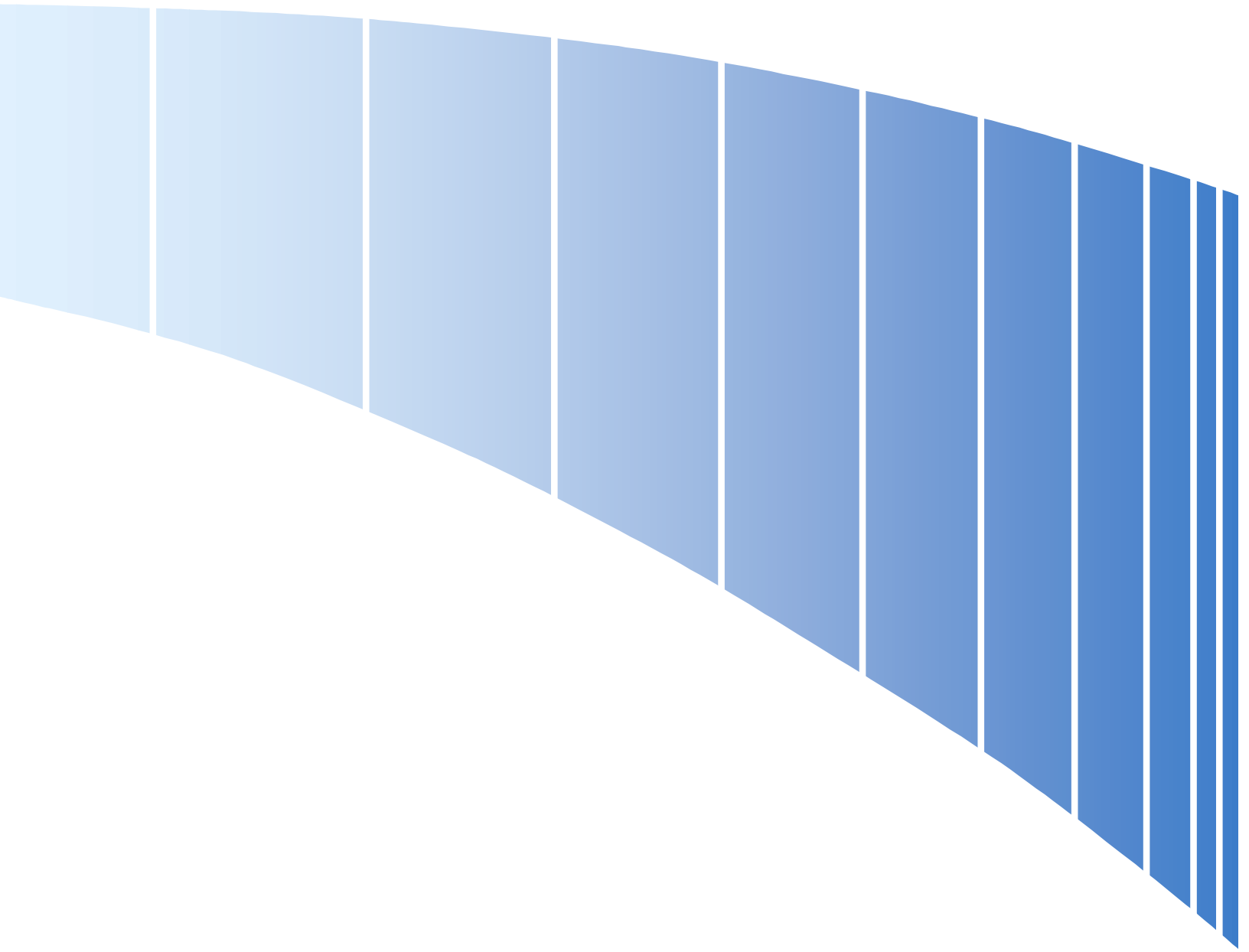
# Payment by Results Guidance for 2010-11



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# List of abbreviations

| | |
|---|---|
| A&E | Accident and emergency |
| BADS | British Association of Day Case Surgery |
| BNF | British National Formulary |
| CAMHS | Child and adolescent mental health services |
| CAP | Clinical Advisory Panel |
| 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 |
| CQUIN | Commissioning for quality and innovation |
| CT | Computerised tomography |
| DES | Device evaluation service |
| DOA | Dead on arrival |
| DSCN | Data set change notice |
| EAG | External Advisory Group |
| EWG | Expert Working Group |
| FCE | Finished consultant episode |
| GP | General practitioner |
| GUM | Genito-urinary medicine |
| HES | Hospital episode statistics |
| HRG | Healthcare resource group |
| HTA | Health technology assessment |
| HTCS | Healthcare travel cost scheme |
| IAPT | Improving access to psychological therapies |
| ICD | International classification of diseases |
| IS | Independent sector |
| ISB | Information Standards Board |
| ISTC | Independent sector treatment centre |
| MFF | Market forces factor |
| MHMDS | Mental health minimum data set |
| MIU | Minor injury unit |
| MRI | Magnetic resonance imaging |
| MSC | Main speciality codes |
| NCA | Non contract activity |
| NHFD | National hip fracture database |
| NHS | National Health Service |
| NICE | National Institute for Health and Clinical Excellence |
| NPSA | National Patient Safety Agency |
| OPCS | Office for population censuses and surveys |
| PAS | Patient administration system |
| PbR | Payment by Results |

| | |
|---|---|
| PCT | Primary care trust |
| PSD | Planned same day |
| PTS | Patient transport services |
| SCG | Specialised commissioning group |
| SHA | Strategic health authority |
| SSC | Specialised service code |
| SSNDS | Specialised service national definition set |
| SUS | Secondary uses service |
| SUS PbR | Secondary uses service, Payment by Results mart |
| TFC | Treatment function code |
| TWG | Technical Working Group |
| UKMi | United Kingdom Medicines information |
| WiC | Walk-in centre |

# Section 1: Introduction

## Purpose

1. This guidance provides information to support the operation of Payment by Results (PbR) in 2010-11. It should be used alongside the following products[1]:

   (a) *2010-11 tariff information spreadsheet*, which includes:

      i) 2010-11 national mandatory tariffs – the mandatory admitted patient, outpatient attendance, outpatient procedure, accident and emergency (A&E), and best practice tariffs

      ii) specialised service top-ups – percentages, ineligible HRGs, eligible providers, ICD and OPCS trigger codes

      iii) PbR exclusions – showing services, procedures, admitted patient care Healthcare Resource Groups (HRGs), outpatient Treatment Function Codes (TFCs), drugs and devices excluded from the scope of PbR

      iv) 2010-11 non-mandatory prices for acute phase of rehabilitation, adult hearing services, adult renal dialysis, dermatology outpatient attendances, direct access diagnostic imaging, direct access spirometry, echocardiograms, non face-to-face outpatient attendances and paediatric diabetes

      v) 2010-11 market forces factor (MFF) capped payment index and underlying index values

      vi) unbundled HRGs – indicating whether they have a separate tariff, have had their costs rebundled, or are excluded from PbR

      vii) worked examples for the marginal rate emergency tariff

   (b) *Step-by-step guide: calculating the 2010-11 national tariff* - where this guidance raises questions about the calculation of the tariff we recommend readers consult the step-by-step guide

   (c) *Code of Conduct for PbR 2010-11* – establishes the principles that should govern organisational behaviour under PbR and sets expectations as to how the system should operate

[1] Available at www.dh.gov.uk/pbr

(d) *PbR and the market forces factor in 2010-11* – comprehensive guidance on the application of the MFF in PbR.

2. This guidance incorporates and updates the *PbR business rules* document which we published separately in 2009-10.

## Main changes in 2010-11

3. Following the significant changes arising from the move to Healthcare Resource Group 4 (HRG4) as the tariff currency in 2009-10, 2010-11 is a year in which we refine some aspects of the tariff structure and its operation based on feedback from our governance groups (paragraph 18). The main changes are:

(a) an **admitted patient care tariff** based on combined day case and ordinary elective prices, although with a limited number of exceptions (paragraph 57). This is intended to address concerns that the 2009-10 planned same day (PSD) structure has under rewarded day case activity. We will however continue to review this arrangement for future years so that the tariff continues to support the requirement that services are provided, where clinically appropriate, in less acute settings

(b) the introduction of **mandatory tariffs for 49 high volume outpatient procedure HRGs**. All other outpatient procedures HRGs will be paid for as part of the relevant mandatory outpatient attendance tariffs (paragraph 119). This removes the need for local price negotiations, but does not preclude the use of flexibilities (paragraph 398)

(c) the **rebundling of diagnostic imaging** with the outpatient attendance tariffs except for direct access (paragraph 146). We have done this as part of a review of the principles to be applied within PbR to the unbundling of any service or part of a service. The rebundling should not be a barrier to the provision of this service in alternative settings and we have published separate non-mandatory prices for direct access diagnostic imaging. These can also be used to support the removal of the costs of imaging from attendances where direct access imaging has already taken place or where pathways are shared between providers

(d) the introduction of **best practice tariffs for cataracts, cholecystectomy (gall bladder removal), fragility hip fracture and stroke** (paragraph 160), meeting the commitment in *High Quality Care*

*For All*[2], Lord Darzi's NHS Next Stage Review report. This initial selection is based on high volume areas with significant unexplained variation in quality of clinical practice and clear evidence of what constitutes best practice

(e) the introduction of **non-mandatory tariffs for adult renal dialysis** (paragraph 323) as an initial step towards a best practice tariff

(f) the publication of **mental health currencies**, meeting the commitment in *High Quality Care For All*. These will be used in shadow form in 2010-11 by those organisations which have the necessary information systems in place, with the expectation that they will be mandated at some point in the future (paragraph 347)

(g) the **exclusion of planned procedures not carried out (WA14Z)** (paragraph 275). This is a high volume HRG and feedback suggests commissioners would prefer more flexibility to negotiate the price locally depending on the reason for failure to carry out a procedure

(h) formalising the **exclusion of spinal cord injury services undertaken in, or by, designated spinal cord injury centres** (paragraph 265) This activity is commissioned separately by specialised commissioning groups (SCGs)

(i) the **inclusion of the NHS element of the patient's stay within the scope of the national tariff where patients pay amenity charges**. Only the amenity charge itself will be excluded (paragraph 264). These patients were excluded from PbR in 2009-10

(j) other routine updates in line with latest data, including updated percentages within the **short stay emergency adjustment** bands, revised **specialised service top-up percentages** and **definition sets**, and updates to the **exclusions list**.

4. We are not now moving from Healthcare Resource Group version 3.2 (HRGv3.2) to HRG4 for A&E, in response to feedback that it would introduce an unacceptably high level of volatility, and advice from our governance groups to review whether A&E services should be funded on a partly fixed and partly variable funding mechanism for 2011-12. It is therefore sensible to maintain the status quo until the review is completed.

[2] Available at http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825

## Other changes

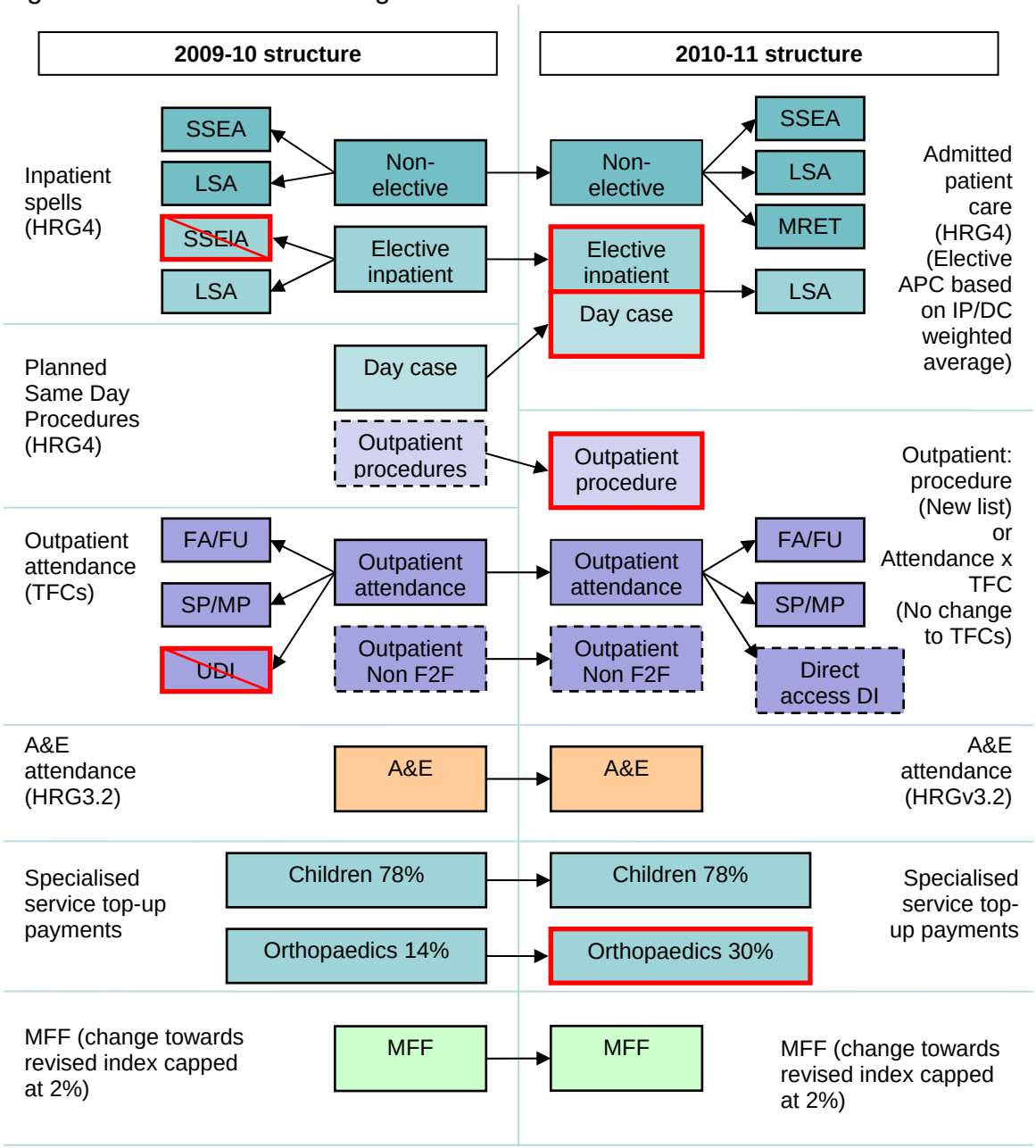
5. In addition to these changes, we are also responding to the more challenging economic circumstances by introducing two new business rules in 2010-11:

   (a) a marginal rate of 30% of the published tariff for the value of emergency admissions above a baseline set at 2008-09 activity priced at 2010-11 national tariff (paragraph 63)

   (b) a flexibility for Strategic Health Authorities (SHAs) to apply to the Department for permission to temporarily suspend contractual arrangements in a local health economy in exceptional circumstances (paragraph 414).

6. Figure 1 and Annex A summarise the main PbR structural changes in 2010-11 compared with 2009-10.

Figure 1: PbR structural changes in 2010-11




Key to Figure 1:

| | | | |
|---|---|---|---|
| SSEA | Short stay emergency adjustment | FA | First attendance |
| LSA | Long stay adjustment | FU | Follow up |
| SSEIA | Short stay elective adjustment | SP | Single professional |
| MRET | Marginal rate emergency tariff | MP | Multi professional |
| DI | Diagnostic imaging | F2F | Face to face |
| Box with bold outline | | Indicates some change between years | |
| Box with broken outline | | Non-mandatory price | |
| Box with strike through | | Feature no longer applied | |

## Scope of the national mandatory tariff

7. In 2010-11 the national mandatory tariff plus an adjustment for MFF is payable by primary care trusts (PCTs) for activity carried out by NHS trusts, NHS foundation trusts, PCTs as providers, independent sector extended choice network and independent sector free choice network providers.

8. The mandatory tariff will be payable for day case, ordinary elective and non-elective admitted patient care, outpatient attendances, outpatient procedures, and A&E services.

9. 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.

10. HRG4 was introduced as the currency underpinning the admitted patient care tariff in 2009-10. The broad scope of services covered by the national tariff remains similar to 2009-10, meaning that not all of the service areas covered by the HRG4 design will have a national tariff in 2010-11. This is due to a number of reasons, such as the quality of available costing and activity data that could underpin a national tariff.

11. The 2010-11 tariff is based on 2007-08 NHS reference costs[3]. The costs of services that are currently outside the scope of reference costs[4] are, by default, not included within the PbR mandatory or non-mandatory tariffs.

12. Some activity remains outside the scope of PbR and subject to local price negotiation. Services not covered by PbR in 2010-11 include primary care services, community services, mental health and ambulance services. Exclusions are covered in detail in Section 7.

## Tariff uplift

13. The tariff uplift will be 0% in 2010-11, and will also apply to all prices in non-tariff service contractual arrangements. The underpinning assumptions are in Table 1.

[3] Available at www.dh.gov.uk/nhscosting
[4] Listed in section 16 (services excluded from reference costs) of 2007-08 reference costs guidance (February 2008) available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082746

Table 1: 2010-11 tariff uplift

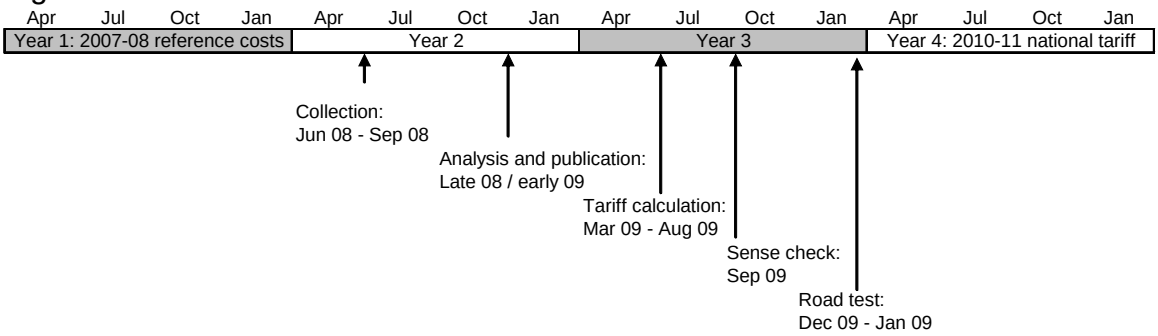
| | % |
|---|---|
| Pay | 2.0 |
| Non-pay inflation | 0.6 |
| Non-pay pressures | 0.9 |
| Efficiency | -3.5 |
| Tariff uplift | 0.0 |

14. We describe our handling of cost pressures arising from the Clinical Negligence Scheme for Trusts (CNST)[5] in paragraph 101.

