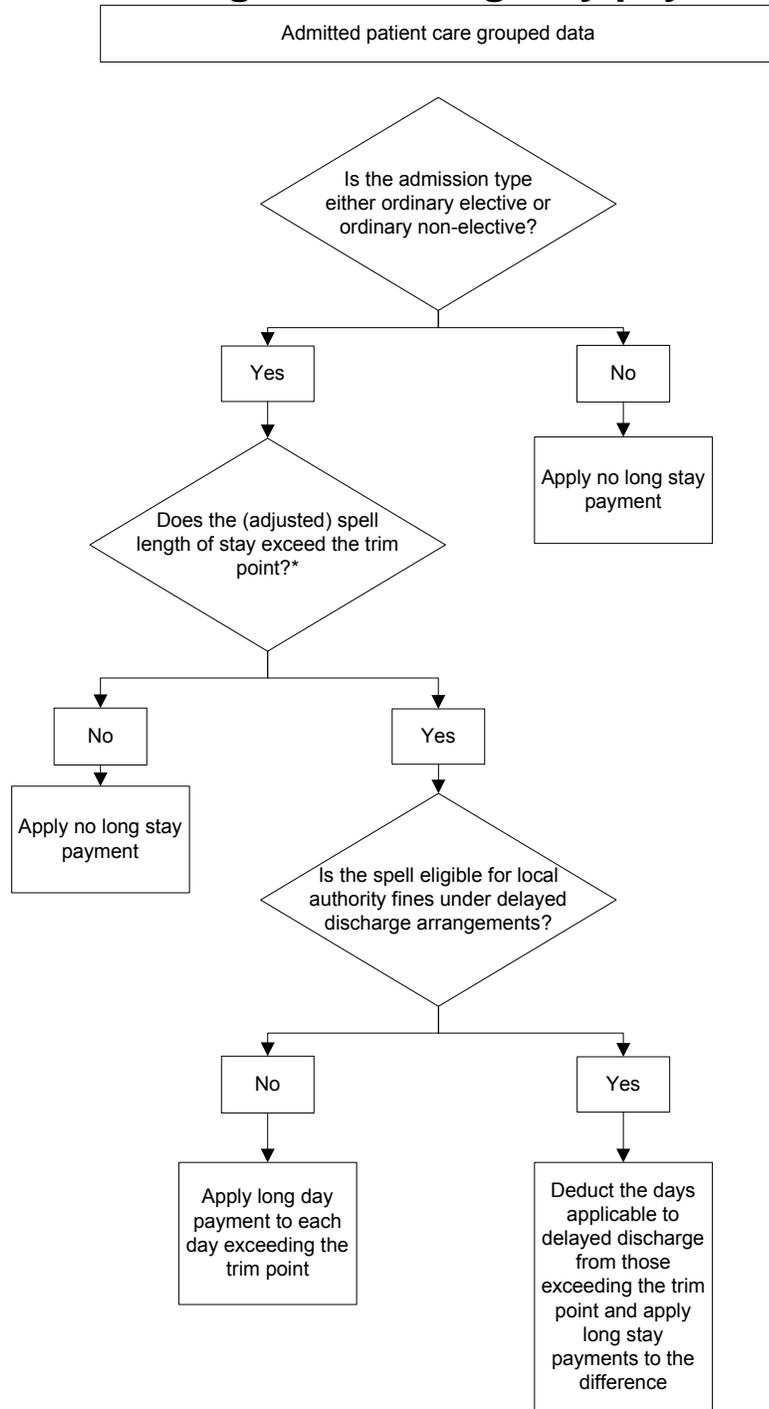
Annex A Figure 1c: Emergency readmissions rule and exclusions