## Updates to tariff calculation

15. The tariff calculation is based on cost and activity data from year 1, collected and analysed in year 2, and used to inform the tariff calculation in year 3 for prospective payments in year 4. The 2010-11 national tariff is informed by 2007-08 national cost and activity data, as illustrated in Figure 2. We give a full explanation in *Step-by-step guide: calculating the 2010-11 national tariff*.

Figure 2: Tariff calculation timeline




16. Robust and good quality data are important to underpin the tariff and make it as accurate as possible. The Audit Commission's PbR data assurance framework contains useful information on data quality and analysis from the second year of clinical coding audits undertaken at all acute NHS trusts in England in 2008-09[6]. The Department, in partnership with the Audit Commission, is reviewing both the quality and uses of reference costs to ensure that it continues to collect the most robust and relevant data.

17. Although we base the tariff on reference costs submitted by NHS organisations, there are several reasons why published national averages might not be closely reflected in final tariff prices. These include:

[5] http://www.nhsla.com/Claims/Schemes/CNST/
[6] Available at http://www.audit-commission.gov.uk/health/audit/paymentbyresults/assuranceframework/pages/default.aspx

(a) the inclusion of costs relating to the MFF
(b) conversion of data from episodes to spells
(c) adjustments for excess bed days
(d) adjustments to reflect policy decisions such as rebundling of diagnostic imaging costs
(e) the exclusion of costs relating to drugs and devices
(f) National Institute for Health and Clinical Excellence (NICE) recommendations
(g) the best practice tariffs programme.

## Governance

18. The development of PbR for 2010-11 has been supported by the following governance groups:

    (a) PbR Programme Board – which oversees delivery of the PbR work programme
    (b) External Advisory Group (EAG) – which provides general and managerial policy advice
    (c) Clinical Advisory Panel (CAP), and through them, the NHS Information Centre's Expert Reference Panels (ERPs)[7], Expert Working Groups (EWGs)[8], High Cost Drugs Steering Group and High Cost Devices Steering Group – which provide clinical advice
    (d) Technical Working Group (TWG) – which provides operational advice.

19. In addition, the PbR children's sub-group makes recommendations on the future development of PbR for children's services to CAP. There are also a number of PbR sub-groups on work areas including mental health services, renal and development sites.

20. These groups have a wide membership including NHS trusts, NHS foundation trusts, PCTs, SHAs, SCGs, the independent sector, industry, Monitor, the Audit Commission, Care Quality Commission, professional membership organisations, clinicians and academics. Further information about PbR governance groups is available from our web pages[9]. We are grateful for their help in developing PbR for 2010-11.

[7] ERPs form part of the Casemix governance structure within the NHS Information Centre. They have a wider remit than single HRG chapters, have NHS and Department membership, and clinical leads and chairs.
[8] EWGs form part of the Casemix governance structure within the NHS Information Centre. They are HRG chapter-specific, have NHS membership, and clinical leads and chairs.
[9] Available at http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_072533

## Queries and feedback

21. 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 leads[10]
    (b) NHS foundation trusts, SHAs and other organisations should contact the PbR team via PbRComms@dh.gsi.gov.uk.

22. 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.

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

    (a) improving the operation of PbR
    (b) innovative local approaches to payment to allow better care for patients
    (c) expanding the best practice tariff programme
    (d) developing mental health currencies.

24. Please contact us at PbRComms@dh.gsi.gov.uk.

[10] Available at http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_4000363

# Section 2: Classification, currency and grouping

## Currency

25. For admitted patient care and A&E, the currencies used are HRGs. Outpatient attendances are based on treatment function code (TFC) [11].

26. HRGs are standard groupings of clinically similar treatments which use common levels of healthcare resource. The latest version, HRG4, was introduced to PbR in 2009-10 and has been specifically designed to support a national tariff payment system for healthcare, with substantial clinical involvement over a number of years. Further information is available on the NHS Information Centre website[12].

27. HRG4 introduced the concept of core and unbundled HRGs. A core HRG represents a care event (consultant episode, outpatient attendance or other care event such as an A&E attendance). An unbundled HRG represents an additional element of care, making it possible to separately record, cost and potentially tariff the different components within a care pathway. An unbundled HRG will always be associated with a core HRG that represents the care event, and will always be produced in addition to a core HRG.

28. Not all unbundled HRGs have a tariff, and during our work with stakeholders in 2009 we established a set of principles and criteria for determining whether a service should be unbundled for payment under PbR (paragraph 145). The *2010-11 tariff information spreadsheet* highlights all unbundled HRGs for PbR in 2010-11, and whether they have a separate tariff or have had their costs rebundled.

29. A spell HRG represents a spell of care from admission to discharge. For single episode spells, the spell HRG will be the same as the episode HRG. Spell HRGs for multi-episode spells are separately derived by the application of grouping logic across all procedures and diagnoses contained within component consultant episodes and in some circumstances spell HRG and episode HRGs may differ.

## Classification

30. Current classification systems for describing information from the patient record are:

[11] 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"
[12] At http://www.ic.nhs.uk/casemix

(a) International Classification of Diseases tenth revision (ICD10) for diagnoses codes, maintained by the World Health Organisation[13]
(b) Office of Population Censuses and Surveys 4.5 (OPCS4.5) for procedure and intervention codes, maintained by NHS Connecting for Health[14].

31. Some HRGs are triggered by diagnosis codes, some are triggered by procedure codes and some use both diagnoses and procedure codes.

## Grouping

32. Grouping is the process by which diagnoses and procedure codes on patient records are grouped to an HRG. The NHS Information Centre produces grouper software[15], which does this automatically. The relevant grouper is the 2010-11 Local Payment Grouper[16]. The NHS Information Centre also publish a Code to Group table containing information on which ICD10 and OPCS4.5 codes map to which HRGs.

33. In general, providers use the Grouper to plan, benchmark and send the results to commissioners as part of their request for payment. Commissioners can also use the Grouper if they have access to the raw data.

34. The Grouper groups data to HRGs, but does not apply exclusions or tariff adjustments to the grouped data. This needs to be done by users or a third party. Secondary Uses Service Payment by Results (SUS PbR)[17] however groups the data and applies exclusions and tariff adjustments. The HRG4 grouping logic is built into SUS PbR and, given the same input as the Grouper, will produce the same results.

35. This guidance assumes that where users are locally grouping data, that they are making use of the 2010-11 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 2010-11 SUS PbR algorithm.

36. HRG design is under continual review for changes in clinical practice and changes will be reflected in the 2010-11 Local Payment Grouper. Annex B summarises the main changes between the 2009-10 Local Payment

[13] http://www.who.int/classifications/icd/en/index.html
[14] http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4
[15] http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment
[16] Available on 1 March 2010, and which will replace the 2010-11 Road Test Grouper.
[17] http://www.connectingforhealth.nhs.uk/systemsandservices/sus/supports/pbr

Grouper and the 2010-11 Road Test Grouper, and anticipated changes between the 2010-11 Road Test Grouper and 2010-11 Local Payment Grouper.

## Data stages

37. 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 |

38. 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<br><br>CDS V6 Type 130 Admitted Patient Care - Finished General Episode CDS<br><br>CDS V6 Type 140 Admitted Patient Care – Finished Delivery Episode CDS<br><br>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

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

40. 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.

41. A full list of exclusions can be found in the *2010-11 tariff information spreadsheet*. Only those marked as pre-processing or pre-processing at episode level should be excluded at this stage.

42. 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.

43. At the pre-processing stage 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.

44. 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.

45. 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.

46. SUS PbR is able to perform the pre-processing stage, which it applies to data submitted by providers in CDS records.

### Grouping stage

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

### PbR post-grouping stage

48. After the grouping process has been run, post-grouping exclusions should be applied to the data. These include outpatient TFC and HRG exclusions. HRG exclusions are only applied post-processing and at the spell level under HRG4.

[18] Available at http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment

## PbR adjustments stage

49. After the data has been pre-processed, grouped and had post-processing exclusions applied, it is ready to have any relevant PbR adjustments applied (paragraph 54 lists these for admitted patient care). The MFF (paragraph 415) is applied to the tariff after any adjustments.

# Section 3: Admitted patient care

## Structure

50. 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 different tariffs include:

    (a) 1,056 combined day case and ordinary elective spell tariffs (except for a small number of HRGs where there are 17 separate day case tariffs and 18 ordinary elective tariffs)
    (b) 1,074 ordinary non-elective spell tariffs.

51. As in previous years, the tariff for admitted patients 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.

52. Separate day case episodes that are 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 day case episode will continue to be spelled separately and attract a separate day case tariff.

53. For spells that start before and finish in 2010-11, the 2010-11 tariff (and adjustments if applicable) should apply on discharge. For clarity:

    (a) patient admitted on 30 March 2010 and discharged on 31 March 2010 – 2009-10 tariff applies
    (b) patient admitted on 31 March 2010 and discharged on 1 April 2010 – 2010-11 tariff applies
    (c) patients admitted and discharged between 1 April 2010 and 31 March 2011 inclusive – 2010-11 tariff applies.

54. A number of adjustments to the admitted patient tariffs may or may not 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 (see Section 6).

55. These adjustments are illustrated in a series of flow diagrams in Annex C.

56. In addition, some of the published tariffs may have been subject to:

(a) NICE adjustments
(b) CNST adjustments
(c) other pricing adjustments.

## Rewarding elective care in 2010-11

57. Over a period of many years, and in most comparative health care systems, one of the main ways to increase the efficiency of the acute sector and the quality of the patient experience has been to drive down length of stay. This has been made possible through changes in clinical practice (e.g. developments in anaesthetics and less invasive treatments) as well as changing models of care and design of services (e.g. admitting patients on the day of surgery and developing day case suites). In the past, much of the focus has been on increasing the use of day case surgery and rates have increased over the years. More recently, the focus has been on the development of ambulatory care and moving care and treatments to other settings where possible, such as outpatient clinics.

58. The tariff for elective care, when first established in PbR, sought to support the desire to move activity into day case settings where appropriate by setting a price that was based on a weighted average of the ordinary elective cost and the cost of day cases. This meant that the price would reward providers that were achieving higher than average levels of day cases and under reward those providers whose day case rate were lower than the average.

59. The PSD tariff introduced in 2009-10 was based on the same underpinning logic, that setting the tariff on a weighted average of the outpatient and day case costs would provide an incentive to deliver care in an outpatient setting. HRG4 allows the capture of procedures in an outpatient setting. However, the collection and coding of outpatient procedure data has been patchy, and we were not able to assess fully the impact of the new structure on individual organisations. As a result of this, we introduced the PSD tariff on a non-mandatory basis for outpatient procedures. Feedback received from the NHS during 2009 suggests that negotiating prices for outpatient procedures has been difficult to handle locally.

60. We have reviewed our approach for rewarding care in 2010-11, to reduce the burden on the local contracting process and to develop a more sustainable process for the future. As a result, we have removed the PSD and short stay elective tariffs and re-introduced combined day case and ordinary elective spell tariffs. Nevertheless, the collection and coding of outpatient procedures is essential to enable PbR to support the development of ambulatory care in future years. We also support the use of

gain sharing flexibilities (paragraph 410) where appropriate shifts from theatre to clinic settings can be achieved to improve the patient experience.

61. We have published 17 separate day case tariffs and 18 ordinary elective tariffs where we received clinical advice that it would be inappropriate to have a combined tariff. Some HRG tariffs have decreased between 2009-10 and 2010-11 due to the weighting of ordinary elective and day cases.

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

## Marginal rate emergency tariff

### Purpose

63. We are introducing a marginal rate of 30% of the relevant published tariff for emergency admissions above a baseline set at the value of 2008-09 activity priced at the 2010-11 national tariff. The marginal rate will provide 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

64. The marginal rate applies to increases, but not decreases, in the value of emergency activity. It therefore differs from the differential tariff for emergency admissions which was removed from PbR after 2008-09[19]. Where the actual value of emergency activity in 2010-11 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 2010-11 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 2010-11 is £1.1 million, then the payment is £1.03 million (being 30% of the difference between actual and baseline).

65. 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.

[19] Payment by Results guidance for 2009-10, paragraphs 11 to 14

66. 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 *2010-11 tariff information spreadsheet* provides examples to illustrate the principles for calculating the difference between the values of actual and baseline activity and making in-year adjustments. Our simplified examples assume an even profile; in reality, emergency activity will probably be monitored using a suitable seasonal profile.

**Defining emergency**

67. Table 4 shows that emergency spells are defined by admission codes 21-24 and 28 for the purposes of the marginal rate.

Table 4: Admission codes for the marginal rate emergency tariff

| Admission code | Description | Does the marginal rate emergency tariff apply? |
|---|---|---|
| 11 | Elective admission: waiting list | No |
| 12 | Elective admission: booked | No |
| 13 | Elective admission: planned | No |
| 21 | Emergency admission: Accident and emergency or dental casualty department of the Health Care Provider | Yes |
| 22 | Emergency admission: General practitioner, after a request for immediate admission has been made direct to a Hospital Provider, i.e. not through a Bed bureau, by a GP or deputy | Yes |
| 23 | Emergency admission: Bed bureau | Yes |
| 24 | Emergency admission: Consultant clinic, of this or another Health Care Provider | Yes |
| 28 | Emergency admission: Other means, examples are<br>- admitted from the Accident And Emergency Department of another provider where they had not been admitted<br>- transfer of an admitted patient from another Hospital Provider in an emergency<br>- baby born at home as intended | Yes |
| 31 | Maternity admission: admitted ante-partum | No |
| 32 | Maternity admission: admitted post-partum | No |
| 82 | Other admission: The birth of a baby in this Health Care Provider | No |
| 83 | Other admission: Baby born outside the Health Care Provider except when born at home as intended | No |
| 81 | Other admission: Transfer of any admitted patient from other Hospital Provider other than in an emergency | No |

68. 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 77(c)).

69. Because it is determined solely by admission code, the marginal rate applies to babies born at home as intended and then subsequently admitted because of clinical need (included in admission code 28) but not other births (admission codes 82 or 83), and it applies to admission codes 21-24 and 28 regardless of TFC (e.g. 501 – obstetrics).

70. The marginal rate does not apply to:

    (a) activity outside the scope of PbR
    (b) activity outside of contracts
    (c) activity paid at best practice tariff
    (d) A&E attendances.

**Setting the baseline**

71. The baseline for the marginal rate 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 2010-11 contract and concluded as part of the 2010-11 contract negotiations.

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

Table 5: Setting the baseline

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

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

73. The baseline is the actual value of the full 12 months of activity in the financial year 2008-09 priced at the 2010-11 tariff. To calculate the baseline, commissioners will need to group 2008-09 activity (on HRG version 3.5 (HRGv3.5)) to HRG4, and price it using the 2010-11 national tariff structure (including 2010-11 short stay emergency spells, long stay payment trim points and specialised top-up percentages). Because the baseline is priced using features of the 2010-11 national tariff, 2008-09 features such as the differential tariff for emergency admissions do not apply.

74. The marginal rate does not apply to activity covered by best practice tariffs. Although the most effective way to do this is to adjust the baseline activity to remove activity covered by best practice tariffs, commissioners and providers should agree an approach that is proportionate and practical. This may include:

    (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
    (d) fully adjusting the baseline and actual outturn values to reflect activity covered by best practice.

75. Where a service opened during 2008-09 then the activity data needs to be annualised, or 2009-10 used. Where a new service is opened or an existing service is significantly reconfigured, then the baseline should be set using 2010-11 plan or annualised part year activity data from 2009-10 depending on when the service is opened or reconfigured.

76. Where a service has transferred between providers since 2008-09, or is to be transferred in 2010-11, 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.

77. The only 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.

78. The marginal rate applies to commissioners in the devolved administrations only where payment for activity commissioned from English providers is at national tariff (for example, as a result of the *Interim protocol on cross border commissioning between England and Wales*) and where there is a contract.

### SHA risk pool

79. In recognition that commissioners have a joint responsibility with providers in managing health system risk, SHAs will be expected to 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.

80. 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

81. 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 C Figure 1a. We have revised the percentages for the adjustment in 2010-11 using 2007-08 national cost and activity data.

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

(a) the emergency admission has admission code 21-24 or 28[21]
(b) the spell is not for a child, defined as aged under 19 years on date of admission
(c) the assignment of the HRG can be based on a diagnosis code, rather than on a procedure code alone
(d) the HRG's average length of non-elective stay is two days or more
(e) the HRG is not defined by length of stay
(f) the patient's length of stay is either zero or one bed day

[21] See Table 4 for a description of admission codes.

83. 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.

84. The short stay emergency prices are published as part of the tariff, based on the revised percentages in Table 6, 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, if an HRG has an average length of stay of 2 days, and the patient's length of stay is 0 or 1 day, the payment is 70% of that HRG's tariff.

Table 6: Short stay emergency adjustment percentages

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

## Long stay payments

85. 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. This adjustment is illustrated in Annex C Figure 1b.

86. The HRG costs reported in the published 2007-08 reference costs do not include the cost of stays beyond a defined trim point (these are listed separately 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 an HRG specific daily rate will apply.

87. Spell lengths of stay should already have been adjusted at the episode level at the pre-processing stage. This is because the adjustment may affect the length of stay for the spell level HRG and therefore affect which HRG it groups to at the spell level (because some HRGs have length of stay logic).