Annex A Figure 1d: Short stay emergency adjustment



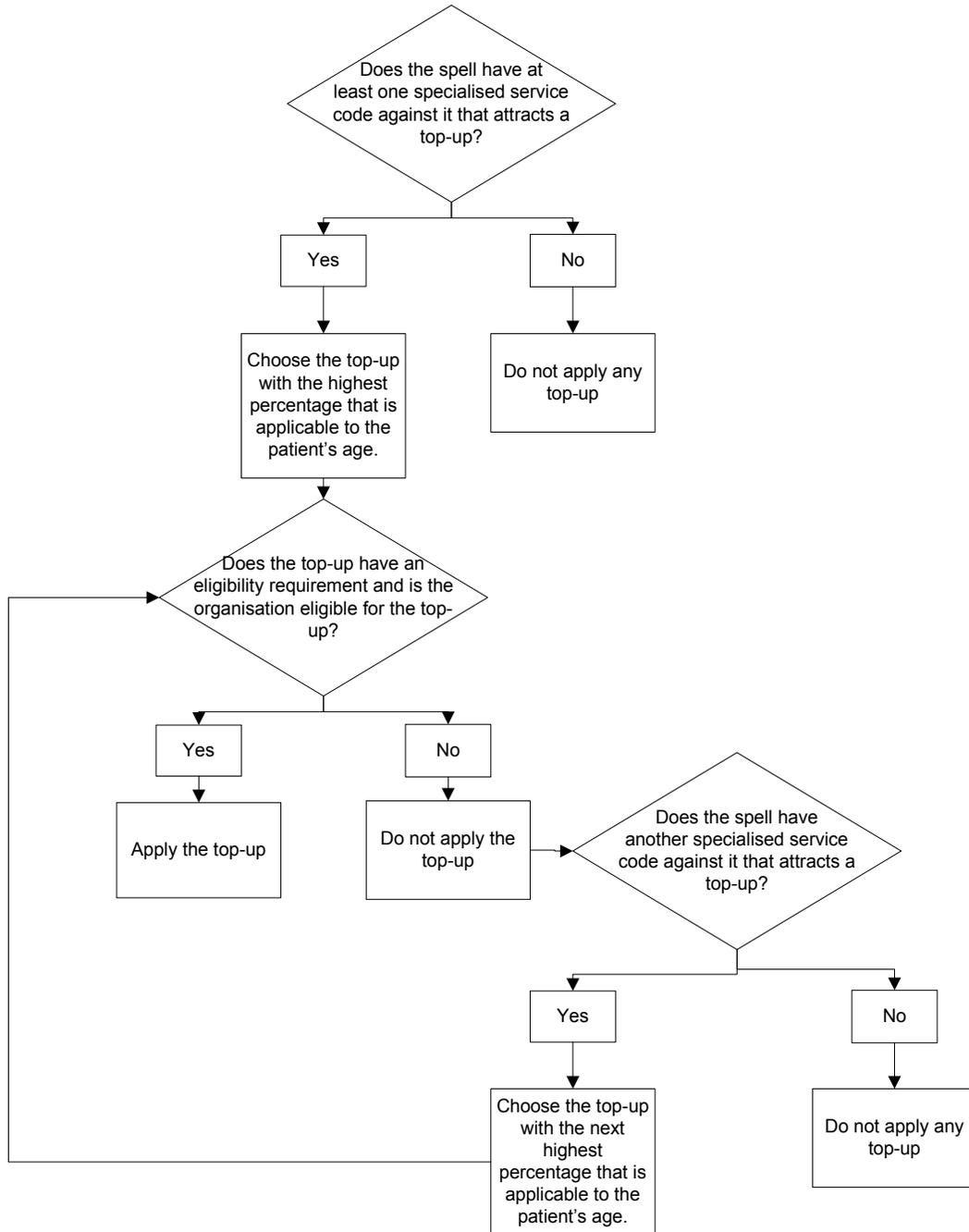
Annex A Figure 1e: Long stay payments



*Elective and non-elective admissions may have different trimpoints

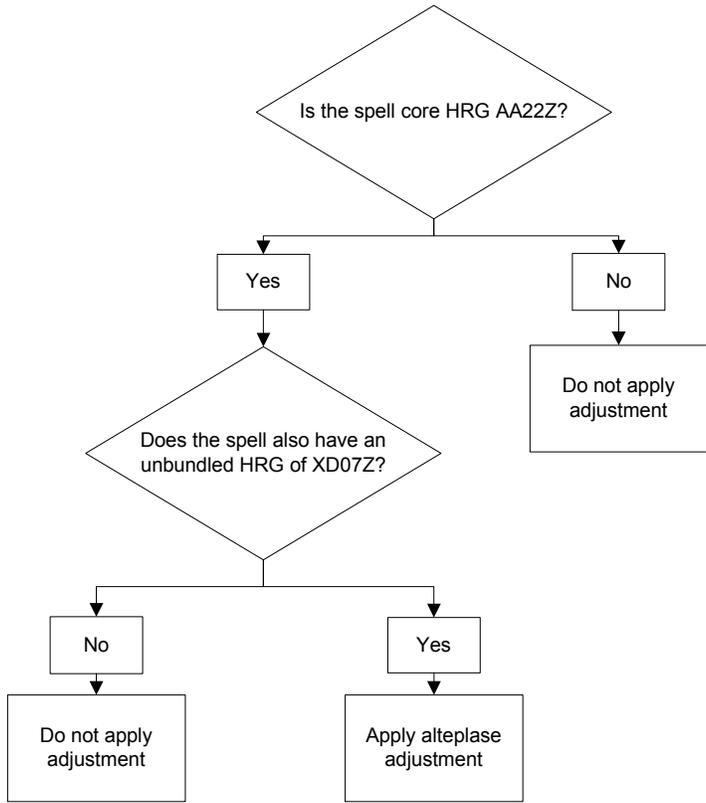
Annex A Figure 1f: Specialised services top-ups

Admitted patient care grouped data



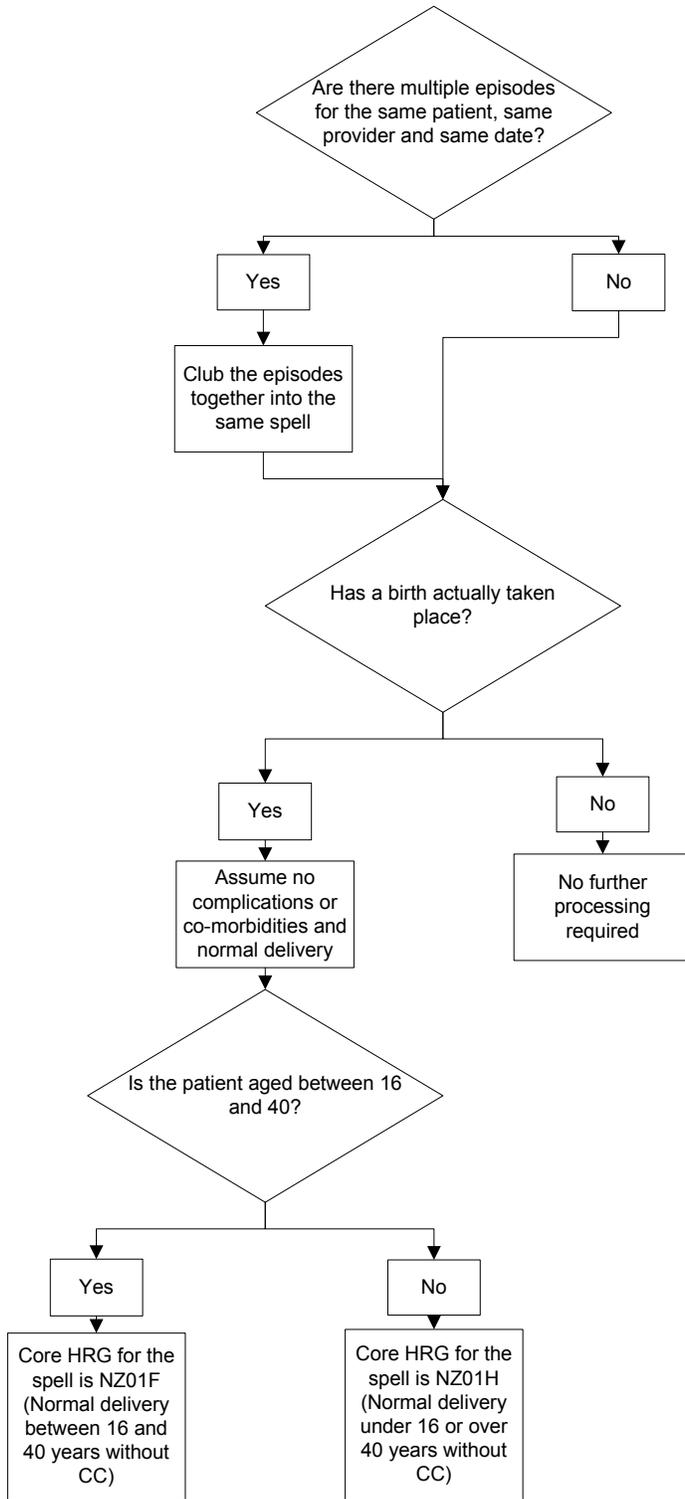
Annex A Figure 1g: Alteplase adjustment

Admitted patient care grouped data

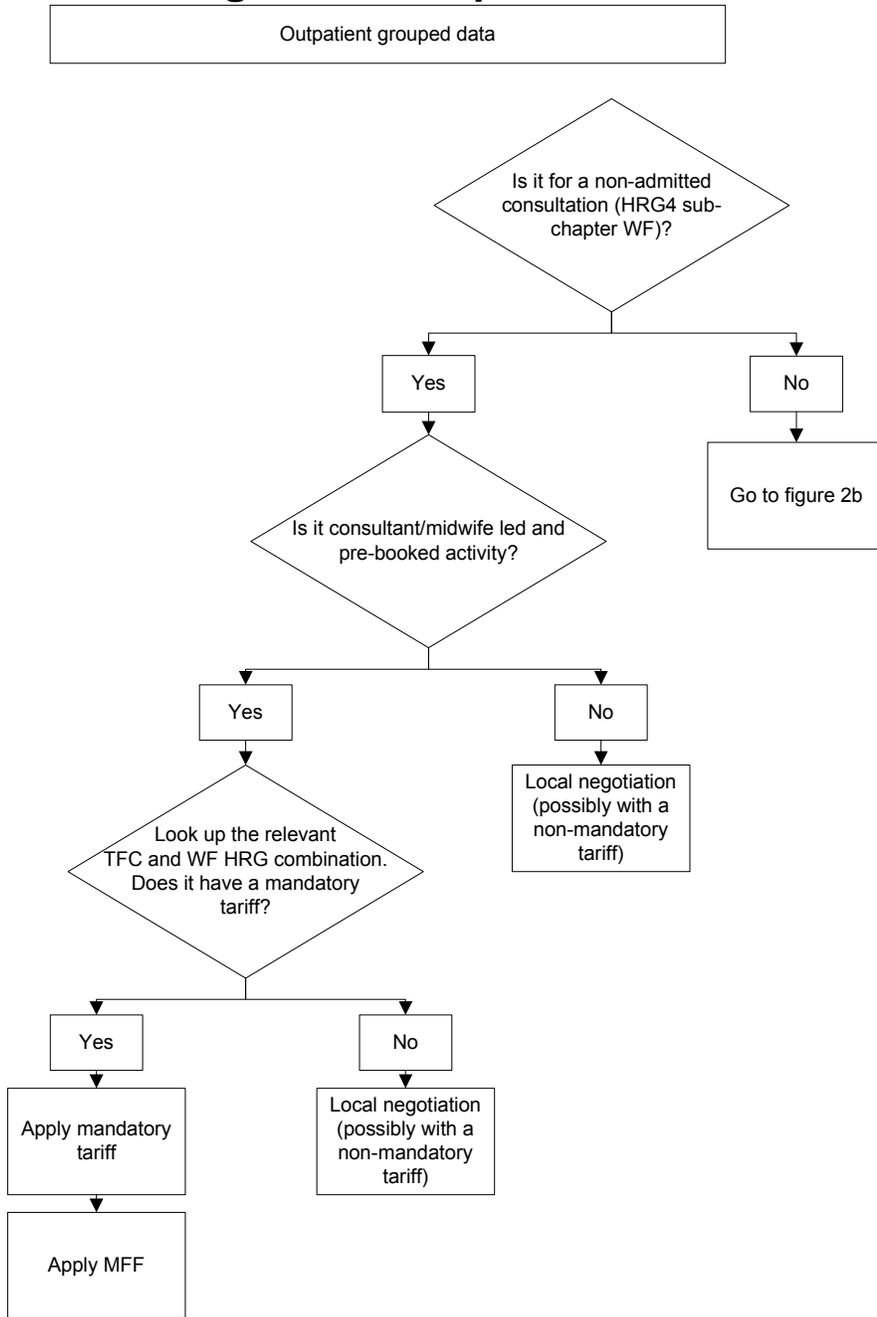


Annex A Figure 1h: Home births

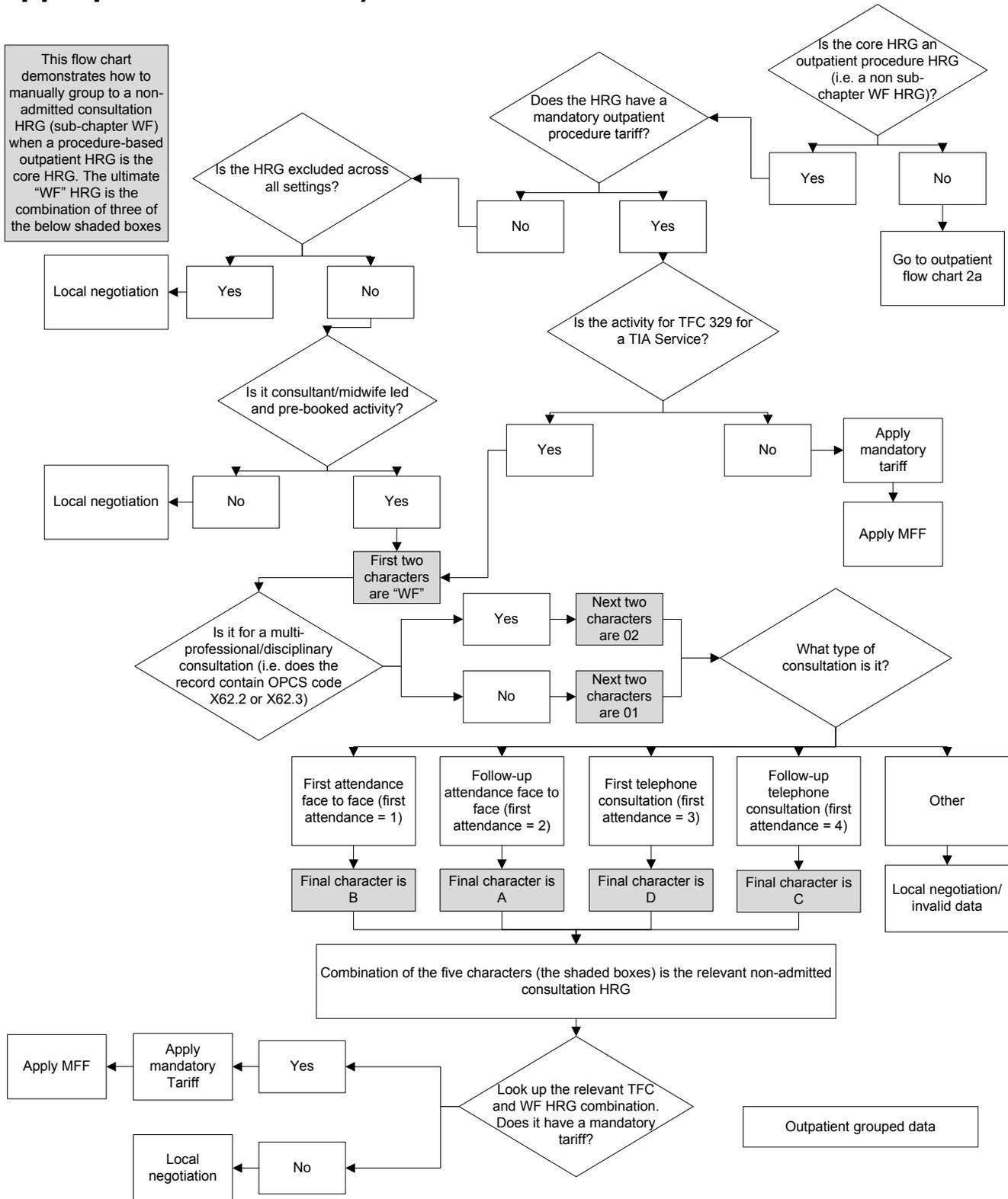
Non-grouped CDS type 160 – other delivery event – data
(to process home birth data)