88. If a patient is medically ready for discharge and delayed discharge payments[22] have been imposed on local authorities under the provisions of the Community Care (Delayed Discharges etc) Act 2003, then PCTs 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

[22] Available at http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Delayeddischarges/index.htm

actual discharge from any long stay payment. This is the only circumstance in which long stay payments may be adjusted.

89. Our approach to the calculation of combined day case and elective trim points is consistent with the approach we took in 2008-09, when there was last a combined day case and elective tariff. The changes made to the tariff structure this year mean that trim points have been calculated on a different basis (as the calculation includes day cases) compared to 2009-10, and so are not directly comparable between years. We will be reviewing our approach to long stay payments in the future.

## Specialised service top-up payments

90. The specialised services that will attract a top-up in 2010-11 for admitted patient care are children (defined as a patient aged under 19 in HRG4) and orthopaedics. This adjustment is illustrated in Annex C Figure 1c.

91. The specialised services for orthopaedics top-up is only applicable to adults but all organisations are eligible. The specialised services for children top-up is available only to those organisations deemed eligible in 2009-10. The list of eligible organisations is included in the *2010-11 tariff information spreadsheet*, and was determined by SCGs and SHAs.

92. Some HRGs already discretely identify specialised activity. Reference costs should already reflect the specialised nature of the activity and these HRGs do not qualify for specialised top-ups. Non-applicable HRGs are listed with the *2010-11 tariff information spreadsheet*.

93. Top-ups are a percentage of the relevant HRG tariff and are shown in Table 7. The orthopaedic top-up moves from 14% in 2009-10 to 30% in 2010-11 while the children's top-up remains 78%.

Table 7: Specialised service top-up percentages

| | Top-up |
|---|---|
| Children | 78% |
| Orthopaedic | 30% |

94. To determine which spells are applicable for specialised service top-ups, the Grouper uses the specialised service code (SSC) trigger list, a list of ICD10 diagnosis and OPCS4.5 procedure codes published in the *2010-11 tariff information spreadsheet,* and applies an SSC flag of 23 for children and 34 for orthopaedic. These codes are based on the third edition of the Specialised Services National Definition Set (SSNDS) published in 2009[23].

[23] Available at http://www.nscg.nhs.uk/index.php/key-documents/specialised-services-national-definitions-set/

To trigger a top-up, the OPCS codes can be in any position in the patient record, however for the ICD codes to trigger a top-up they must be in the primary position.

95. Because the Local Payment 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. In addition, the Grouper may output multiple specialised service top-ups for the same spell.

96. 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.

## Alteplase adjustment

97. In 2010-11 we are releasing a best practice tariff for stroke (paragraph 227). However, 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 of £828 when HRG AA22Z (non-transcient stroke or cerebrovascular accident, nervous systems infection or encephalopathy) is coded with unbundled HRG XD07Z (fibrinolytic drugs band 1). XD07Z is the unbundled HRG that contains the OPCS code X83.3 (fibrinolytic drugs). This adjustment is illustrated in Annex C Figure 1d.

## NICE adjustments

98. NICE produces a range of guidance including technology appraisals (recommendations on the use of new and existing medicines and treatments).

99. To date, we have focused on technology appraisals because these are normally supported by a three-month funding direction, taking account of their cost implications through:

    (a) an adjustment within the tariff uplift
    (b) specific adjustments to the national tariff prices directly
    (c) an exclusion to PbR, e.g. high cost drug exclusion.

100. For the 2010-11 tariff we have considered all technology appraisals published from April 2008. The alteplase adjustment is a response to NICE guidance. We are also continuing the adjustment for drug-eluting stents for coronary artery disease (TA152[24]), published by NICE in July 2008, by

[24] Available at http://guidance.nice.org.uk/TA152

increasing the tariffs for HRGs EA31Z, EA32Z, EA33Z and EA34Z by £20.3m in proportion to activity.

## CNST adjustments

101. Rather than include the cost pressure arising from NHS contributions to the CNST in the overall tariff uplift, we have made £62 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).

102. 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 scheme. Note that we adjusted only the standard and high tariffs for A&E services.

Table 8: Apportioning CNST costs to HRGs

| HRG chapter or sub-chapter | Specialty | Increase on tariff prices |
|---|---|---|
| AA | Neurology, neurosurgery | 0.45% |
| B | Ophthalmology | 0.11% |
| CZ | Otolaryngology, plastic surgery | 0.06% |
| D | Respiratory | 0.02% |
| E | Cardiology, cardiothoracic surgery | 0.07% |
| F | General surgery | 0.24% |
| G | General surgery | 0.27% |
| H | Plastic surgery, trauma and orthopaedics | 0.19% |
| J | General surgery, plastic surgery | 0.16% |
| LA | Renal procedures and disorders | 0.03% |
| LB | Urology | 0.07% |
| N | Obstetrics and gynaecology | 1.90% |
| P | Paediatrics | 0.45% |
| Q | General surgery | 0.17% |
| VA | Trauma and orthopaedics | 0.19% |
| A&E | A&E | 0.93% |

## Pricing adjustments

103. We have worked closely with key stakeholders to identify a list of those areas of the tariff that did not seem to be rewarding activity appropriately. As a result, we made a number of pricing adjustments to tariffs, both so that they make clinical sense compared to other prices and so that potential perverse incentives are removed. These are described more fully in *Step-by-step guide: calculating the 2010-11 national tariff*.

## Home births

104. In 2010-11, home births will continue to be reimbursed at the same rate as a normal delivery without complications. SUS PbR will include a SUS specific HRG for home birth, and calculate a tariff, for data submitted via the CDS type 160 (other delivery event). This adjustment is illustrated in Annex C Figure 1e.

## Antenatal admissions

105. HRG4 has 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. However, the new HRGs continue to be subject to what appears to be inconsistent coding and poor costing. Therefore we have made pricing adjustments by shifting costs from the non-delivery HRGs into the delivery HRGs (NZ01 to NZ03).

106. We are planning to work with maternity PbR sites to understand the reasons for some of the variation in reported costs and to understand what should be reported as outpatient or admitted activity, with a view to identifying the appropriate price for this activity. Because of this work, we expect the tariff prices for zero length of stay activity to reduce in future years, whilst the prices for other maternity HRGs could increase.

107. Locally, we strongly suggest that providers review their current processes to ensure that activity is correctly coded, both clinically and administratively, and correctly costed. We would also encourage commissioners to work with providers to benchmark this activity to understand what clinical activity takes place during these contacts.

108. This local work needs to consider the overall policy direction set out in *Maternity Matters*[25] of increasing investment in maternity services. Any

[25] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312

resulting changes in funding should be managed locally over a sensible time period. Where the published tariff is clearly unreflective of actual local costs as a result of changes made to local coding practices (rather than just inefficient service) commissioners should consider the use of a time-limited payment flexibility (paragraph 399), with review, to manage the situation.

## Never events

109. Never events are serious patient safety events that are largely preventable. From April 2010, PCTs should continue to use the national set of never events, published by the National Patient Safety Agency (NPSA)[26], as part of their contract agreements with providers. During 2010-11, development of this policy will focus on promoting clear reporting and discussion mechanisms for never events as part of a programme of commissioning for safety. PCTs will monitor and publicly report the occurrence of never events, as well as investigations and action plans, within the services they commission, to assure themselves and the public that providers are as safe as possible. Never events should be reported to the NPSA and publicly reported as part of annual reporting on quality and safety. From 2010-11, no payment should be made where treatment results in one of the following seven never events:

    (a) wrong site surgery
    (b) retained instrument post-operation
    (c) wrong route administration of chemotherapy
    (d) misplaced naso or orogastric tube not detected prior to use
    (e) inpatient suicide using non-collapsible rails
    (f) in-hospital maternal death from post-partum haemorrhage after elective caesarean section
    (g) intravenous administration of mis-selected concentrated potassium chloride

110. SUS PbR will still generate payments, which will need to be adjusted locally through contracts.

111. NPSA plan to consult on whether further never events ought to be added to this list for future years.

## Zero price

112. HRGs that have a mandatory tariff of zero pounds (£0) are shown in

[26] Available at www.npsa.nhs.uk

Table 9. No payment should be agreed or made for this activity.

Table 9: Zero price HRGs

| HRG code | Description | Justification |
|---|---|---|
| PB03Z | Healthy baby | Costs are included with the mother's care |
| UZ01Z | Data invalid for grouping | Organisations should not be funded for invalid data |

## No tariff price

113. Where insufficient costing or activity data was submitted to support calculation of a tariff for an HRG we have not included that HRG in the national tariff, for example DZ49Z Respiratory Nurse and AHP education/support. However, these HRGs can still be used as contract currencies with locally agreed prices.

114. No tariff information (£-) has been supplied in the 2010-11 tariff information spreadsheet where the HRG:

    (a) has a mandatory combined day case and ordinary elective tariff, and not separate day case and ordinary elective tariffs
    (b) has separate mandatory day case and ordinary elective tariffs, because we were advised it would be clinically inappropriate to have a combined tariff
    (c) was not considered appropriate for either a day case or ordinary elective setting (JC09Z patch tests)
    (d) is not included in the list of 49 mandatory outpatient procedure HRG tariffs (paragraph 119)

## Interventional radiology

115. The NHS Information Centre is working to develop an interventional radiology HRG sub-chapter. In the interim, to assist planning within providers, the current HRGs that are done entirely or mainly on an interventional radiology basis are shown in Annex D.

# Section 4: Outpatient care

## Structure

116. The outpatient attendance tariff is based on attendance by TFC. In 2010-11, we are also introducing a list of 49 mandatory outpatient procedure HRG tariffs for high volume procedures undertaken in an outpatient setting. We have rebundled the costs and activity for remaining outpatient procedure HRGs that are not on this list into the relevant outpatient attendance TFCs, as described in *Step-by-step guide: calculating the 2010-11 national tariff.* Remaining outpatient procedures HRGs that are not on this list will therefore be reimbursed using one of the 47 TFC based outpatient attendance tariffs, unless commissioners and providers wish to employ the flexibility at paragraph 398.

117. Where patient data has been grouped 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 C Figure 2a.

118. Where patient data has been grouped 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 C Figure 2b.

## Outpatient procedures

119. The list of 49 mandatory outpatient procedure HRG tariffs were chosen initially because they have no fewer than 5,000 procedures nationally and no fewer than 20 providers submitting data in 2007-08 reference costs, and then amended following clinical advice.

120. The outpatient procedure HRG tariff is always 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. 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.

## Outpatient attendances

### Eligibility

121. The mandatory outpatient attendance tariff is applicable only to pre-booked, consultant led attendances. The pre-booked requirement is not limited to Choose and Book[27], and may include local systems accepting patients based on GP letters or phone calls. 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. Payments for other outpatient attendances are subject to local negotiation between commissioners and providers.

122. 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.

123. 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 can be fed into SUS PbR. Home visits are not eligible and should be subject to local pricing. We will be considering how to bring home visits into the scope of PbR in future years and encourage local payment for these on an activity basis.

124. 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.

125. We are aware that SUS PbR applies a tariff where the Attended or Did Not Attend field in the outpatient CDS is empty. This data item is not mandated on the CDS record, but has a 99% completion rate. Commissioners should agree locally with providers whether to make payment for activity where the field has not been completed.

[27] 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

## Consultant led and non-consultant led

126. The NHS Data Model and Dictionary definition of a consultant led service is a "service where a consultant retains overall clinical responsibility for the service, care professional team or treatment. The consultant will not necessarily be physically present for each consultant led activity but the consultant takes clinical responsibility for each patient's care.[28]" A consultant led service does not apply to nurse consultants or physiotherapist consultants.

127. 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." However, we encourage health economies to consider setting local prices for this activity.

128. 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 activity[29], 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

129. 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 episode (or series) ends when the patient is not given a further appointment by the consultant 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 a new episode and the attendance is classified as a first attendance.

130. The end of a financial year does not necessarily signify the end of a particular outpatient episode. If two outpatient attendances for the same course of treatment are in two different financial years but are less than six

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

29 which may include community midwife clinics provided that the principles in paragraphs 10.1.6 and 10.1.7 of the PbR Code of Conduct apply

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

131. In order to provide incentives to minimise follow-ups where these are not necessary, we have structured the tariff to front-load the reimbursement so that follow-ups have a relatively low reimbursement rate compared with a first attendance. As in previous years, we have set this front-loading at 10% of the follow-up costs. This means that we have added 10% of the costs of follow-up attendances to the first attendance costs making the tariff for first attendance relatively higher.

132. Where 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, then commissioners and providers may wish to discuss an adjustment to funding to recognise that a proportion of appointments being recognised in the data flow as first attendances are, as far as the patient is concerned, follow up visits.

133. We are again publishing a non-mandatory price for non face-to-face outpatient activity (paragraph 343), which commissioners and providers may wish to use to facilitate changes to outpatient pathways.

**Multi-professional and multi-disciplinary**

134. 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 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

135. In 2010-11, we have refined the definitions for multi-professional and multi-disciplinary attendances, following feedback that there has been uncertainty about when to code attendances as multi-professional or multi-disciplinary. The refined definitions are not a reason in themselves to change the way in which a patient is seen. Multi-professional and multi-disciplinary attendances should add benefit to the patient's treatment above that which could be gained by a single attendance and be developed in conjunction with commissioners.

136. 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.

137. 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.

138. 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.

139. They do not apply if one professional is supporting another, clinically or otherwise, e.g. in the taking of notes, acting as a chaperone, training, professional update purposes, operating equipment and passing instruments. They also do not apply where a patient sees single professionals sequentially as part of the same clinic. Such sequential appointments count as two separate attendances and should be recorded as such in line with existing NHS Data Model and Dictionary guidance on joint consultant clinics[30].

140. 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.

141. 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 when determining where multi-professional or multi-disciplinary applies.

142. Some examples of multi-professional attendances are:

    (a) where 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) where a patient sees a cardiology consultant to give a diagnosis and a cardiology nurse specialist to discuss their treatment plan

[30] Available at http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/help/faqs-07/sharedcare

(c) where an orthopaedic nurse specialist assesses a patient and a physiotherapist provides physiotherapy during the same appointment.

143. Some examples of multi-disciplinary attendances are:

(a) where a breast surgeon and an oncologist discuss with the patient options for surgery and treatment of breast cancer.

(b) where 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) where a patient sees a paediatrician to discuss their disease and a clinical geneticist to discuss familial risk factors.

144. 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.

**Rebundling of diagnostic imaging**

145. Unbundling involves the breaking down of components of care pathways into individual service elements such as rehabilitation, high cost drugs and critical care. This allows these elements to be priced and commissioned separately. As part of its design, HRG4 incorporates a number of unbundled service areas. In 2009-10 we provided non-mandatory prices for unbundled diagnostic imaging to encourage plurality of provision and help achieve waiting time targets. We have been advised however that separate prices for imaging does not incentivise providers to manage the number of images which are requested. During our work with stakeholders in 2009,

we therefore established a set of 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*[31] 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.

146. In line with these principles, in 2010-11 we are rebundling 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 2010-11 national tariff* provides more detail on our approach.

147. 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 335), which can also be used to support the removal of imaging from consultations where direct access imaging has already taken place or where pathways are shared between providers.

148. We have also provided a flexibility for more complex diagnostic imaging (paragraph 401).

**Paediatric TFCs**

149. The paediatric TFCs are for specialised services designed for children (aged under 19), with appropriate facilities and support staff to provide such a service.

150. A paediatric diabetes TFC does not exist. As an interim measure, we are publishing a non-mandatory price (paragraph 346) for paediatric diabetes in 2010-11.

[31] Available at www.dh.gov.uk/pbr

### Pre-operative assessments

151. Where a pre-operative assessment takes place following admission, the costs are reflected in the admitted patient care HRG.

152. Where the assessment takes place prior to admission, and constitutes a pre-booked consultant-led outpatient attendance, it will be recorded as an outpatient attendance and may attract the relevant tariff. Some commissioners have contracts in place preventing separate payments for pre-operative assessments occurring on the same day as an admission. 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.

## Zero price

153. Outpatient 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: Accident and emergency services

154. The A&E tariff will continue to be based on HRGv3.2 in 2010-11. It is illustrated in Annex C Figure 3.

155. Although we had intended to introduce HRG4 for A&E services to bring them into line with the rest of the tariff, we received feedback that it would introduce an unacceptably high level of volatility, and 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. It is therefore sensible to maintain the status quo until the review is completed.

156. There are three A&E tariffs (high, standard and minor) for services delivered in A&E and minor injury units (MIUs), spread over twelve reference cost classifications based on investigation and disposal. We have uplifted the high and standard tariffs to take into account changes in the underlying reference costs and increasing payments to cover the costs of CNST. Walk in centres (WiCs) continue to be excluded from the scope of PbR.

157. MIUs and non-24 hour A&E units remain eligible for the minor tariff only regardless of which HRG is triggered from the data. MIUs can be identified by the A&E Department Type field.

158. Likewise, patients who are dead on arrival (DOA) should always attract the standard tariff. DOAs do not have an HRG under HRGv3.2 and are triggered by the A&E Patient Group code 70 (brought in dead). SUS PbR will include a SUS-specific HRG for DOA.

159. The 2010-11 Local Payment Grouper will include A&E databases for both HRGv3.2 and HRG4 until a decision is made to move to HRG4 in future years.

# Section 6: Best practice tariffs

## Introduction

160. This guidance supports the release of the first set of best practice tariffs for:

    (a) cataracts
    (b) cholecystectomy (gall bladder removal)
    (c) fragility hip fracture
    (d) stroke care.

161. A best practice tariff is also under development for renal dialysis. For 2010-11, we have provided non-mandatory prices for adult renal dialysis as an initial step (paragraph 323).

162. The rationale for the policy as a whole, and for the specific pricing models developed, is set out below. We suggest some further reading in Annex G, which may be helpful to organisations wishing to adapt services in light of the best practice tariffs described here.

163. The best practice tariffs are mandatory and therefore share the same status as the rest of the national tariff, including the opportunity to use the same flexibilities described in Section 10 where the principles of application apply.