Annex A Figure 2a: Outpatient attendances

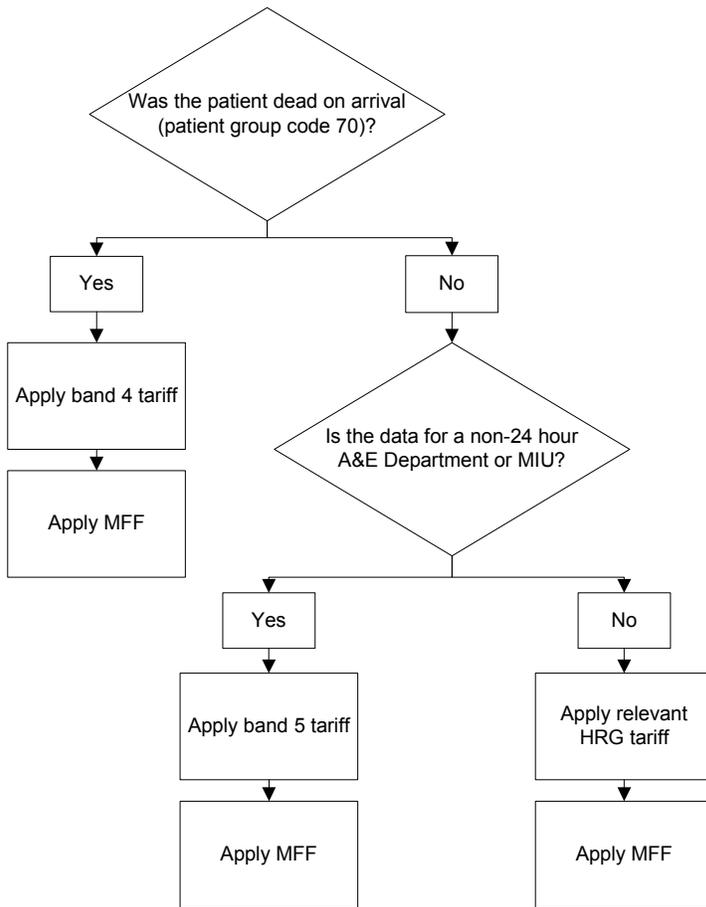


Annex A Figure 2b: Outpatient procedures (and determining appropriate attendance)



Annex A Figure 3: A&E

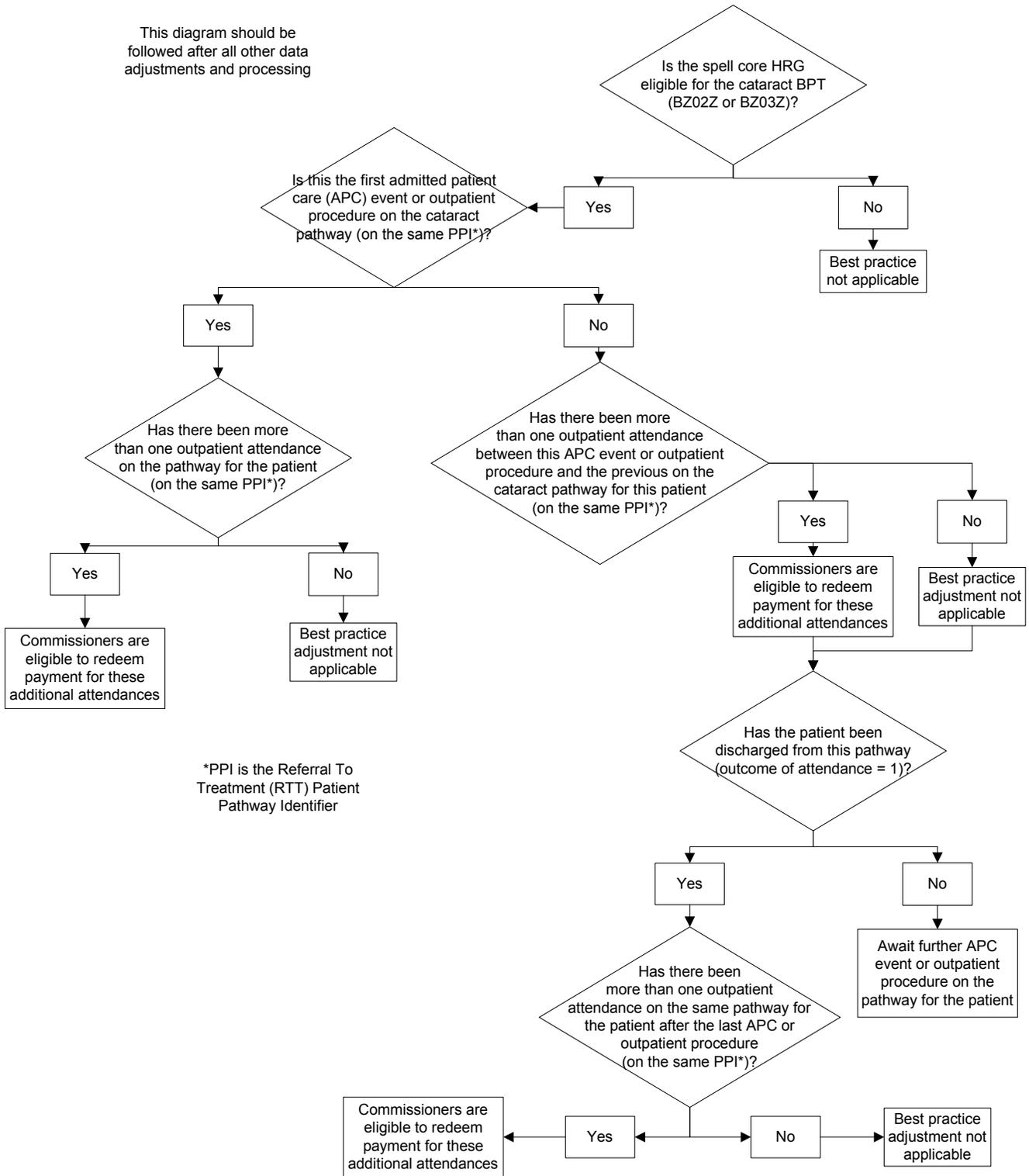
A&E grouped data



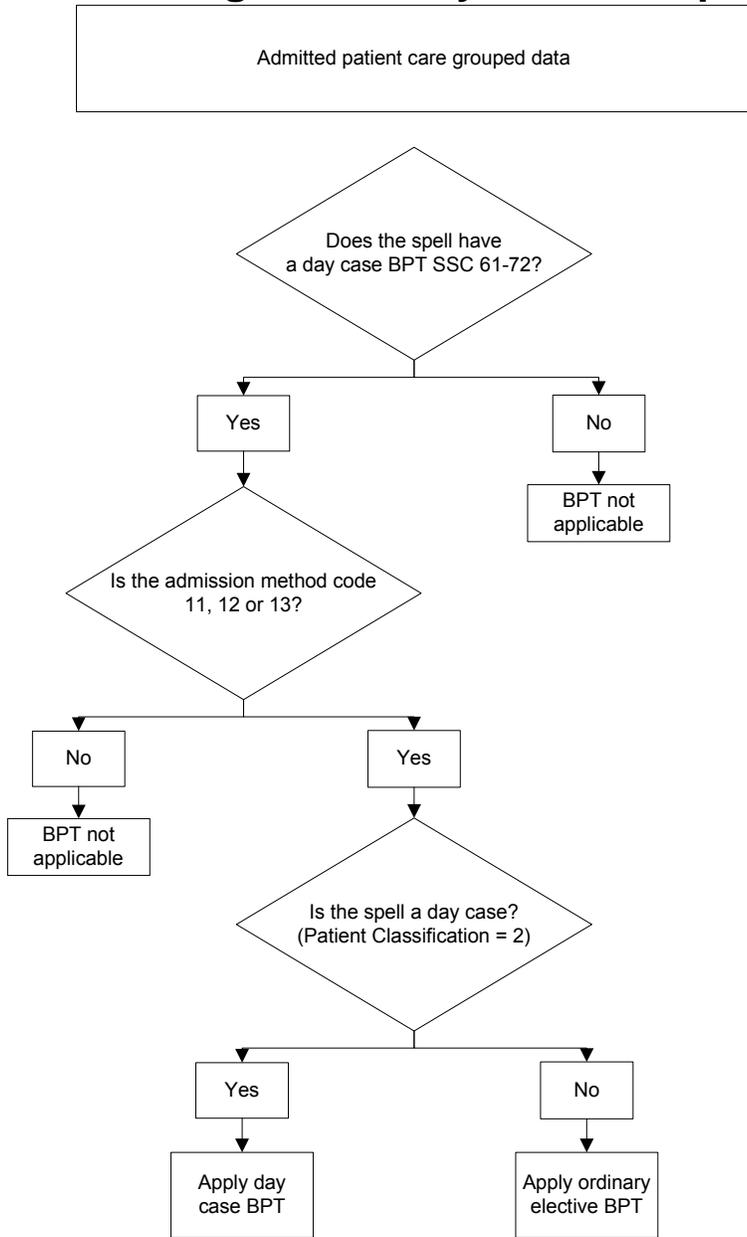
Annex A Figure 4a: Cataracts best practice tariff