## The quality framework and best practice tariffs

164. The quality framework brings together activity across the Department of Health and the NHS to achieve the vision set out in *High Quality Care for All*. The framework sets out a plan of action to achieve the overriding objective of putting quality at the heart of everything we do, and consists of seven steps to quality:

    (a) bringing clarity to quality
    (b) measuring quality
    (c) publishing quality performance
    (d) recognising and rewarding quality
    (e) raising standards
    (f) safeguarding quality
    (g) staying ahead.

165. Best practice tariffs have evolved out of this commitment to make quality the organising principle of the NHS, whilst also responding to the need to make efficiency and value a key part of this drive for improvement. Best practice tariffs are designed to enable the NHS to achieve these quality and efficiency gains together.

166. They achieve this by recognising and rewarding quality, working with clinicians as well as organisations like NICE and the NHS Institute to identify characteristics of best practice care that the national tariffs have the scope to encourage.

## Development process

167. We have developed the broad principles of best practice tariffs with the oversight of our established PbR governance groups, and service specific tariff detail with clinical experts, including the National Clinical Directors for stroke care and trauma care, plus other key clinical stakeholders. We have sought clinical, provider and commissioner perspectives in the development of the tariffs.

## Evidence base

168. We have built on the foundations of existing widely accepted clinical evidence:

    (a) for fragility hip fracture, the British Orthopaedic Association and British Geriatric Society's Blue Book, which describe standards and guidance in relation to care of patients with fragility hip fractures, has been the central guiding document
    (b) for stroke, key sources of evidence have been the National Strategy for Stroke, the Intercollegiate Stroke Working Party's National Clinical Guideline for Stroke, and the National Sentinel Stroke Audit 2008
    (c) the foundations for the gall bladder removal and cataract treatment tariffs are the NHS Institute's *Delivering Quality and Value High Volume Care Focus on*[32] publications. The reports follow work in partnership with the NHS, to provide the key characteristics of the patient pathways and identify measures for improvement.

## Background on best practice tariffs

169. Each service area for the best practice tariffs is characterised by significant unexplained variation in practice and a clear consensus of what clinical best practice constitutes. The tariffs are designed in accordance with issues affecting quality and value in each service area, and are structured and priced to both incentivise and adequately reimburse for the costs of high quality care.

170. A best practice tariff is therefore a national tariff that has been priced and structured in order to improve the quality and value for money of a service

[32] http://www.institute.nhs.uk/quality_and_value/introduction/quality_and_value.html

area. For 2010-11, we have developed three distinct payment models to address specific quality and value issues in each of the four service areas:

(a) model one – "streamlined pathway" – applied to cataract treatment
(b) model two – "incentivise day case activity" – applied to cholecystectomy (gall bladder removal)
(c) model three – "paying for best practice" – applied to stroke and fragility hip fracture care.

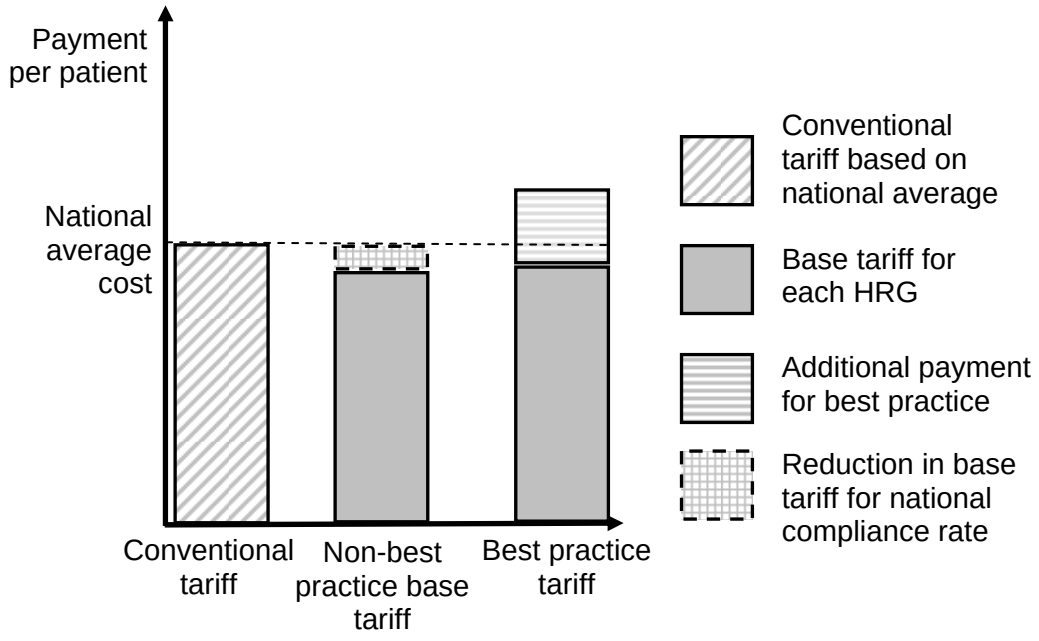
## Pricing principles of best practice tariffs

171. Essentially, the best practice tariffs are set not just at the national average but instead to better reflect the costs of delivering best practice. We have also built financial incentives into the prices to encourage uptake of best practice in the early stages. We expect over time to remove such financial incentives and align future tariffs with the actual cost of best practice. Whilst some tariffs are higher than the conventional tariff, this does not mean that the financial incentive is always with the provider. Commissioners should see financial gains from commissioning services that are best practice, both in-year and from any reductions in the future to align the tariffs with cost of best practice.

172. The financial incentives are not all about paying more for best practice. For example, the cataracts tariff will not fund providers for elements of the pathway that are not in line with best practice. With cholecystectomy, the overall envelope of funds has been reduced to reflect a higher day case rate. The cost of the initial CT scan for stroke was previously included in the conventional tariff but is now removed so that providers will only be reimbursed for scans that are in line with best practice.

173. One of the key principles in setting the tariffs is that PCTs should not pay more for providers who stand still. To achieve this principle with model three (stroke and fragility hip fracture), the base tariff paid to all patients irrespective of the level of care is below the national average cost. We have set it so that, on average, no PCT pays more for current compliance to the criteria. This also means that providers who are below average performers have an added financial incentive to change practice for the benefit of the patient, as illustrated in Figure 3.

Figure 3: Pricing best practice tariffs




174. In line with PbR policy, we will ensure that the overall PbR quantum will not increase because of introducing the new best practice tariffs. The effect then is redistributive to the best practice service areas. For model three tariffs, PCTs will pay more per HRG if best practice is met, but overall across PbR services PCTs should not see an increase in expenditure due to the introduction of these tariffs.

## Best practice tariff models

### "Streamlined pathway": cataracts

*Target characteristics of clinical best practice*

175. In cataract treatment, an important element of best practice is to treat patients in a joined-up and efficient way, by carrying out all assessments before surgery at the same time, operating as a day case procedure in all but exceptional cases, and then carrying out all follow-up assessments on one day around two weeks later. Again, this approach is preferred by patients, who do not have to spend unnecessary time waiting for appointments, while also providing a model of care that is more efficient and better value for money.

176. The best practice tariff developed for cataracts therefore aims to encourage a streamlined pathway. This pathway has been recommended as best practice in the *Focus on: cataracts* report published by the NHS Institute in

2008[33], the Royal College of Ophthalmologists' guidelines, and is in line with the 18 weeks patient pathway.

177. Since cataracts removal is one of the highest volume surgical procedures for most acute providers, improvements made in streamlining the patient pathway can generate substantial benefits in terms of time and cost savings, as well as providing a more patient centred service. Although the national day case rate for cataract surgery has improved significantly to an average of 96%, there is still much variation in how care is delivered between ophthalmology units. In particular, most improvements have so far been delivered in the pre-assessment stage, which means that there is still scope for further improvements across the entire pathway. Table 11 shows the stages in the best practice pathway for cataracts.

Table 11: Cataracts pathway

| Level | Description | Events |
|---|---|---|
| 1 | Initial diagnosis of cataract | Usually done in primary care, either by GP or optometrist |
| 2 | Confirmation of diagnosis and listing for surgery | First outpatient attendance |
| 3 | Pre-operative assessment | |
| 4 | Cataract removal procedure | Most likely to be on a day case basis[34] 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 (2nd 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 and 4 – 6 week review by local optometrist |

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

[33] Available at http://www.institute.nhs.uk/quality_and_value/high_volume_care/cataracts.html
[34] Cataract surgery may be coded as an outpatient procedure but should be remunerated at day case level as the difference is related to coding not to setting.

*Tariff structure and prices*

179. The best practice tariff for cataract treatment consists of a single tariff intended to cover the entire elective cataract pathway. For each cataract HRG there are two tariffs applicable, depending on whether a patient has cataract extraction on one or both eyes. This is illustrated in Annex C Figure 4a.

180. The tariffs correspond to the elements of the best practice pathway. 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.

181. The tariff prices in Table 12 cover the sum of the costs of the individual outpatient attendances and the surgical event (with a combined elective and day case price) and apply to HRGs BZ02Z and BZ03Z. The clinical view is that BZ01Z enhanced cataract surgery is not appropriate for this streamlined pathway approach and is therefore not applicable for the best practice tariff.

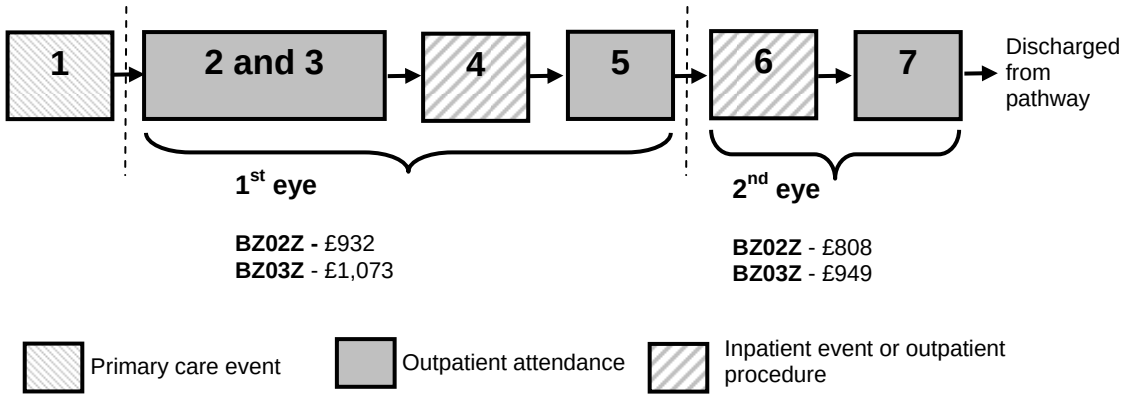
Table 12: Cataracts best practice tariff prices

| HRG code | HRG name | 1st eye (levels 2-5) | 2nd eye (levels 6-7) | Both eyes (levels 2-7)[35] |
|---|---|---|---|---|
| BZ02Z | Phacoemulsification cataract extraction and lens implant | £932 | £808 | £1,740 |
| BZ03Z | Non-phacoemulsification cataract surgery | £1,073 | £949 | £2,022 |

182. The pathway is illustrated in Figure 4.

[35] Where the cataract extraction on the 1st eye is under BZ02Z and on the 2nd eye under BZ03Z then the tariff price will be £932 + £949 = £1,881. Where the cataract extraction on the 1st eye is under BZ03Z and on the 2nd eye under BZ02Z then the tariff price will be £1,073 + £808 = £1,881.

Figure 4: Cataract pathway levels




183. Long stay payments and specialised service top-up payments are applicable to the admitted patient care event for cataracts where the criteria for these payments are met.

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

185. The best practice pathway is still relevant for pathways that span multiple secondary care organisations, e.g. where outpatient attendances take place at one organisation and the surgery is provided at another. Organisations should co-ordinate the pathway so that multiple outpatient attendances pre- and post-surgery are avoided (paragraph 193).

186. The best practice tariff is mandatory from 1 April 2010 and applies to patients whose pathway (level 2 onwards) begins from this date.

*Implementation*

187. SUS PbR cannot automatically exclude outpatient attendances for cataracts because diagnoses are not currently nationally recorded for outpatient attendances. However, additional functionality has been built into SUS PbR to help commissioners to implement this pathway tariff. Commissioners and providers will be able to access an extract that links events along a patient pathway and use this to monitor compliance and inform tariff payments.

188. This SUS PbR cataracts extract will link events along a pathway using the Patient Pathway ID field[36]. The extract will list events per patient pathway in chronological order detailing the number of days between each event and indicate which events appear to fall outside of the best practice pathway.

[36] This is one of the 18 weeks (referral to treatment) fields mandated in October 2009 for compliance in January 2010.

The extract will provide all the fields necessary for validation and will enable commissioners to identify where the number of attendances is not in line with the best practice pathway and adjust payment accordingly. This manual process may mean that commissioners make any financial adjustments on a quarterly rather than monthly basis.

189. Technical information to support the use of the SUS PbR cataract extract will be made available by SUS and published on the Connecting for Health website[37]. The specification of the extract will be published and an e-learning module to accompany SUS PbR release 7 will include a section on the use of SUS extracts. We expect that this technical information along with the PbR guidance will be sufficient to implement the tariff. We will continue to review this and provide supplementary guidance where necessary.

190. The SUS PbR cataracts extract is not mandatory. Where organisations are able to identify the diagnosis relevant to each ophthalmic outpatient attendance, and where payment can be excluded using this local data, then this is a valid alternative method of implementing the best practice tariff for cataracts.

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

192. Payment of the pathway tariff should ideally occur once the pathway has been completed, i.e. once the patient is discharged from the consultant's care. To minimise the time between the procedure and reimbursement for patients having both eyes treated, reimbursement of the first part of the pathway tariff may be made at level 5 and then subsequent payment on discharge.

193. The pathway for some patients will span multiple providers, for example due to configuration of services in the health economy or through patient choice. The national pathway tariff can be implemented across multiple providers only where there is robust reporting of information between providers using the inter-provider minimum dataset (IPMDS) locally. Where this data is

[37] The What's new section of the website at http://www.connectingforhealth.nhs.uk/systemsandservices/sus/whatsnew will detail guidance as and when it become available

sufficiently robust, we recommend that it is used in local implementation across multiple providers. To facilitate this pathway and similar pathway approaches in the future, we encourage organisations to capture and flow information in the IPMDS. Where robust reporting is not in place, commissioners will need to make arrangements locally to monitor compliance in order to make the financial adjustments.

194. As an elective procedure, cataract surgery falls under the 18 weeks patient pathway. Rules for 18 weeks stipulate that bilateral procedures such as cataracts should be on a single pathway with two status periods. Patients requiring surgery on both eyes should not, therefore, be discharged after the first eye and then re-referred for the second. Re-referral for the second eye should only be the case for patients whose visual acuity is not sufficiently impaired to justify surgery at that time.

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

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

**“Incentivise day case activity”: cholecystectomy (gall bladder removal)**

*Target characteristics of clinical best practice*

197. For gall bladder removal, one aspect of best practice is providing surgery as a laparoscopic day case procedure whenever clinically appropriate and suitable for the patient, i.e. providing a service that is not only more efficient but also provides a better experience for the majority of patients.

198. The best practice tariff model developed for elective cholecystectomy has therefore been designed to incentivise day case laparoscopic surgery, where clinically appropriate. This model has been developed in recognition that there is currently wide variation in practice across the country. The national average day case rate for cholecystectomies is 19%[38]. The British Association of Day Surgery (BADS) Directory of Procedures states that at

[38] Based on 2007-08 activity data in GA10B cholecystectomy without CC (HES data converted to spell basis in line with tariff calculation methodology).

least 60% of patients having this operation could be managed on a day case basis. Although BADS caveats this rate, which means that it may not be achievable by all, it is a level that a number of high performing trusts in England are already achieving or exceeding.

199. Performing this procedure as a day case offers advantages to both the patient and trust. Patients prefer to recuperate in their familiar home environment, while trusts benefit from reduced pressure on inpatient beds. BADS has no evidence to suggest that a shortened length of stay produces any greater risk in relation to potential post-operative complications or readmission rates.

200. While the 2010-11 best practice tariff focuses only on day case and ordinary elective cholecystectomies, discussions and any service reconfigurations should also consider the emergency cholecystectomy pathway. The NHS Institute publications on cholecystectomy (listed in Annex G) include sections on improving the emergency pathway.

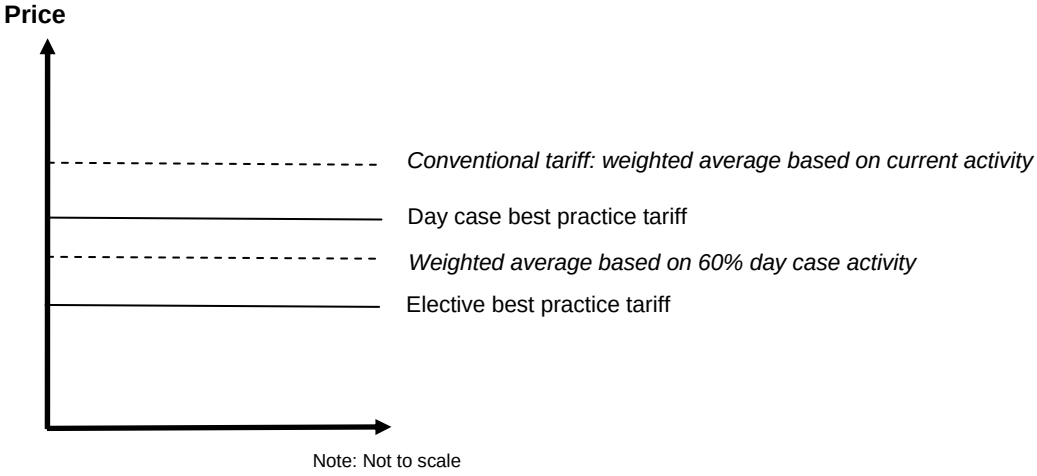
*Tariff structure and prices*

201. We have set the tariffs in 2010-11 to financially incentivise providers to increase their day case rate whilst ensuring that overall best practice does not cost PCTs more. This has been achieved by:

    (a) setting prices to reflect an increase in the day case rate rather than the current rate. With day cases costing less than ordinary elective spells this means the best practice tariff prices are lower than if we had calculated them on the conventional basis of a weighted average of current activity
    (b) providing separate tariff prices for day case and ordinary elective spell cholecystectomy procedures with the day case tariff set deliberately higher than the ordinary elective tariff.

202. Figure 5 illustrates this approach.

Figure 5: Pricing the cholecystectomy best practice tariff




203. Day cases will not be priced at this level indefinitely. The differential tariff is designed to change practice and will be monitored. In future years, the price will return to a combined tariff that reflects a higher day case rate.

204. The NHS Information Centre have also redesigned the HRGs for cholecystectomy to make it easier to differentiate between types of practice. There are now separate HRGs for open and laparoscopic procedures and the laparoscopic HRGs are further split into those with a zero length of stay and those with a length of stay of 1 day or more.

205. The best practice tariff applies only to cholecystectomies without complications and co-morbidities (HRG codes GA10C, GA10D and GA10E) and not to cholecystectomies with complications or co-morbidities (GA10F). Table 13 gives the tariff prices.

Table 13: Cholecystectomy best practice tariff prices

| HRG | Description | Combined day case and elective | Day case | Elective |
|---|---|---|---|---|
| GA10C | Open cholecystectomy without complications and co-morbidities (CC) | £1,369 | - | - |
| GA10D | Laparoscopic cholecystectomy with length of stay 1 day or more without CC | - | - | £1,369 |
| GA10E [39] | Laparoscopic cholecystectomy with length of stay 0 days without CC | - | £1,694 | £1,369 |

[39] For GA10E, a price is listed for ordinary elective spell admission even though the HRG has a zero length of stay because a day case has to be planned as such.

206. Long stay payments and specialised service top-up payments are applicable to the best practice tariff for cholecystectomy where the criteria for these payments are met.

207. The best practice tariff is mandatory from 1 April 2010 and applies to patients admitted from this date.

*Implementation*

208. There are no specific implementation requirements for providers or commissioners as payment will occur in the usual manner depending on the HRG to which the spell groups.

209. The Grouper will group to the new HRGs listed above, with GA10A and GA10B (used for payment in 2009-10) becoming redundant.

210. The new HRGs should make it easier for both commissioners and providers to monitor practice and form the basis for identifying where improvements can be made.

211. Commissioners and providers should ensure that there is not a perverse clinical incentive to carry out more day cases than appropriate by monitoring the quality of care and readmission rates.

**"Paying for best practice": fragility hip fracture**

*Target characteristics of clinical best practice*

212. For patients with a fragility hip fracture, care needs to be quickly and carefully organised to prepare them for surgery. By quickly stabilising patients and ensuring that expert clinical teams respond to their frail conditions and complex needs, the most positive outcomes can be achieved. For many patients, best practice care, from the moment patients arrive at hospital, can make the difference between independence and lack of independence, and even life and death. Equally, the care that these patients receive following surgery is just as important, as it is in the initial days following surgery that the greatest gains can be made in patient outcomes. Supporting the high quality delivery of the patient pathway should lead to savings in health and social care costs through reduced length of stay, lower complication rates and improved functional outcomes with reduced long-term care needs[40]. More importantly, a better quality service for hip fracture patients can have enormous benefits in terms of health outcomes and well-being for patients and their families.

[40] Delivering Quality and Value; Focusing on: fractured neck of femur (page 4). NHS Institute for Innovation and Improvement 2008.

213. The best practice tariff for fragility hip fractures in 2010-11 is designed to encourage compliance with two key clinical characteristics of best practice, chosen by a group of clinicians and service managers chaired by the National Clinical Director for trauma care, relating to time to surgery and (ortho) geriatric input. These characteristic are:

    (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) involvement of an (ortho) geriatrician:
        i) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon
        ii) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia
        iii) assessed by a geriatrician[41] in the perioperative period[42]
        iv) postoperative geriatrician-directed
            a. multi-professional rehabilitation team
            b. fracture prevention assessments (falls and bone health).

214. The time to surgery was set at 36 hours rather than the 48 hours outlined in the Blue Book[43] as this was considered to be a more appropriate level for best practice while 48 hours was a minimum standard.

215. To quality for the best practice tariff, all the characteristics in (a) and (b) (i) to (iv) above must be achieved[44].

216. Looking ahead, we are working with NICE to ensure that the tariffs will be aligned with forthcoming clinical guidelines for hip fracture care, due for release in 2010.

*Tariff structure and prices*

217. The best practice tariff applies to a subset of patients within the hip procedure for trauma HRGs HA11-14. All of these patients will receive the base tariff with those meeting the characteristics of best practice receiving an additional payment.

[41] Geriatrician defined as consultant, non-consultant career grade (NCCG), or specialist trainee ST3+
[42] Perioperative period defined as within 72 hours of admission
[43] The Blue Book Guide for the Care of Patients with Fragility Hip Fracture. Published by the British Orthopaedic Association in conjunction with the British Geriatrics Society (September 2007).
[44] It is recognised that around 10% of patients will never be medically fit for surgery within 36 hours and this has been factored into the tariff prices.

218. We have calculated the base tariff payable to all patients flagged with the relevant diagnosis and procedure codes using national average reference costs, but reduced it by £110 to take account of current compliance. If national compliance does not increase, expenditure will not increase.

219. An additional payment of £445 will apply on top of the appropriate base tariff price if all of the best practice compliance criteria are met. The tariff structure is illustrated in Annex C Figure 4b and the prices are shown in Table 14.

Table 14: Fragility hip fracture best practice tariff prices

| HRG code | HRG name | Base tariff (£) | Best practice tariff (£) |
|---|---|---|---|
| HA11A | Major Hip Procedures Category 2 for Trauma with Major CC | 9,121 | 9,566 |
| HA11B | Major Hip Procedures Category 2 for Trauma with Intermediate CC | 9,073 | 9,518 |
| HA11C | Major Hip Procedures Category 2 for Trauma without CC | 8,928 | 9,373 |
| HA12B | Major Hip Procedures Category 1 for Trauma with CC | 8,125 | 8,570 |
| HA12C | Major Hip Procedures Category 1 for Trauma without CC | 7,918 | 8,363 |
| HA13A | Intermediate Hip Procedures for Trauma with Major CC | 6,966 | 7,411 |
| HA13B | Intermediate Hip Procedures for Trauma with Intermediate CC | 5,839 | 6,284 |
| HA13C | Intermediate Hip Procedures for Trauma without CC | 5,530 | 5,975 |
| HA14A | Minor Hip Procedures for Trauma with Major CC | 2,543 | 2,988 |
| HA14B | Minor Hip Procedures for Trauma with Intermediate CC | 1,995 | 2,440 |
| HA14C | Minor Hip Procedures for Trauma without CC | 1,327 | 1,772 |

220. Long stay payments and specialised service top-up payments are applicable to the base tariff for fragility hip fracture where the criteria for these payments are met. The short stay adjustment is not applicable.

221. The best practice tariff is mandatory from 1 April 2010 and applies to patients admitted from this date.

*Implementation*

222. HRGs HA11-14 cover all hip procedure patients and not specifically fragility hip fracture. To target the best practice tariff towards fragility hip fracture

patients, the Local Payment Grouper will flag spells meeting the following criteria with an SSC of 88[45]:

(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 Table 15.

Table 15: Fragility hip fracture ICD and OPCS codes

| Code | Name |
|---|---|
| **ICD-10** | |
| S720 | Fracture of neck of femur |
| S7200 | Fracture of neck of femur-closed |
| S7201 | Fracture of neck of femur-open |
| S721 | Pertrochanteric fracture |
| S7210 | Pertrochanteric fracture-closed |
| S7211 | Pertrochanteric fracture-open |
| S722 | Subtrochanteric fracture |
| S7220 | Subtrochanteric fracture-closed |
| S7221 | Subtrochanteric fracture-open |
| **OPCS4.5** | |
| W19.1 | Primary open reduction of fracture of neck of femur and open fixation using pin and plate |
| W19.2 | Primary open reduction of fracture of long bone and fixation using rigid nail NEC |
| W24.1 | Closed reduction of intracapsular fracture of neck of femur and fixation using nail or screw |
| W24.2 | Closed reduction of fracture of long bone and rigid internal fixation NEC |
| W37.1 | Primary total prosthetic replacement of hip joint using cement |
| W38.1 | Primary total prosthetic replacement of hip joint not using cement |
| W39.1 | Primary total prosthetic replacement of hip joint NEC |
| W46.1 | Primary prosthetic replacement of head of femur using cement |
| W47.1 | Primary prosthetic replacement of head of femur not using cement |
| W48.1 | Primary prosthetic replacement of head of femur NEC |
| W57.2 | Primary excision arthroplasty of joint NEC |
| W65.4 | Primary open reduction of fracture dislocation of joint and internal fixation NEC |
| W93.1 | Primary hybrid prosthetic replacement of hip joint using cemented acetabular component |
| W94.1 | Primary hybrid prosthetic replacement of hip joint using cemented femoral component |
| W95.1 | Primary hybrid prosthetic replacement of hip joint using cement NEC |

[45] The Local Payment Grouper and SUS PbR can output multiple SSCs where a spell is eligible for multiple SSCs (e.g 88 and 34).

223. SUS PbR will apply the base tariff to spells that group to one of the HRGs in HA11-14 with an SSC 88 flag.

224. Compliance will be determined using data from the National Hip Fracture Database (NHFD)[46], so it will be necessary for providers to submit data to this database to record hip fracture patients. The NHFD is being updated to include the best practice tariff compliance criteria.

225. The NHFD will produce a quarterly report for commissioners with details of all patients entered on the NHFD for whom they have commissioned services. This will indicate whether the patient's care has met the two compliance criteria and therefore whether they are eligible for the additional best practice payment. It will also contain unique patient identifiers as well as other data validation fields, which can be compared with SUS PbR output on the spells that have an SSC of 88. Commissioners will be able to link these two reports to determine the number of flagged spells who are eligible for the additional payment, which they will make on a quarterly basis. Further information and guidance on the NHFD report will be made available[47] in due course.

226. Commissioners may agree alternative implementation although this approach has been designed to minimise the administrative burden as far as possible.

**"Paying for best practice": stroke care**

*Target characteristics of clinical best practice*

227. 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 rehabilitation from the moment they enter hospital, and maximise their potential for recovery.

228. Evidence based best practice shows that patient outcomes are greatly improved if admitted directly to a stroke unit. Patients presenting with symptoms of stroke should not be admitted to a Medical Assessment Unit. They should be admitted to the acute stroke unit either directly from A&E or by the ambulance service or via brain imaging.

229. Patients should receive a brain scan as soon as possible to identify the type of stroke they have had. For those whose time of onset of stroke symptoms is known, an immediate scan will determine if thrombolysis can be administered.

[46] Available at www.nhfd.co.uk
[47] At www.nhfd.co.uk and www.dh.gov.uk/pbr

230. The best practice tariff for stroke is designed to support improvements in clinical quality in the acute part of the patient pathway. The intention is to incentivise key components of the clinical practice set out in the National Stroke Strategy and NICE clinical guideline CG68[48]. Specifically:

    (a) urgent brain imaging[49] for all suitable patients

        Patients with indications for immediate brain imaging should be scanned immediately, ideally in the next slot and definitely within one hour of arrival in hospital. For those without indications for an urgent scan, scanning should be performed as soon as possible, but within a maximum of 24 hours of presentation at hospital. The scan should not only be done in these timescales but immediately interpreted and acted upon by a suitably experienced physician or radiologist. Annex E contains a flow chart for determining the urgency of the brain imaging needed for patients[50]

    (b) stroke care delivered within an acute stroke unit

        An acute stroke unit is one that provides high dependency care including physiological and neurological monitoring and rapid treatment of stroke and associated complications, early rehabilitation and palliative care[51]. All stroke patients should have prompt access to a high-quality acute stroke unit and spend the majority of their time (which, with direct admission, should be close to 100%) in hospital in a stroke unit with high quality stroke specialist care. Hyper-acute stroke services should provide, as a minimum, 24 hour and 7 day access to brain imaging, expert interpretation and the opinion of a consultant stroke specialist (using telemedicine where appropriate), with thrombolysis given to those who can benefit.

*Tariff structure and prices*

231. The tariff 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.

[48] http://guidance.nice.org.uk/CG68
[49] Implementing the National Stroke Strategy – An Imaging Guide (page 13 algorithm) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085146
[50] Ibid.
[51] Quality marker 9: "Treatment" in National Stroke Strategy, DH, December 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

232. 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.

233. An additional payment of £342 should be made for all patients admitted directly[52] to an acute stroke unit[53] following initial assessment from either the community, an A&E department[54] or the ambulance service, and treated on a stroke unit with high quality, multi-disciplinary stroke specialist care for the majority[55] 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:

    (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/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.

234. The tier 1 Vital Sign for implementation of the stroke strategy (VSA14) does not specifically measure whether a patient is admitted directly to an acute stroke unit. VSA14 is a lever to improve performance whereas the best practice tariff should be paid only where patients have received best practice care. For a provider to earn the additional payment, each patient will be admitted directly to the acute stroke unit and spend the majority of their time, which with direct admission should be close to 100%, on a stroke unit. PCTs may take into account particularly exceptional circumstances related to patients with serious significant conditions in addition to stroke who are admitted to another specialist ward.

[52] 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.
[53] Or similar facility where the patient can expect to receive the service set out in quality marker 9 of the Stroke Strategy
[54] In line with NICE Clinical Guideline for Stroke, Recommendation 17 "Specialist Stroke Units". *Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA)*. NICE guideline CG68 July 2008.
[55] Defined as greater than or equal to 90% of the patient's stay within the spell that groups to either AA22Z or AA23Z.

235. An additional payment of £133 for the initial brain imaging should be made if the CT scan is delivered in accordance with best practice guidelines (paragraph 230(b)).

236. Where patients are thrombolysed using alteplase in accordance with the NICE technology appraisal guidance[56], they will continue to receive the targeted adjustment introduced in 2008-09. This adjustment covers the drugs themselves, and the additional cost of nurse input and the follow-on CT scan. The adjustment of £828 is additional to the best practice payments.

237. The conventional tariff is redundant for stroke patients in these HRGs.

238. The tariff prices are provided in Table 16 and the structure illustrated in Annex C Figure 4c.

Table 16: Stroke care best practice tariff prices

| Tariff elements | AA22Z | AA23Z |
|---|---|---|
| Conventional tariff* | £4,348 | £4,411 |
| | | |
| Base tariff ** | £4,095 | £4,158 |
| | | |
| Best practice additional payments | | |
| Timely brain imaging | £133 | £133 |
| Acute stroke unit | £342 | £342 |
| | | |
| Best practice tariff | £4,570 | £4,633 |
| | | |
| Alteplase adjustment *** | £828 | - |

* 2010-11 price prior to non-best practice adjustments
** National tariff less an adjustment to reflect current compliance to the criteria and deduction of £133 for brain imaging
*** Alteplase not applicable for AA23Z as patients in this HRG have a haemorrhagic stroke rather than ischaemic

239. The short stay adjustment percentages in Table 6, long stay payments and specialised service top-up payments are applicable to the base tariff for stroke where the criteria for these payments are met.

240. The best practice tariff is mandatory from 1 April 2010. It applies to patients admitted from this date.

[56] Available at www.nice.org.uk/TA122

*Implementation*

241. To target the tariff specifically to patients diagnosed with a stroke, the Local Payment 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). This functionality has not been built into the Road Test Grouper but will form part of the Local Payment Grouper.

242. 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.

243. Ideally, payment of the tariff adjustments should be at patient level. However, local data collection may only enable quality to be monitored at provider level in some areas. As stroke care networks are working with commissioners and providers to support implementation of the National Stroke Strategy and to meet VSA14, we anticipate that commissioners and providers will already be in the process of agreeing provider level performance targets and mechanisms for monitoring compliance. The stroke best practice tariff should therefore form part of these discussions, plus the agreements surrounding payment for performance.

## Stroke and TIA

244. The best practice tariff for stroke care concentrates on the acute and hyper-acute phase of the pathway. It does not include the pathway for patients with a transient ischaemic attack (TIA), also known as a mini-stroke.

245. We expect to develop a national tariff for a TIA follow-up service in 2011-12 that is aligned with the National Stroke Strategy quality markers 5 and 6 (assessment and treatment). We will consider what a best practice tariff looks like for TIA services not only in terms of the price level but also around aspects of the structure, for example should the tariff differentiate between the different risk levels of the patient.

246. For 2010-11, we expect that providers will remain committed to driving up the quality of the service, reaching the required levels identified in the National Stroke Strategy and Vital Sign guidance[57], and locally negotiating prices with commissioners to reward fairly investment in improved service models. For those looking to develop local prices in 2010-11 the Stroke Improvement programme have a library of case studies[58].

[57] Available in UNIFY2.
[58] Available at http://www.improvement.nhs.uk/stroke

247. We suggest that in 2010-11 commissioners and providers will use the first and follow-up outpatient attendance tariff prices for general medicine (TFC 300) and geriatric medicine (TFC 430) as the basis for a locally agreed price for a TIA follow-up service. Included in these prices are the:

    (a) relevant first and follow-up consultation costs, including consultant time, case note review, clinical support worker time and administration time
    (b) costs of regular tests, examinations and recordings such as blood tests, echocardiogram, ECGs, and the use of Dopplers
    (c) costs of MRI and CT scans, (because we are rebundling diagnostic imaging, where not directly accessed, into outpatient attendances), though they are unlikely to fully reflect the higher than average rates of brain imaging required in a TIA service.

248. Not included in these prices are excluded high cost drugs, rehabilitation services and diagnostic imaging accessed directly. They are also unlikely to cover any additional costs associated with extended opening hours beyond usual outpatient clinic times.