Admitted patient care grouped data and outpatient grouped data

This diagram should be followed after all other data adjustments and processing

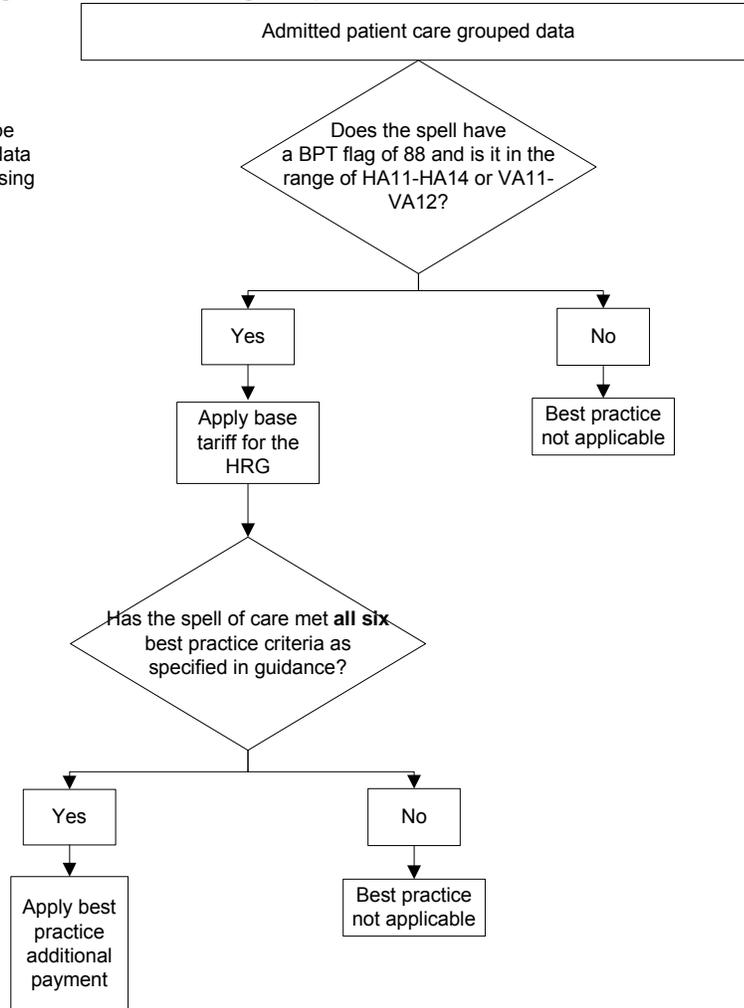


Annex A Figure 4b: Day case best practice tariffs

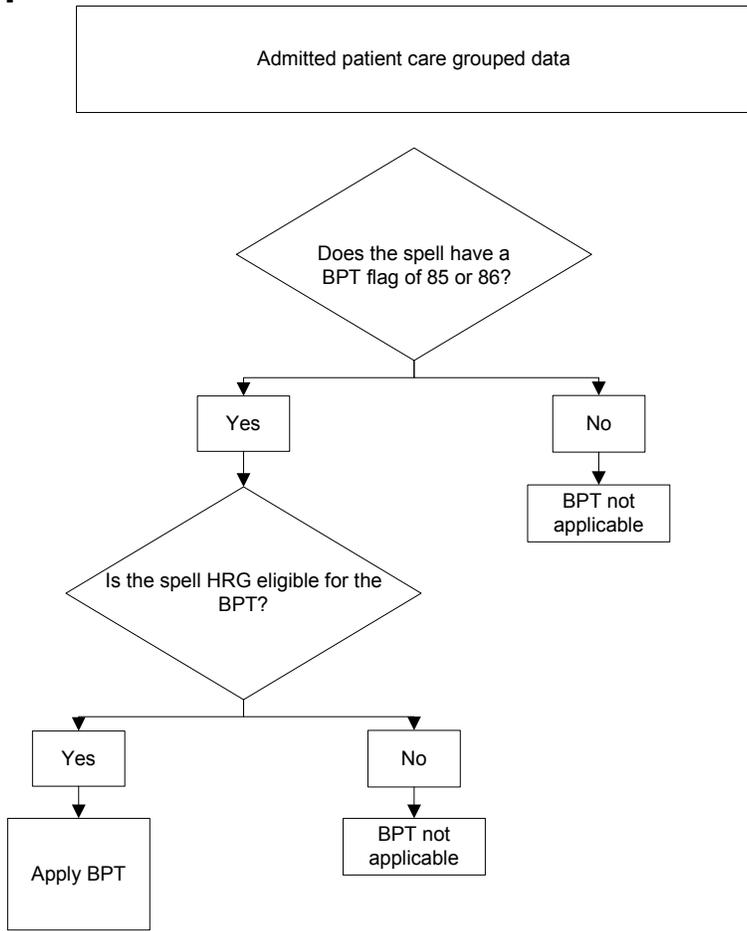


Annex A Figure 4c: Fragility hip fracture best practice tariff

This diagram should be followed after all other data adjustments and processing has been done



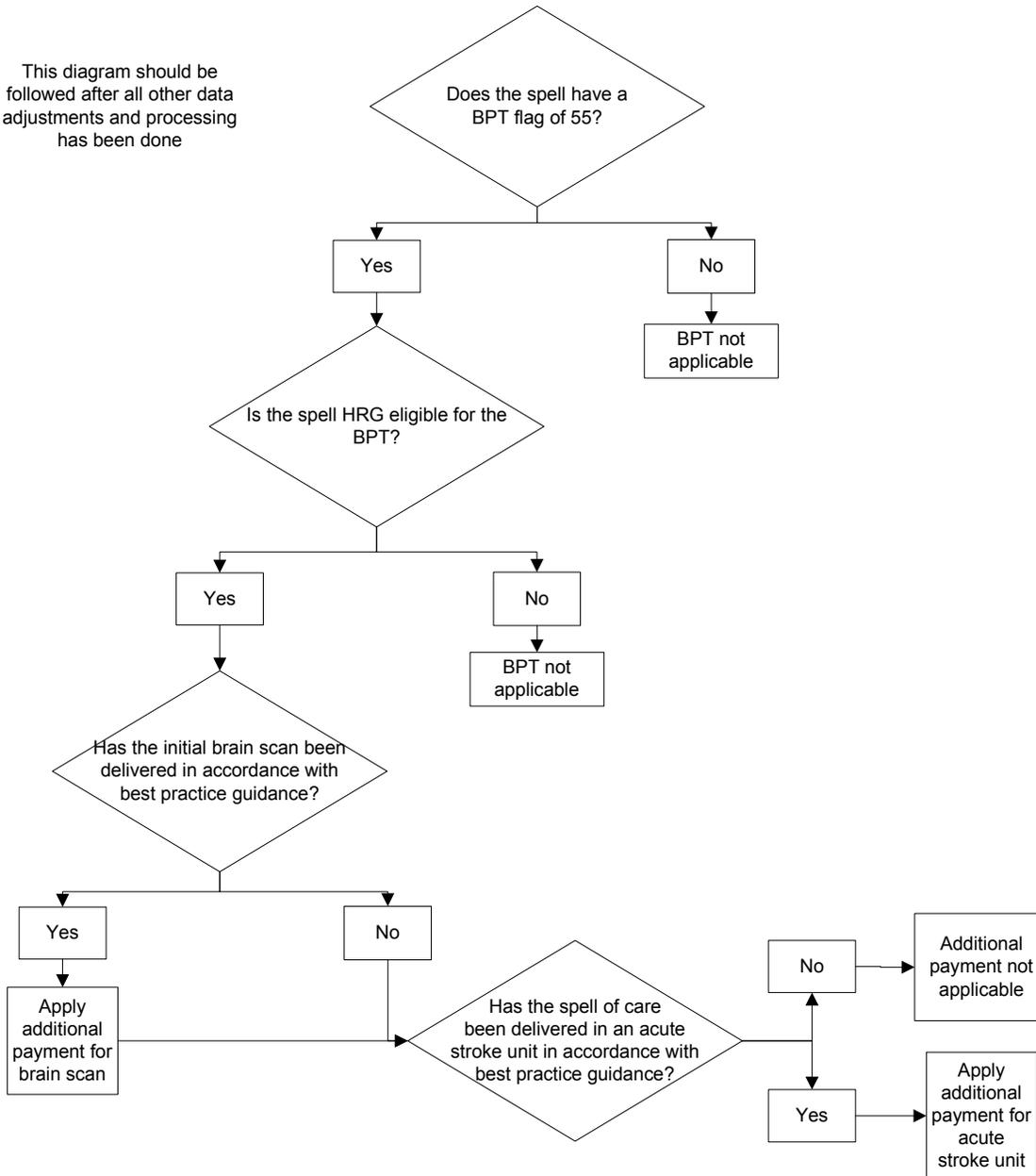
Annex A Figure 4d: Primary total hip and knee replacement best practice tariff



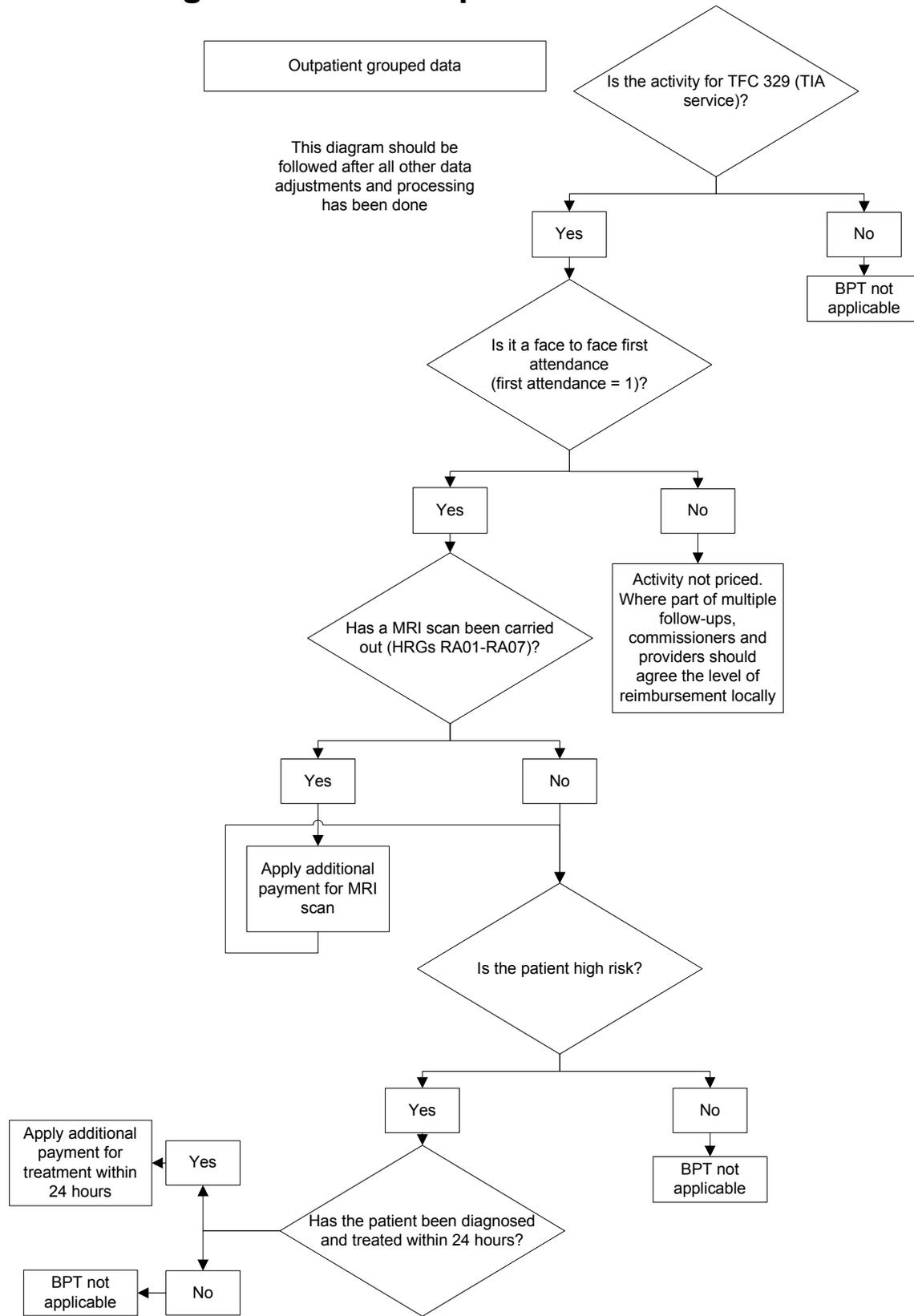
Annex A Figure 4e: Stroke best practice tariff

Admitted patient care grouped data

This diagram should be followed after all other data adjustments and processing has been done



Annex A Figure 4f: TIA best practice tariff



Annex B: Identification flags

The HRG4 2011-12 Local Payment Grouper uses codes, generally referred to as identification flags¹¹⁴, to flag that a spell meets certain criteria. There are three categories of code, each generated in the SSC column of the Grouper output:

- specialised service codes (SSC)
- best practice tariff (BPT) flags
- spell report flag

We use these flags to support the implementation of best practice tariffs. BPTs apply to specific clinical areas that do not always neatly fit with HRG design because:

- target clinical areas can map to several HRGs
- HRGs may contain other activity not applicable to the target clinical area
- there may be additional qualifiers required to target the clinical area the BPT targets e.g. patient age.