249. As patients are likely to require a follow-up with a stroke specialist following diagnostic tests and scans it would be reasonable to include a follow-up attendance as well as a first attendance in any locally negotiated price for TIA follow-up services. The relevant provider MFF payment index value will also apply.

## Commissioning with best practice tariffs

250. The best practice tariffs are intended to facilitate discussions and negotiations between commissioners and providers around improvements to the quality and value of services. Commissioners may use the tariffs to support them in fulfilling the world class commissioning competencies[59], specifically; clinical engagement (*competency 4*); promoting improvement and innovation (*competency 8*); contracting and procurement (*competency 9*); managing local health systems (*competency 10*) and promoting efficiency and effectiveness of spend (*competency 11*).

251. Suggestions of how the best practice tariffs can support PCTs as world class commissioners include:

    (a) *Clinical engagement* – the tariffs, and the defined characteristics of 'best practice' that these tariffs are designed to promote, can form part

[59] See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105117 for more details.

of broader discussions between commissioners and clinical teams on progress towards achieving the highest standards of care. Where compliance with these standards are low, clinicians may be able to advise reducing barriers to improvement.

(b) *Promoting improvement and innovation* – the best practice tariffs identify areas in which there is significant potential for improvement at a national level. Commissioners, in conjunction with clinicians and providers, should look at local performance in these areas, and see to what extent local services are already displaying the characteristics of best practice. The references in this document, particularly those from the NHS Institute, provide more information on measures for improvement and service redesign.

This guidance is also intended to help commissioners to identify other improvement opportunities in these service areas by highlighting clinical guidelines of recognised best practice and specific interventions that are required in these patient pathways. Sources of clinical evidence for comparison, including the NHFD, are also referenced. By making use of these guidelines and promoting the best practice interventions identified in this guidance, PCTs can demonstrate that they are specifying required quality and outcomes, facilitating supplier and contractor innovation that delivers at best value.

(c) *Contracting and procurement* – these national best practice tariffs attach payment to defined characteristics of best practice. Commissioners who negotiate contracts around the defined variables suggested by the best practice tariffs, should be able to deliver significant improvements in productivity, patient experience and quality of care.

(d) *Managing local health systems* – the tariffs are expected to be part of discussions between commissioners and providers in relation to contract compliance and ensuring continuous improvements in quality and outcomes, as well as value for money. Commissioners that are engaged in continuous performance improvement discussions with their providers, in line with competency ten, will be able to make most effective use of the best practice tariffs.

(e) *Ensuring efficiency and effectiveness of spend* – finally, the best practice tariffs identify some areas where there is national potential for improving the efficiency and effectiveness of spend (particularly cataracts and gall bladder removal). The tariffs provide ready-made incentives to improve efficiency in these areas, while also identifying the clinical evidence base to show that these efficiency improvements

are also improvements in quality for the patient. In addition, the references mentioned in this document pinpoint recommended milestones relative to national best practice in relation to target day case rates (see BADS guide to laparoscopic day case cholecystectomies[60])

252. The areas covered by best practice tariffs in 2010-11 were announced in *High Quality Care for All* in 2008. Some health economies may also be driving improvement in these areas using the Commissioning for quality and innovation (CQUIN[61]) payment framework. In these cases, commissioners are encouraged to consider how CQUIN payments and the national tariffs can work together as tools for delivering improvements in quality and value locally and to avoid double payment for achieving the same quality goals. This could mean focussing CQUIN goals on part of the care pathway that is not yet covered by the best practice tariff (e.g. stroke rehabilitation) or by setting stretching goals that go even further than the national requirements to trigger a best practice tariff payment.

## Best practice beyond best practice tariffs

253. The characteristics of best practice care identified in this document are not considered to describe all-encompassing best practice service models. Rather, they highlight key areas recognised as requiring improvement nationally, and have been chosen for the potential for a payment structure to influence improvements. For each of the services, there are many additional facets to the definitions of best practice care. Much useful material is available, not only describing what good practice looks like, but also highlighting ways to achieve it, including service redesign strategies and key measures for providers, commissioners and clinical teams to use to aid improvements. We list some of these documents in Annex F.

[60] Day case laparoscopic cholecystectomy. Published by the British Association of Day Surgery (December 2004).

[61] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

# Section 7: Exclusions

## Introduction

254. The national tariff is mandatory for activity within the scope of PbR. Some services, procedures, admitted patient care HRGs, outpatient TFCs, drugs and devices are outside the scope of PbR and therefore subject to locally agreed payments. The *2010-11 tariff information spreadsheet*, determined after wide-ranging consultation with stakeholders, gives a full list and further information. 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 explicitly on the exclusions list.

255. 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 therefore not be fairly reimbursed if they were 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 national tariff on historic cost data submitted to us by the NHS, new medical devices introduced after the base year may not be fully reflected in the tariff price.

256. 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 admitted patient HRG, outpatient procedure HRG or outpatient attendance tariff. For example, if a patient is admitted to hospital for a procedure involving an endovascular stent graft, the normal HRG based tariff should be paid for the admitted patient spell, with an additional payment to cover the additional cost of the stent grant itself. This additional payment is the only part of the total price that will be subject to local determination.

257. 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 over and above the cost of any drug, product, device and associated consumables and preparation, and these costs should also be taken into consideration in determining the appropriate additional payment. The level of this additional payment should be agreed between commissioners and providers, and local activity monitoring arrangements should be established.

Further information on payment for services outside the scope of the mandatory tariff can be found in the NHS standard contract[62].

258. 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.

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

260. 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.

261. Table 17 summarises the main changes to the exclusions list in 2010-11.

Table 17: Changes to the exclusions list

| No longer excluded in 2010-11 | Newly excluded in 2010-11 |
|---|---|
| **Services** | |
| Patients in amenity beds (paragraph 264) | Spinal cord injury services undertaken in, or by, designated spinal cord injury centres |
| **Procedures** | |
| | Head and neck reconstructive surgery (paragraph 273) |
| **Admitted patient care HRGs** | |
| DZ30Z Chest Physiotherapy<br>DZ37Z Non-Invasive Ventilation Support Assessment<br>DZ38Z Oxygen Assessment and Monitoring<br>DZ42Z TB Nurse Support<br>EA08Z Pace 3 - Biventricular and all congenital pacemaker Procedures - Resynchronisation Therapy and other | CZ20Z Complex major maxillo-facial procedures with restoration<br>DZ15A Asthma with major CC with intubation<br>DZ21D Chronic obstructive pulmonary disease or bronchitis with intubation without CC<br>HA84A Traumatic amputations with major CC<br>HD35A Other wounds or injuries with major |

[62] Available at http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Systemmanagement/DH_085048

| No longer excluded in 2010-11 | Newly excluded in 2010-11 |
|---|---|
| (Catheterisation; EP; Ablation; Percutaneous Coronary Intervention)<br>EA43Z Implantation of Prosthetic Heart or Ventricular Assist Device<br>EB05Z Cardiac Arrest<br>JC11Z Investigative procedures 3<br>JC19Z Electrical and other invasive therapy 4<br>JC29Z Phototherapy<br>JC32Z Photochemotherapy<br>SA14Z Plasma Exchanges 2 to 9<br>SA15Z Plasma Exchanges 10 to 19 | CC<br>HD35B Other Wounds or Injuries with CC<br>HD35C Other Wounds or Injuries without CC<br>JA04Z Pedicled Myocutaneous Breast Reconstruction with Insertion of Prosthesis<br>LB43Z Treatment of Erectile Dysfunction<br>LB45Z Retroperitoneal Lymph Node Dissection<br>SA06D Myelodysplastic Syndrome with CC<br>WA13Y Convalescent or other relief care without CC<br>WA14Z Planned Procedures not carried out (paragraph 275) |
| **Outpatient TFCs** | |
| No changes | |
| **Drugs** | |
| Efalizumab | Alglucosidase alfa<br>Antithymocyte Immunoglobulin<br>Azacitadine<br>C1 Esterase inhibitor<br>Canakinumab<br>Cladribine<br>Co-careldopa internal tube intestinal gel<br>Fomepizole<br>Icatibant<br>Plerixafor<br>Privigen<br>Rilonacept<br>Romiplostim<br>Temsirolimus<br>Tesamorelin<br>Tolvaptan<br>Ustekinumab |
| **Devices** | |
| Balloon Kyphoplasty<br>Biliary stents<br>Cardiac Resynchronisation Therapy (CRT)<br>Colorectal/colonic, oesophageal and pyloric stents<br>CPAP/BiPAP (paragraph 290)<br>Disposable hysteroscope<br>Gastric Bands<br>Gliadel wafers<br>Implantable loop recorders<br>Porcine collagen<br>Ultrasonic dissecting devices | Artificial urinary sphincter<br>Atherectomy devices<br>Bone anchored hearing aids<br>Bone growth stimulators<br>Consumables associated with per oral/per anal single operator cholangioscope (includes Per-oral single operator cholangioscope and Biopsy Forceps for bile duct abnormalities (Spyglass))<br>Drug-eluting peripheral angioplasty balloon<br>Maxillofacial bespoke prostheses (includes ear prostheses)<br>Occluder vascular and septal devices (includes occluder septal devices)<br>Radiofrequency ablation - probes and catheters (includes Surgical and percutaneous electrical ablation - probes and catheters)<br>Ventricular Assist devices (VAD) (includes left VADs) |

## Excluded services

262. Major services not covered by a tariff include mental health, community, and ambulance services. Adult critical care (paragraph 293) and chemotherapy (paragraph 299) are considered later in this section. Other exclusions are largely unchanged from 2009-10.

263. We have made a minor amendment to the method for excluding neonatal critical care to bring it in line with paediatric and adult critical care (i.e. by excluding the neonatal critical care HRGs in sub-chapter XA).

264. In 2009-10 patients in amenity beds were excluded from PbR. This is a patient with an Administrative Category code of 03 in the CDS, and described in the NHS Data Model and Dictionary as "one who pays for the use of a single room or small ward in accord with section 12 of the NHS Act 1977, as amended by section 7(12) and (14) of the Health and Medicine Act 1988". Although the private element of paying for the use of a single room or small ward will remain outside the scope of PbR, and reference costs, we are no longer excluding the treatment or diagnosis of these patients from PbR in 2010-11. We would not expect payments made by patients to be netted off the tariff.

265. We are formalising spinal cord injury services undertaken in, or by, designated spinal cord injury centres as an exclusion in 2010-11. There are only a small number of spinal cord injury centres across the country and their services are commissioned separately by SCGs. Their activity tends to fall into basic HRGs such as minor pain or bladder procedures but is characterised with very long lengths of stay because the patients have spinal lesions and associated complications.

266. The tariffs do not include Patient Transport Services (PTS) and Healthcare Travel Costs Scheme (HTCS) costs. PCTs will need to commission PTS, and consider adjustments to non-tariff prices if necessary. Provider units (NHS trusts and NHS foundation trusts, or PCTs in cases where the provider is not an NHS trust) are legally obliged to pay the NHS travel expenses of eligible patients through the HTCS. PCTs will reimburse provider units for payments made under the scheme for all patients for whom they are the responsible commissioner.

## Excluded procedures

267. We are continuing to exclude the following five procedures in 2010-11:

(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.

### Soft tissue sarcoma surgery

268. This surgery is only delivered in a very small number of units and is defined in Table 18 (conditions in both columns to be satisfied). Note that in 2010-11 the diagnosis of C47 (malignant neoplasm of peripheral nerves and autonomic nervous system) has been added to the definition.

Table 18: Definition of soft tissue sarcoma surgery procedure exclusion

| ICD10 (in any position) | OPCS |
|---|---|
| C40 Malignant neoplasm of bone and articular cartilage of limbs<br><br>C41 Malignant neoplasm of bone and articular cartilage of other and unspecified<br><br>C47 Malignant neoplasm of peripheral nerves and autonomic nervous system<br><br>C48 Malignant neoplasm of retroperitoneum and peritoneum<br><br>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

269. PETCT scans only had dedicated codes created for them in the OPCS coding classification in 2009-10 and the underlying reference costs do not reflect this type of scan. Therefore, we are continuing to exclude it in 2010-11.

### SPECTCT

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

### Cardiovascular Magnetic Resonance Imaging

271. There is some ongoing development work with the British Society of Cardiovascular Magnetic Resonance (BSCMR) on the coding and classification of this activity and until this work is completed, we are continuing to exclude it.

### Pelvic reconstructions

272. 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)”. We will continue to exclude them because they represent a disproportionate cost in relation to other activity within the same HRGs.

### Head and neck reconstructive surgery

273. Head and neck reconstructive surgery (for the excision of and reconstruction for, upper aerodigestive tract, skull base, salivary and thyroid gland malignancies) ceased to be excluded with the introduction of HRG4 in 2009-10. However, we have been advised that this work is significantly more expensive than either excision or reconstruction alone and that a new HRG is required. We are therefore excluding this procedure whilst the HRG is being developed.

## Excluded admitted patient care HRGs

274. In the main, admitted patient care HRG exclusions from 2009-10 are being carried forward to 2010-11.

### Planned procedures not carried out

275. In 2010-11 we are also excluding planned procedures not carried out (WA14Z), after feedback that the tariff caused issues for the service in 2009-10. The reason why patients do not have a planned procedure carried out will include both legitimate clinical reasons and reasons that are related to organisational rather than clinical issues. Excluding this HRG from the scope of the mandatory tariff in 2010-11 will enable commissioners and providers to discuss the nature of any spells attracting WA14Z and agree what level of funding is appropriate. We are undertaking some work with the NHS Information Centre to review WA14Z.

## Excluded outpatient TFCs

276. We are carrying forward outpatient TFCs that are excluded because of low volumes and, with the exception of dermatology (paragraph 333), not publishing non-mandatory prices.

## Excluded drugs

277. The High Cost Drugs Steering Group has reviewed high cost drugs for 2010-11. They considered excluding high cost 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 in England each year.

278. Their review has included the UK Medicine information (UKMi) Horizon Scanning Report and has resulted in further exclusions.

279. The exclusions list contains details of the individual high cost drugs excluded from PbR as at 30 November 2009. Excluded drugs will also create unbundled HRGs where they are coded. In order to avoid obsolescence in our annual guidance, high cost drug exclusions are linked to British National Formulary (BNF)[63] categories where possible. As far as possible the generic names of medicines are used when referring to excluded drugs. Corresponding brand names can be found in the BNF. The general principle is that where a drug is a named exclusion it is excluded from both mandatory and published non-mandatory prices.

280. 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.

281. 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.

282. 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

[63] Available at www.bnf.org.uk

BNF section 6.6.1 then it will not be excluded as currently only teriparatide is excluded in this section.

283. 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 indication(s) an excluded drug will be funded. Drugs can also be stated exclusions for a specific use or purpose. For example, in 2010-11 Sildenafil is only excluded (as part of BNF section 2.5.1/7.4.5) when used for pulmonary arterial hypertension.

284. 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.

285. 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

286. As in previous years, all blood products are excluded from PbR regardless of whether or not they are listed in the BNF.

## Excluded devices

287. The High Cost Devices Steering Group has reviewed the list of high cost device exclusions for 2010-11. They considered existing exclusions and devices which were:

    (a) new to the NHS since 2007-08 and likely to be in use up to and including 2010-11
    (b) high cost and represented 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

288. As a result of the Group's review, we have subsumed some devices from the 2009-10 exclusion list within other exclusions in 2010-11, and revised some device headings to make the exclusion more specific. We have removed devices from the list where the Group advised that they do not

meet the exclusion criteria. The reasons for this included low volumes, low cost, or costs being adequately reflected in the tariff. The Group also considered how and when future HRG design will reflect the relevant procedure and where appropriate made a commitment to exclude in 2010-11 and 2011-12.

289. Table 19 summarises changes to the 2009-10 device exclusion list. It does not include the new additions to the list in 2010-11 from Table 17.

Table 19: Changes to the 2009-10 device exclusion list

| Name of device in 2009-10 | Comments |
|---|---|
| 3 dimensional navigation system mapping catheters | 2010-11 exclusion and would expect to be excluded in 2011-12 |
| Aneurysm coils | 2010-11 exclusion |
| Aortic stent grafts | Now covered under the heading of Endovascular stent grafts |
| Balloon Kyphoplasty | Not 2010-11 exclusion – did not meet exclusion criteria (paragraph 292) |
| Bespoke orthopaedic prostheses* | 2010-11 exclusion |
| Biliary stents | Not 2010-11 exclusion - Now covered by relevant HRGs |
| Devices used in connection with pulmonary artery banding | 2010-11 exclusion |
| Cardiac Resynchronisation Therapy (CRT) | Not 2010-11 exclusion - Now covered by relevant HRGs |
| Carotid, iliac and renal stents | 2010-11 exclusion |
| Colorectal-colonic, oesophageal and pyloric stents | Not 2010-11 exclusion - Now covered by relevant HRGs |
| Consumables for robotic surgery | 2010-11 exclusion and would expect to be excluded in 2011-12 |
| CPAP-BiPAP | Not 2010-11 exclusion - To be covered under loan equipment (paragraph 290) |
| Deep brain, vagal, sacral, spinal cord and occipital nerve stimulators | 2010-11 exclusion |
| Disposable hysteroscope | Not 2010-11 exclusion - Did not meet exclusion criteria, as is not considered high cost |
| Ear prostheses | Now covered under the heading of Maxillofacial bespoke prostheses |
| Endovascular stent graft | 2010-11 exclusion |
| Gastric Bands | Not 2010-11 exclusion - Now covered by relevant HRG |
| Gliadel wafers | Not 2010-11 exclusion – now covered under chemotherapy exclusion |
| ICD with CRT capability | 2010-11 exclusion |
| Illizarov frames | 2010-11 exclusion |
| Implantable defibrillators (ICD) | 2010-11 exclusion |
| Implantable loop recorders | Not 2010-11 exclusion - can now be mapped to a single chamber pacemaker implant. |
| Insulin pumps and pump consumables | 2010-11 exclusion |
| Intracranial stents | 2010-11 exclusion |
| Intrathecal drug delivery pumps | 2010-11 exclusion |
| Left Ventricular Assist devices (VAD) | Now covered under the heading of Ventricular Assist devices (VAD) |

| Name of device in 2009-10 | Comments |
|---|---|
| Minimal Invasive Mitral Valve Replacement Pack | Now covered under the heading of Percutaneous valve replacement devices |
| Occluder septal devices | Name changed to Occluder vascular and septal devices |
| Penile prosthesis | 2010-11 exclusion |
| Percutaneous valve replacement devices | 2010-11 exclusion |
| Peripheral vascular stents | 2010-11 exclusion |
| Per-oral single operator cholangioscope and Biopsy Forceps for bile duct abnormalities (Spyglass) | Name changed to Consumables associated with per oral-per anal single operator cholangioscope |
| Porcine Collagen | Not 2010-11 exclusion - Now covered by relevant HRG or part of an excluded HRG (breast reconstruction surgery) |
| Surgical and percutaneous electrical ablation - probes and catheters | Device name made more specific to reflect the original intention -Radiofrequency ablation - probes and catheters – would also expect to be excluded for 2011-12 |
| Ultrasonic dissecting devices (harmonic scalpel) | Not 2010-11 exclusion - Did not meet the high cost exclusion criteria |
| Video Capsule for Endoscopy | 2010-11 exclusion but expect to be covered by specific HRG in tariff for 2011-12 |

290. As set out in paragraphs 12 and 254, 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 (which we have removed from the exclusions list) should now be covered under local commissioning arrangements for equipment in hospital and home equipment loans.