Where a clinical area does not neatly fit within current HRG design, we can redesign the HRGs to support a BPT, as in the case of renal dialysis, or we can use a BPT flag to target activity within the HRGs.

For example, activity for the fragility hip fracture BPT groups to a range of HRGs and does not always constitute the majority of the activity within the HRG. Table 39 illustrates.

Table 39: Fragility hip fracture activity

HRG	Label	Fragility hip fracture proportion (%)
HA11A	Major hip procedures category 2 for trauma with major cc	41%
HA11B	Major hip procedures category 2 for trauma with intermediate cc	57%
HA11C	Major hip procedures category 2 for trauma without cc	49%
HA12B	Major hip procedures category 1 for trauma with cc	73%
HA12C	Major hip procedures category 1 for trauma without cc	55%
HA13A	Intermediate hip procedures for trauma with major cc	86%
HA13B	Intermediate hip procedures for trauma with intermediate cc	97%
HA13C	Intermediate hip procedures for trauma without cc	78%
HA14A	Minor hip procedures for trauma with major cc	81%
HA14B	Minor hip procedures for trauma with intermediate cc	86%
HA14C	Minor hip procedures for trauma without cc	56%

The fragility hip fracture BPT applies only to patients aged 60 and over. Because the HRG design does not differentiate by age then there is a need for an additional qualifier. In order to target the BPT correctly, the Grouper generates a BPT flag of 88 where the relevant ICD-10

¹¹⁴ Further information about identification flags is available at <http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment>

and OPCS-4 codes are present in the spell, the patient is aged 60 and over, and the admission type is non-elective.

Table 40 summarises the BPT flags.

Table 40: BPT flags

Procedure	SSC flag
Acute stroke	55
Sentinel node mapping and resection	61
Simple mastectomy	62
Repair of umbilical hernia	63
Primary repair of inguinal hernia	64
Repair of recurrent inguinal hernia	65
Primary repair of femoral hernia	66
Operations to manage female incontinence	67
Therapeutic arthroscopy of shoulder - subacromial decompression	68
Bunion operations with or without internal fixation and soft tissue correction	69
Dupuytren's fasciectomy	70
Endoscopic resection of prostate (TUR)	71
Resection of prostate by laser	72
Elective primary total hip replacement	85
Elective primary total knee replacement	86
Fragility hip fracture	88

Annex C: NHFD reports for the fragility hip fracture best practice tariff

Roles and responsibilities

NHFD

- Ensure data is collected in a safe environment
- Determine responsible commissioner prior to generating the on-line report
- Produce quarterly on-line reports for commissioners and providers (report content detailed below)
- Ensure that registered users are notified when the report is available
- Undertake random trend analysis to monitor integrity of data

Commissioners

- Access report from NHFD database when available
- Link NHFD data to SUS-PbR data to validate BPT qualification
- Ensure that additional payments are made to those cases that meet the BPT criteria
- Resolve any queries about the data with relevant provider

Providers

- Ensure quality and integrity of NHFD data recorded – this will be the responsibility of the NHFD lead clinician for the provider.
- Confirm the BPT on-line report is correct prior to releasing to commissioners
- Liaise with commissioners to resolve any queries and solve any problems

NHS Information Centre

- Issuing user name and passwords to commissioner data representatives
- Linkage of NHS numbers to responsible commissioners

PbR

- Coordinating requests from commissioners for access to NHFD report
- Coordinating any queries from commissioners regarding the reporting process notified through pbrcomms@dh.gsi.gov.uk

Ongoing BPT-NHFD provider report

This report is continuously available to hospitals and includes patients that have been discharged by quarter. It includes the following fields:

- Hospital number
- Patient name
- NHS number
- Hours to surgery
- Orthopaedic GMC number
- Geriatrician GMC number
- Admitted using a jointly agreed assessment protocol (Yes/No)
- Geriatrician grade (Consultant, SAS or ST3+)

- Hours to geriatrician assessment
- Multidisciplinary rehabilitation team assessment (Yes/No)
- Specialist falls assessment
- Bone protection medication
- BPT uplift qualification (Yes/No)

BPT-NHFD provider report

This report is created quarterly after matching to commissioners. It is intended to give the providers a way of viewing the data to be sent to the commissioners in the same format as the commissioners will receive it. It includes the following fields:

- Hospital number
- Patient name
- NHS number
- PCT
- Surgery within 36 hours (Yes/No)
- Orthopaedic GMC number and geriatrician GMC number (Yes/No)
- Admitted using a jointly agreed assessment protocol (Yes/No)
- Geriatrician grade (consultant, SAS or ST3+) and assessment within 72 hours (Yes/No)
- Multidisciplinary rehabilitation team assessment (Yes/No)
- Specialist falls assessment and bone health assessment (Yes/No)
- BPT additional payment qualification (Yes/No)

BPT-NHFD commissioner report

This report will be sorted by hospital and include the following fields:

- Hospital name
- NHS number
- Date and time of A&E admission
- Date and time of surgery
- Surgery within 36 hours (Yes/No)
- Orthopaedic GMC number and geriatrician GMC number (Yes/No)
- Admitted using a jointly agreed assessment protocol (Yes/No)
- Geriatrician grade (consultant, SAS or ST3+) and assessment within 72 hours (Yes/No)
- Multidisciplinary rehabilitation team assessment (Yes/No)
- Specialist falls assessment and bone health assessment (Yes/No)
- BPT additional payment qualification (Yes/No)

Annex D: Coding guidance to generate BPTs for EVAR and UFE

Classification codes for EVAR

ICD-10 codes

I71.0 Dissection of aorta [any part]
I71.1 Thoracic aortic aneurysm, ruptured
I71.2 Thoracic aortic aneurysm, without mention of rupture
I71.3 Abdominal aortic aneurysm, ruptured
I71.4 Abdominal aortic aneurysm, without mention of rupture
I71.5 Thoracoabdominal aortic aneurysm, ruptured
I71.6 Thoracoabdominal aortic aneurysm, without mention of rupture
I71.8 Aortic aneurysm of unspecified site, ruptured
I71.9 Aortic aneurysm of unspecified site, without mention of rupture
I35.8 Other aortic valve disorders (Includes but is not limited to aneurysm of aortic valve)
Q25.4 Other congenital malformations of aorta (Includes but is not limited to congenital aortic aneurysm)
A52.0 Cardiovascular syphilis
I79.0 Aneurysm of aorta in diseases classified elsewhere