291. As in 2009-10, 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.

292. Where devices have been removed from the exclusions list, commissioners and providers may wish to consider the use of innovation payments, previously known as pass through payments (paragraph 408), to support funding.

## Adult critical care

293. One of the key requirements for including critical care services within the scope of PbR is suitable casemix measures backed up by appropriate information systems and collection. A programme of development has been underway to introduce HRGs for adult critical care services for a number of years. The adult Critical Care Minimum Dataset (CCMDS) has been in use since 1 April 2006, and supports the HRGs for adult critical care services. CCMDS data is grouped at patient level to determine the relevant HRG for the total number of organs supported within a critical care stay. Payment structure would be the HRG price multiplied by the number of bed days of the stay.

294. When we compared 2008-09 income in a sample of 24 providers against what they would have received under a PbR tariff, we found that that there would be a large impact across the NHS of introducing national prices for adult critical care. Therefore, we are publishing comparative pricing information, sourced from 2007-08 reference costs, for these HRGs in Table 20.

Table 20: Adult critical care benchmark data

| HRG | 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 (2010-11 prices) |
|---|---|---|---|---|---|
| XC01Z | 6 | 1.0% | NA | NA | £1,638 |
| XC02Z | 5 | 5.3% | NA | NA | £1,568 |
| XC03Z | 4 | 11.3% | 13 | 19% | £1,511 |
| XC04Z | 3 | 20.7% | 9 | 29% | £1,386 |
| XC05Z | 2 | 27.1% | 5 | 33% | £1,106 |
| XC06Z | 1 | 32.9% | 3 | 50% | £769 |
| XC07Z | 0 | 1.6% | 2 | 67% | £260 |

Notes to the table

- includes the total cost of outreach services, as submitted in reference costs
- excludes critical care activity in specialist burn units, spinal units and specialist hepatic (liver) critical care units.
- excludes costs of high cost drugs and blood products published as exclusions to PbR
- benchmark prices exclude MFF

295. Commissioners and providers can use the information in Table 20 to help inform the contracting process, and to provide an impetus to improving the quality of data reported. During 2007-08, a project was undertaken with a number of critical care networks to examine actual critical care activity and

their associated reference costs. The average profile of bed days per HRG (the casemix) from providers that took part in the 2007-08 project is given, with other comparative information that may be useful for the contracting process. The information does not signal a non-mandatory price for each HRG, but indicates that the direction of travel is to introduce prices for these HRGs in the future.

296. Commissioners and providers should agree the structure of their funding model as part of the contract negotiations: a capacity funding model, a 100% patient-based model, or a different model, and introduce agreed local arrangements for the payment structure for long-stay patients.

297. In addition, the CCMDS does not capture activity within coronary care units. The cost of this service is more directly attributable to specific HRGs. Consequently, coronary care unit costs are treated as an overhead to HRGs associated with cardiac activity across chapter E HRGs in proportion to relative costs. The tariff therefore includes reimbursement for the provision of coronary care unit services.

298. Further information on the adult critical care HRGs, their derivation, scope and use can be found at the Department's website[64] and also at the NHS Information Centre's website[65].

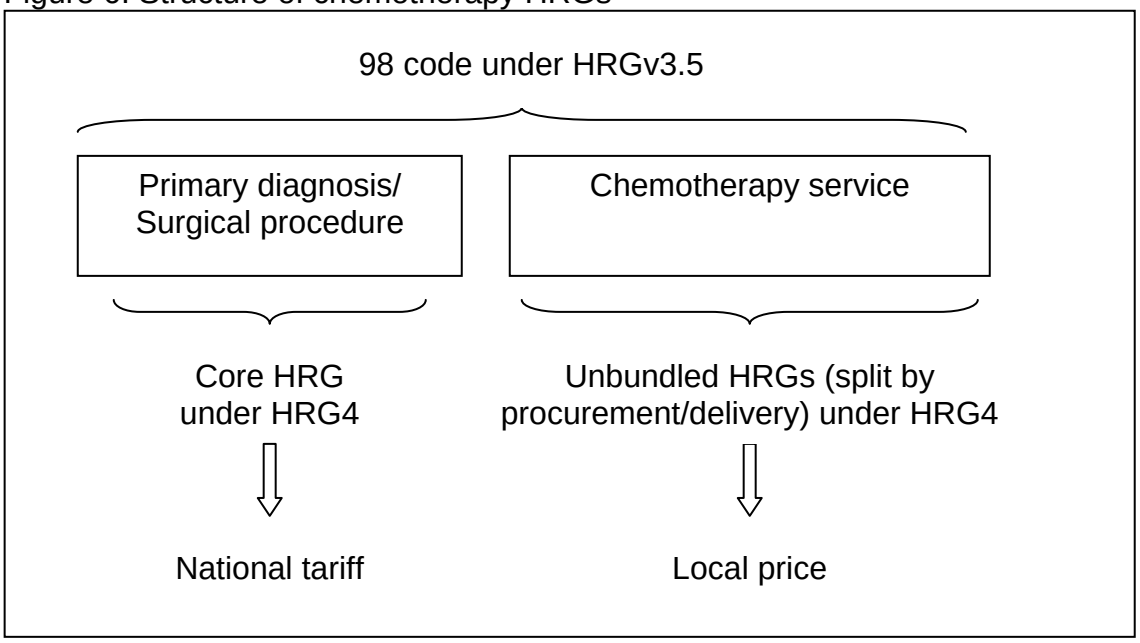
## Chemotherapy

299. Chemotherapy remains excluded from PbR in 2010-11, 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).

300. Under HRGv3.5, HRGs that ended with "98" were excluded from PbR. The "98" codes included care for both a primary diagnosis as well as chemotherapy. As the entire "98" code was excluded, both care related to the primary diagnosis as well as chemotherapy were excluded from tariff. Under HRG4, chemotherapy can no longer be identified by the "98" ending codes and the two elements of care within the same spell are now separated. This is illustrated in Figure 6.

[64] http://www.dh.gov.uk/en/Healthcare/Emergencycare/Modernisingemergencycare/index.htm
[65] http://www.ic.nhs.uk/services/casemix/hrg4/prepare-for-hrg4

Figure 6: Structure of chemotherapy HRGs




301. In 2010-11, as in 2009-10, core HRGs will be in scope of tariff, however the unbundled elements related to the chemotherapy service will remain out of scope of tariff and prices will need to be agreed locally.

302. The unbundled chemotherapy HRGs are intended to cover both the delivery costs and the chemotherapy drug costs, inclusive of any pharmacy dispensing oncosts and the range of associated drugs to deal with the symptoms or side effects of the chemotherapy drugs themselves.

303. 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 10 such regimen bands.

304. 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).

305. 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.

306. The delivery HRGs can be generated for day cases, outpatients, regular day admissions and regular night admissions only. Note that regular admissions are excluded from PbR. They should not be generated for ordinary admissions, as OPCS delivery codes are not recorded for ordinary admissions. Instead, for ordinary admissions, costs of chemotherapy delivery are included within the costs of the core HRG.

307. 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 21.

Table 21: 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 chemotherapy delivery | HRG generated, agree payment locally | No HRG generated |
| Day case and outpatient | HRG generated, within scope of tariff | 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 | | |

308. Nationally we are working to simplify this situation. To avoid over-payment, we intend to introduce a new core HRG for 2009-10 reference costs called Sameday chemotherapy admission/ attendance which will be 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 cores which would otherwise be generated are diagnosis driven HRGs (no major procedures have taken place).

309. Our expectation is that this core HRG would in future attract a zero (£) 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.

310. 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.

# Section 8: Non-mandatory prices

## Introduction

311. 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.

312. There are several reasons for this, including:

    (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 not sufficient data flows to support a mandatory tariff, but we wish to make pricing information available.

313. There will be new non-mandatory prices in 2010-11 for:

    (a) adult renal dialysis
    (b) direct access spirometry
    (c) paediatric diabetes.

314. The following services will continue to have non-mandatory prices in 2010-11 as they did in 2009-10 :

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

315. 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 MFF which will need to be separately applied.

316. The following services will no longer have non-mandatory prices in 2010-11:

    (a) non-direct access diagnostic imaging activity – because we have rebundled non-direct access diagnostic imaging into outpatient attendances (paragraph 146)

(b) outpatient procedures – because funding for outpatient procedure HRGs without a mandatory tariff is contained within the relevant mandatory outpatient attendance tariffs (see paragraph 120).

## Acute phase of rehabilitation

317. HRG4 introduced unbundled HRGs for rehabilitation. As in 2009-10, we are not setting a mandatory tariff for these in 2010-11, because clarity is needed in defining where a patient's acute spell ends and where discrete rehabilitation begins. We are instead continuing to publish non-mandatory prices for the acute phase of care for stroke, pneumonia, hip replacement and fragility hip fracture, based on the typical length of the acute phase for the HRGs. The published prices do not relate to discrete rehabilitation.

318. The intention of these non-mandatory prices is to provide flexibility within the tariff structure to adapt to local service models. Where the immediate post-acute care is delivered by a different provider to that delivering the acute element, the full tariff may no longer be considered appropriate. In these cases, commissioners may wish to agree with the acute provider reimbursement using the non-mandatory tariff estimated to cover the acute phase of care only.

319. For example, where a provider is delivering just the acute part of the stroke pathway in AA22Z commissioners may wish to apply the non-mandatory tariff of £1,732 rather than the full tariff of £4,095. The difference of £2,363 may then be used to fund the post-acute care delivered by a different provider.

320. The stroke and fragility hip fracture HRGs are also the subject of best practice tariffs in 2010-11. These non-mandatory prices are carried forward from 2009-10 and are not part of the best practice tariffs. They apply to the base tariff prices[66] and not to any additional payment arising from best practice tariffs.

321. The NHS Information Centre have established a rehabilitation expert reference panel to review the design of the HRGs to properly reflect 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 and fragility hip fracture services.

[66] The base tariff prices are £110 less of the conventional tariff prices. The conventional tariff prices are listed in the tariff information spreadsheet in the worksheet marked '1. APC & OPROC'. The base tariff prices are listed in the worksheet marked '4. Best Practice Tariffs'. The worksheet marked '5. Non-Mandatory' contains the actual acute phase of rehabilitation tariff prices.

## Adult hearing services

322. As in 2009-10, we are publishing non-mandatory prices for direct access adult hearing services based on pathways developed by the Department's Audiology Board.

## Adult renal dialysis

323. A best practice tariff is under development for adult renal dialysis, and will encourage specific aspects of good practice such as haemodialysis via a fistula and providing access to home dialysis, whenever clinically appropriate. For 2010-11, we are providing non-mandatory tariff prices for adult renal dialysis as an initial step. The prices are set in order to signal the intentions for mandatory pricing of renal dialysis in subsequent years, which will bring renal dialysis into the scope of PbR. The development of these prices has been led by a reference group of renal clinical experts and representatives from commissioners and providers.

324. We calculated the prices in Table 22 from 2007-08 reference costs and HES, excluding regular day and night attenders, for the renal dialysis HRGs. We have not included children's dialysis session tariffs, as further work is needed to understand better the costs of this activity at a national level. Commissioners and providers of paediatric dialysis should continue to contract according to current local pricing arrangements.

Table 22: Adult renal dialysis non-mandatory prices

| HRG | Description | Price £ | Per |
|---|---|---|---|
| LC01A | Haemodialysis/Filtration on patient with hepatitis B 19 years and over[67] | 152 | Session |
| LC02A | Haemodialysis/Filtration 19 years and over | 144 | Session |
| LC03A | Peritoneal Dialysis on patient with hepatitis B 19 years and over | 48 | Day |
| LC04A | Peritoneal Dialysis 19 years and over[68] | 48 | Day |

325. The haemodialysis tariff covers a session of dialysis, defined as each session of dialysis treatment on a given day for each patient. Identifying the actual number of sessions can be problematic if providers do not currently use their patient administration system (PAS) for activity recording

[67] The 2010-11 haemodialysis LC01A tariff is based on 2007-08 reference costs. The HRG name and logic has since been updated for 2008-09 reference costs, but the 2010-11 Local Payment Grouper retains the 2007-08 information.

[68] The 2010-11 peritoneal dialysis tariffs are based on reference costs from 2007-08, in which activity was grouped separately depending on the presence of hepatitis B. There is now a single HRG for peritoneal dialysis, i.e. there is no differentiation based on the presence of hepatitis B, which means future tariffs will be calculated for the single grouping of activity.

(particularly for home haemodialysis). Local reporting (often reflecting commissioning arrangements) should be used.

326. The peritoneal dialysis tariff covers a day of treatment. It is assumed that renal units will know approximately how many sessions of haemodialysis or days on peritoneal dialysis their patients have had ('days' of dialysis being used as a proxy for sessions for peritoneal dialysis).

327. The prices set out above are suggested to be equally applicable to satellite and hospital dialysis, as well as the home setting[69] for haemodialysis.

328. 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.

329. 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. If this is the case, you may wish to agree a more appropriate price for the small percentage of patients receiving over three home haemodialysis sessions per week. There should be no cap of the number of patients having access to home haemodialysis or the total number of home haemodialysis sessions that can be prescribed; these discussions should however help balance any financial risk between commissioner and provider.

330. We recognise that commissioners and providers of renal dialysis have established contracting agreements, which may consist of monthly or yearly contract prices for dialysis activity. The session prices here can be scaled up to the unit of payment that is most appropriate locally. Prices have been given here for a session or day of dialysis to recognise the importance of understanding unit costs of activity and to signal likely future tariff arrangements.

331. Because the high cost drugs Epoetin alfa, beta and zeta are usually administered as part of the core outpatient or admitted patient care event, we would expect their costs to be included in the core event tariff, and not in these non-mandatory renal prices. Feedback suggests that other drugs for dialysis patients (Cinacalcet, Sevelamer and Lanthanum) have not been

[69] Home setting is defined as within the patient's home.

reported as part of dialysis reference costs as they are generally prescribed (and costed) as part of a separate outpatient clinic attendance[70]. Therefore, the dialysis reference costs on which these tariff prices are based are likely not to recognise the cost of these drugs. Commissioners and providers should discuss local prescribing mechanisms for these drugs when agreeing reimbursement. We are looking into how the costs of these drugs can be best captured and reimbursed in the future.

332. The tariffs suggested here may be of use in agreeing reimbursements for dialysis away from base. The provision of non-mandatory prices, and a movement towards mandatory prices for renal dialysis, is intended to provide better national consistency in pricing arrangements and reimbursements for dialysis away from base.

## Dermatology outpatient attendances

333. In 2010-11 we are continuing to publish non-mandatory prices for dermatology outpatient attendances, because of variations in service delivery. These prices should inform local negotiations. The local price for the service should also take into account any local service reconfigurations and the resulting changes to the casemix being seen by both primary and secondary providers.

334. There are some dermatological procedures on the list of outpatient procedure tariffs, which are not expected to be affected by the more general changes to service delivery and which should receive the mandatory tariff.

## Direct access diagnostic imaging

335. As explained in paragraph 146, we are rebundling diagnostic imaging into the outpatient attendances tariffs, except diagnostic imaging accessed directly (e.g. when requested by a GP) where we are continuing to publish non-mandatory prices in 2010-11. This is in line with PbR policy on unbundling.

336. It is not currently possible to use national data flows (i.e. through SUS PbR) to automatically 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. If the patient has been for directly accessed diagnostic imaging and subsequently has an outpatient attendance, the commissioner can reduce

[70] A number of haemodialysis patients also get their drugs prescribed on the renal unit rather than as outpatient.

the attendance tariff as they have already paid for the diagnostic imaging. Figure 7 gives a case study from NHS Leicester and Rutland.

Figure 7: NHS Leicester and Rutland case study

NHS Leicester and Rutland is co-ordinating commissioner for University Hospitals of Leicester NHS Trust. A diagnostics tariff share policy was agreed in April 2008 which applies for all associates to the contract and which operates in the following way:

- The Royal Colleges guide *Right test, right time right place* published by the Royal College of Radiologists and Royal College of General Practitioners provides a protocol for appropriate access to imaging within primary care, with a copy provided to every GP practice.
- Providers of direct access imaging are required to provide a patient level dataset which forms the basis of activity based payment for the imaging undertaken.

| NHS number | Patient number | Name | Date of birth | Postcode | Referring GP | National indicative tariff code | National indicative tariff description | Examination date | Report date |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

- An agreed list of imaging providers is maintained as a schedule to the NHS standard contract. This can be added to as new providers are commissioned, through variations to the contract.
- Referring clinicians incorporate test results into the referral letter accompanying outpatient referral.
- The patient level dataset is matched with outpatient commissioning datasets to apply a patient level discount to outpatient tariffs where the patient had had relevant imaging undertaken within 13 weeks of outpatient consultation.
- The level of discount to the standard bundled outpatient tariff is based on University Hospitals of Leicester NHS Trust's agreed prices for direct access imaging.
- The approach is also applied to direct access echocardiogram where alternative providers are also commissioned to provide direct access alternative choices for patients.