OPCS-4 codes

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

Codes in category L27 require the addition of a code from O20.- Endovascular placement of stent graft to identify the number and type of stents used. If the type and number of stents is unknown, the code O20.9 Unspecified endovascular placement of stent graft should be assigned:

O201 Endovascular placement of one branched stent graft
O202 Endovascular placement of one fenestrated stent graft
O203 Endovascular placement of one stent graft NEC
O204 Endovascular placement of two stent grafts
O205 Endovascular placement of three or more stent grafts
O208 Other specified endovascular placement of stent graft
O209 Unspecified endovascular placement of stent graft

A supplementary code from category Y78.- Arteriotomy approach to organ under image control is assigned in addition to the codes given above to indicate that an arteriotomy has been performed under image control:

Y781 Arteriotomy approach to organ using image guidance with fluoroscopy
Y782 Arteriotomy approach to organ using image guidance with CT
Y783 Arteriotomy approach to organ using image guidance with ultrasound
Y784 Arteriotomy approach to organ using image guidance with image intensifier
Y785 Arteriotomy approach to organ using image guidance with video control
Y786 Arteriotomy approach to organ using image guidance with MRI control
Y788 Other specified arteriotomy approach to organ under image control
Y789 Unspecified arteriotomy approach to organ under image control

For example:

Insertion of one endovascular stent graft into infrarenal abdominal aortic aneurysm using fluoroscopic guidance via femoral artery incision would be coded:

L271 Endovascular insertion of stent graft for infrarenal abdominal aortic aneurysm
O203 Endovascular placement of one stent graft NEC
Y781 Arteriotomy approach to organ using image guidance with fluoroscopy

Classification codes for UFE

The new HRG for UFE is included in the Grouper. Activity will be grouped to this HRG for the following OPCS-4 codes.

Note: All three must be coded simultaneously for the Grouper to generate the UFE HRG.

L713 Percutaneous transluminal embolisation of artery
Y53 Approach to organ under image control (Fourth character is dependent upon which type of image control is used)
Z966 Uterine artery

Relevant references to OPCS-4.5 Clinical Coding Instruction Manual - EVAR

Guidance regarding OPCS-4.5 codes which relate to endovascular procedures for the treatment of aortic aneurysms and the codes that are used to specify the type and number of stents/stent grafts within these procedures, can be found on pages L-14 to L-15 and L-25 of the OPCS-4.5 Clinical Coding Instruction Manual (Version 3).

Further guidance on the assignment of additional codes to identify the approach used for operations on arteries and veins can be found on pages L-3, L-6, L-7, L-15, L-18 and L-28 of the OPCS-4.5 Clinical Coding Instruction Manual (Version 3).

Relevant references to OPCS-4.5 Clinical Coding Instruction Manual - UFE

Guidance that specifically relates to this procedure which includes an explanation of the procedure and how it should be coded can be found on page L-23 of the OPCS-4 Clinical Coding Instruction Manual (Version 3).

Annex E: Best practice characteristics for primary total hip and knee replacements

Source of evidence: British Orthopaedic Association's guides to good practice

The BOA have published guides to good practice for total hip and knee replacements. The guides cover the entire pathway from indications for referral for the operation to follow-up of patients. Both guides can be downloaded from BOA website:

<http://www.boa.ac.uk/site/showpublications.aspx?ID=59>

Source of evidence: NHS Institute

The NHS Institute's report, *Focus on: Primary Hip and Knee Replacement*, identified a range of clinical factors which are considered best practice, for example:

- day of surgery admission.
- early mobilisation.
- patient preparation leading to realistic patient expectations.
- postoperative pain management.

This report found that “despite the information being available to providers, managers and clinicians, there remains wide variation in the implementation of these proven improvements in quality and cost effectiveness”.

However, it also found that, for providers who have adopted best practice, there have been “outstanding results in terms of quality, patient satisfaction and safe reductions in the patient's length of stay”. The report goes on to give more detailed information on the:

- characteristics of best practice.
- benefits of best practice.
- evidence base.

The report can be found at:

http://www.institute.nhs.uk/option.com_joomcart/Itemid,26/main_page,document_product_info/products_id,191.html

Source of evidence: the enhanced recovery programme

The enhanced recovery programme (ERP) provides detailed information on the characteristics of best practice along the full patient pathway for hip and knee replacements (amongst other procedures). The ERP splits the enhanced recovery pathway into the following areas:

Getting the patient in the best possible condition for surgery.

Managing patients' expectations.

Pre-referral from primary care:

- Optimising a patient's condition;
- Identify peri-operative risk; and
- Pre-operative assessment and preparation.

Admission:

- Day of surgery admission;
- Avoidance of pre-medication;
- Nutrition; and
- Avoidance of oral bowel preparation where appropriate.

Ensuring the patient has the best possible management during their operation.

Anaesthetic factors:

- Individualised goal-directed fluid therapy;
- Use of anaesthetic agents;
- Prevent hypothermia;
- Effective opiate-sparing analgesia; and
- Minimise the risk of post-operative nausea and vomiting.

Surgical factors:

- Surgical techniques;
- Laparoscopic surgery;
- Minimise complications;
- Minimise the use of drains; and
- Minimise use of nasogastric tubes in abdominal surgery.

Ensuring the patient has the best post-operative rehabilitation:

- Early nutrition;
- Early mobilisation;
- Removal of catheters as soon as possible following surgery;
- Post-operative training and support;
- Early planned discharge; and
- Follow-up and support.

Implementing the enhanced recovery pathway.

The ERP has identified significant benefits relating to, amongst others:

Increased quality, e.g.:

- Improved clinical outcomes.
- Early detection of complications.

Patient experience, e.g.:

- Planned, earlier rehabilitation.
- Earlier return to 'normal' activities e.g. work.

Productivity, e.g.:

- Reduced length of stay.
- Bed day savings.

- Potential to treat more patients with same resources.
- Increased capacity.

Further information on the ERP can be found at:

<http://www.dh.gov.uk/en/Healthcare/Electivecare/Enhancedrecovery/index.htm>

The ERP report, *Delivering enhanced recovery*, can be found at:

www.dh.gov.uk/publications

Source of Evidence: Map of Medicine

Map of Medicine pathways provide a starting point for “clinically-led service improvement, design and redesign activities. The pathways are comprehensive, trustworthy and easy to understand, incorporating evidence-based information, expert knowledge and national policy”.

Organisations have used Map of Medicine to “lower healthcare delivery costs, improve clinical effectiveness and reduce health inequalities.” Map of Medicine also offers a full implementation support package.

Further information on Map of Medicine can be found at:

<http://www.mapofmedicine.com/>

Information on the Map of Medicine pathway for hip replacements can be found at:

http://eng.mapofmedicine.com/evidence/map/elective_hip_surgery2.html

Information on the Map of Medicine pathway for knee replacements can be found at:

http://eng.mapofmedicine.com/evidence/map/elective_knee_surgery2.html

Other sources of evidence

The sources of evidence on the characteristics of best practice, the benefits of best practice, and the evidence base are not limited to the above. Providers should seek out the material which they find the most useful e.g. the North West SHA’s *Advancing Quality* programme can be found at:

<http://www.advancingqualitynw.nhs.uk/index.php>