The benefits of this approach are:

- that it does not rely on predicting percentages of patients for which a scan will be undertaken
- is flexible to differences in primary care practice leading to differing uptake levels for the same condition
- and has the potential for patient level adjustments which can be applied to practice based commissioning costed activity reporting at practice or cluster level.

The approach was taken as part of a co-ordinated approach to delivering 18 weeks in which a standard 2 week maximum wait for imaging, subject to clinically agreed exclusions, was implemented.

338. We will consider making these tariffs mandatory in future years, taking into account the issue of long-term independent sector contracts for diagnostic imaging services.

339. 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

340. In 2010-11, a new, unbundled HRG for simple echocardiograms (RA60Z) replaces 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 (e.g. when requested by a GP), 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.

341. There is also a mandatory HRG for complex echocardiograms (EA45Z).

## Direct access spirometry

342. We are introducing a new non-mandatory tariff for direct access spirometry. This will use the HRG code DZ44Z (simple air flow studies).

## Non face-to-face outpatient attendances

343. The non-mandatory price for non face-to-face outpatient attendances is unchanged in 2010-11, and is designed to support the use of convenient communication for patients.

344. It applies to all TFCs that have a mandatory tariff for face-to-face activity and is applicable to both consultant-led and non consultant-led activity. The funding for this activity is no longer in the outpatient attendance tariff as an overhead. The definition of a non face-to-face consultation is a consultation 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.

345. The price applies 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.

## Paediatric diabetes

346. The move to paediatric TFCs for reimbursement of paediatric outpatient activity in 2009-10 means that paediatric diabetes activity is no longer

separately identified for payment, as a paediatric diabetes TFC does not exist. As an interim measure for 2010-11, we have established a separate non-mandatory price for paediatric diabetes, based on the prices for children's diabetes in the 2008-09 tariff. This will not flow through SUS PbR, so it will need to be counted and then reimbursed through local arrangements.

# Section 9: Mental health currencies

## Background

347. It is useful to read this section in tandem with the *Practical Guide to preparing for Mental Health PbR*[71].

348. *High Quality Care for All* [72]committed the Department to make national mental health currencies available for use in 2010-11. The currency unit that is proposed for mental health is not an HRG, but a care cluster. The Care Pathways and Packages Project, a consortium of NHS commissioners and providers from NHS Yorkshire and NHS North East, developed the care cluster currency.

- **Currencies** are the unit of healthcare for which a payment is made. They can take a number of forms, covering different time periods – for instance, in acute physical PbR, outpatient attendances are paid on a contact basis, whilst for long term conditions we are looking to develop annual payments adjusted for complexity, which would be more like the care cluster approach. Our initial commitment in mental health is to develop currencies that are being used nationally.

- **Tariffs** are set prices for a given currency unit. The collected nationally determined prices for HRGs are sometimes referred to as the tariff. We have committed to examining the case for a national mental health tariff following the establishment of national currencies. Without a national tariff, prices for a given currency can be set locally or regionally (i.e. at SHA level).

349. The care clusters focus on the characteristics of a service user, rather than the interventions they receive. 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*.[73]

350. For 2010-11, as well as nationally agreed care clusters, we will also be making available the clustering tool that will help mental health professionals determine which cluster best describes the characteristics of a particular service user.

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[71] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100816

[72] *High Quality Care for All*, chapter 4 para 23.

[73] *Putting People First, A shared vision and commitment to the transformation of Adult Social Care*, HM Government, December 2007

351. The finalised data items for the clustering tool and the care clusters are available in the *Mental Health Clustering Booklet 2010-11*[74].

## Data Set Change Notice

352. We are currently working with the Information Standards Board (ISB) to establish both the clustering tool and the mental health care clusters as information standards. These standards will also be included in the Mental Health Minimum Data Set (MHMDS) so that they can flow centrally. All mental health providers are required, as part of the mental health standard contract, to submit the MHMDS.

353. ISB have approved the requirement for these standards and an advance notification has been issued[75]. The Department is aiming to have an approved Data Set Change Notice (DSCN) for these standards published in March/April 2010. Once the DSCN is published, we anticipate that software suppliers will have up to a year to change their systems, although we hope many will make the changes promptly.

## Expectations for 2010-11 and beyond

354. Allowing the necessary time to update information systems is one reason why we are not mandating use of the care clusters in 2010-11. Some providers have already requested the data items be included in their own bespoke IT systems. For those providers who do not have this flexibility we recommend considering alternative ways of capturing the data – for instance, London providers have been using an online tool.

355. We therefore strongly encourage providers to make use of the care clusters in 2010-11, as the first stage of implementation. This could mean a provider identifying the number of service users they have in each cluster and then seeing how this fits with their existing contracting arrangements.

356. This year will also be a chance to refine and develop mental health PbR. Just as with acute physical PbR, we will be looking to make annual updates to its structure and operating principles. The feedback of people using the care clusters will be crucial to making improved updates. For how to offer suggestions for development, please see paragraph 23.

357. Preparation in 2010-11 will help commissioners and providers be ready for 2011-12 when we expect all health economies should be using the currencies in some form and be establishing local prices.

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[74] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100818

[75] See AN/0906 at http://www.connectingforhealth.nhs.uk/dscn/dscn2009/advance

## Mental health clustering tool

358. Patients are allocated to HRGs for acute physical healthcare on the basis of their diagnosis (ICD10 codes) or the procedure carried out on them (OPCS codes). Mental health PbR does not use ICD10 or OPCS codes – instead mental health professionals will rate service users using the Mental Health Clustering Tool (MHCT)[76]. 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), an outcome measure which is already part of the Mental Health Minimum Data Set. Each scale is given a rating from 0 (no problem) to 4 (severe to very severe problem).

359. 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.

360. The final decision on which cluster to allocate a service user to is that of the mental health professional. Because clustering is linked to payment the Department is exploring options for review, audit and validation. The Department is also considering the possibility of developing algorithm software to support the clustering decision – prototype algorithms have been used in development work by the West Midlands and London.

## Care clusters

361. 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.

362. The care clusters are numbered 0-21, although cluster 9 is a blank cluster, following the decision not to include it.[77] We will consider revising the cluster numbering for 2011-12, so that it is able to incorporate both new clusters and subdivisions to existing clusters.

[76] The complete Mental Health Clustering Tool and the Care Clusters can be found in the *Mental Health Clustering Booklet 2010-11.*

[77] 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.

363. 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 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.

364. 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 (see care transition protocols below).

365. 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

366. 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 a green prescription for exercise.

367. 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.

368. Table 23 (which we will update once the final clusters for 2010-11 are confirmed) sets out for each of the clusters the expected review interval. They vary considerably from cluster to cluster as some clusters relate to short episode of mental illness, others to mental health as a long-term condition. The maximum review interval is annually, in line with the Care Programme Approach (CPA) guidance that reviews should take place at least once a year.

Table 23: Mental health clusters

| Cluster No. | Cluster label | Cluster review interval (maximum) |
|---|---|---|
| 0 | Variance | Not applicable |
| 1 | Common mental health problems (low severity) | 8 weeks |
| 2 | Common mental health problems | 12 weeks |
| 3 | Non-psychotic (moderate severity) | 4 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 |
| 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 |

369. For some clusters e.g. cluster 1, common mental health problems (low severity), service users would not normally be reallocated to the same cluster following review – they would either be discharged or step up to a higher cluster. Further detail is contained in the *Care Transition Protocols*.[78]

## Initial assessment

370. The clusters are designed to be a holistic currency, covering the totality of mental health care an individual receives. However, we are unsure whether the initial assessment should be included within the cluster for two main reasons:

[78] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100818

(a) first, some people who are referred into mental health services do not then need care by specialist mental health care providers, but are instead sent back to GPs with advice on managing their condition. This care needs to be identified and reimbursed.
(b) second, even for those people who are then allocated to a cluster, the first assessment can be particularly intensive and inclusion of this within the cluster could distort costs when compared to someone who has been re-allocated to a cluster as part of ongoing treatment.

371. On the other hand, separating out the initial assessment could be complicated as:

(a) assessment may be a major part of a cluster e.g. a memory assessment as part of cluster 18, cognitive impairment low need.
(b) assessments in mental health vary considerably in terms of the number of consultations needed and the number of professionals involved so paying for "an assessment" would be complicated.

372. This will be a development issue we will be looking at in 2010. Figure 8 shares some local work that has already been done.

Figure 8: West Midlands pathways

West Midlands have developed A-D pathways (to contrast with the numerical clusters) for individuals who are not allocated to a cluster post-assessment.

- **A** – Inappropriate referrals that require return to referring agent and require no further action
- **B** – One off assessments that include face to face contact with the client. This may also include 'signposting' on to other agencies
- **C** – Assessments that have involved two or more professionals or team contact prior to being referred back or signposted
- **D** – Did not attend

## Clusters as contract currency

373. 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.

374. To support this it will be key to develop quality and outcomes measures for each of the clusters and we will be working on this during 2010.

375. In 2010-11, we expect some commissioners and providers will choose to shadow the clusters alongside their existing contract arrangement, seeing how much care is being provided and starting to think how they might relate

to local prices for each cluster. 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.

376. As a contract currency, the clusters operate on a 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. 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.

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 exclusions in paragraph 383).

## Care transition protocols

380. Allocation to clusters will occur at three points:

(a) on initial referral (initial assessment)
(b) at a cluster review interval (planned re-assessment)
(c) in the event of a significant change in need (unplanned re-assessment)[79].

381. Clearly if treatment is successful then an individual's score on the allocation and assessment tool should decrease over time. However, there is a danger that care will be ineffective if service users are discharged before an appropriate course of treatment is completed. Therefore care transition

[79] Unplanned re-assessments 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.

protocols have been developed that set out where it is legitimate for a service user to step up or step down between clusters or to be discharged from the care of mental health services completely.

382. Where an individual has an unplanned reassessment and moves cluster not at a scheduled cluster review interval, for contracting purposes a pro rata payment will be necessary. How this should be calculated will be considered nationally, but suggestions are welcomed.

## Exclusions

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

384. The following services are not covered by the care clusters:

(a) child and adolescent mental health services (CAMHS)
(b) secure services (low, medium and high)
(c) learning disability services (see other known issues with regard to mental health services for people with learning disabilities)
(d) services in the specialist definition set for mental health (with the exception of perinatal mental health services, mental health services for deaf people, complex and refractory disorder services and tier 4 severe personality disorder services)[80].

385. Most of these exclusions are being considered in local PbR development projects and we will look to increase the scope of the mental health currencies over time.

## Clusters and IAPT

386. There is considerable overlap between the clusters and the improving access to psychological therapies (IAPT) steps. Ideally the clusters should be used as the currency for service users with the same characteristics, regardless of whether they are accessing IAPT or non-IAPT services. However, there are challenges to overcome in terms of information flows and data collection. We will be examining this issue in 2010.

[80] Exactly how the currency will work for these four specialised services will be considered in 2010.

## Non-contract activity[81]

387. 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).

## Interaction between care cluster and acute HRGs

388. 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.

389. 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 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 Complications and Co-morbidities (CC) rather than HRG HB23C Intermediate Knee Procedures for non Trauma without CC. HB23B has a tariff price £300 higher than its counterpart without complications.

390. 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.

391. 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.

[81] This section is in line with *Who pays? Establishing the responsible commissioner,* Department of Health, 2007.

## Other known issues

392. This is the first year that the care clusters have been made available for use 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) are the clusters applicable to autism and attention deficit hyperactivity disorder?
(c) 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?
(d) should carer support be intrinsic to the clusters or an additional element?
(e) how can the cluster operate for people with learning disabilities who have mental health problems given the learning disability will affect the clustering decision?
(f) how should local care co-ordination be funded if a service user is in an out of area specialist placement?

# Section 10: Flexibilities

## Introduction

393. PbR is meant to be a tool, not a strait jacket. We recognise 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 and/or tariffs is referred to as a flexibility.

394. In 2010-11 we are introducing some new flexibilities:

(a) additional outpatient procedure HRGs
(b) antenatal admissions
(c) complex diagnostic imaging
(d) hospital at home
(e) suspension by an SHA of contractual arrangements within a health economy in extreme circumstances and with the approval of the Department.

395. Other flexibilities continue to apply in 2010-11.

396. 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 and is not simply a change to national price** – local flexibilities are not a means of reducing or increasing national prices without any change to how services are provided. This would 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.

397. The flexibilities operate at three levels:

(a) local flexibilities agreed between commissioners and providers
(b) SHA flexibilities exercised at the discretion of the SHA
(c) flexibilities requiring the approval of the Department.

## Local flexibilities

### Additional outpatient procedure HRGs

398. Where commissioners and providers agreed local prices in 2009-10 for outpatient procedures that are not covered by the mandatory list in 2010-11, 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 abate the prices negotiated in 2009-10 to reflect the national bundling of outpatient procedures (other than the mandatory 49) into the outpatient attendance tariffs in 2010-11. We do not expect this flexibility to apply to diagnostic imaging.

### Antenatal admissions

399. 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 unreflective of actual local costs, commissioners and providers should consider the use of a payment flexibility to manage the situation until the provider has time to review and adjust coding 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, of no more than three years with interim reviews, from one level of payment to the other.

## Bundling for pathways

400. The Department is committed to exploring the development and implementation of pathways 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.

## Complex diagnostic imaging

401. Where a specialist provider can demonstrate that it carries out more complex and costly diagnostic tests than the average (for example MRI scans), commissioners should consider if there is a case for paying more than the mandatory tariffs for outpatient attendances.

## Emergency readmissions

402. It is generally undesirable for a patient to be readmitted shortly after a hospital stay. Emergency readmissions should not attract full reimbursement if the provider did not provide sufficient quality of service or prepare patients adequately for discharge.

403. A single national approach to determining appropriate reimbursement is not possible at present because overall, emergency readmissions will comprise elements of care that are beneficial as well as those that may indicate poorer quality of care. Instead, local arrangements will enable commissioners and providers to determine and agree the appropriate level of emergency readmissions that are acceptable. This should take into account the nature of the services being delivered and the extent of the open access and other arrangements. Commissioners will be entitled to deduct certain emergency readmissions from their overall weighted activity commissioned from a provider. They may only do so if:

    (a) the readmission is above a locally agreed rate (likely to be informed by considering the previous year's rate) and
    (b) the readmission is to the same provider and
    (c) the readmission is within 14 days of discharge and
    (d) the readmission is not part of any planned open access arrangement.

404. PCTs and providers should agree as part of contract discussions what level of emergency readmissions are to be expected in the coming year. This estimate will take account of the specific services noted above and any other local services where open access arrangements are a feature. Historical levels of readmissions should be reviewed along with the reasons for the existing levels. Any emergency readmissions above this locally

agreed rate can be considered for adjustments to the level of reimbursement by PCTs at year-end.

405. There are some services and groups of patients where open access arrangements are commissioned. In these cases the readmissions are unplanned in the sense that no firm date has been assigned but where the readmission is part of a planned package of care that has been agreed. Cancer services and many services for children (especially those with long term conditions) typically include some component of open access arrangements. These arrangements should not be undermined or discouraged where they provide appropriate and good quality care pathways.

**Hospital at home**

406. Chronic obstructive pulmonary disease (COPD) with length of stay less than one day discharged home (DZ21A), is designed to support hospital at home services. The intention was that patients who came under this HRG would be discharged into hospital at home care. However, there is no national discharge code to indicate transfer into hospital at home care, so instead the HRG acts as a short stay HRG for a COPD admission. As part of taking forward the imminent national clinical strategy on COPD we will examine the potential for creating a national discharge code that could facilitate a tariff for hospital at home care. In the interim, we encourage commissioners and providers to consider developing pathways for hospital at home care. These pathways could be reimbursed at a percentage rate of the tariff for longer stay COPD admissions.

**Infectious disease isolation units**

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

**Innovation payments**

408. Innovation payments (previously pass through 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.

409. 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) commissioners should have regard to the existing cost effectiveness evidence including any NICE guidance, health technology assessments (HTAs), device evaluation service (DES) reports or other relevant national guidance

(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) if appropriate, the device, technology or procedure should be included on the NICE list of interventional procedures[82]

(e) commissioners should have due regard to the procurement arrangements for these drugs, devices, technologies or treatments identified as being suitable for funding.

### Service redesign, joint incentives and gain sharing

410. 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.

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

### Unbundling

412. During our work with stakeholders in 2009, we established a set of principles for determining whether a service should be unbundled for payment under PbR. Commissioners and providers may continue to unbundle services where it is consistent with the principles set out in paragraph 145.

## SHA flexibilities

413. SHAs will retain the flexibilities they had in 2009-10 to manage:

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

(a) transition towards full implementation of the revised MFF indices
(b) the financial impact of the move to tariffs based on HRG4
(c) risk associated with PbR development sites
(d) exceptional revenue pressure as a result of changes in national accounting requirements.

## Flexibilities requiring the approval of the Department

### Suspending contractual arrangements within a health economy

414. During 2010-11, SHAs will be able to apply to the Department[83], in extreme circumstances, for permission to temporarily suspend contractual arrangements within a local health economy where it is demonstrably not operating in the interests of their patients. This would include, but not be limited to, the inability of commissioners to meet their obligations under the tariff when they fell due. SHAs will need to set out why they are seeking exemption and what has already been done to manage the situation, including the use of existing contractual arrangements. Our expectation is that SHAs should manage any issues locally and should not need to exercise this option. The Department will fully consult with Monitor ahead of any such development where it involves an NHS Foundation Trust.

[83] Applications should be made to the Director-General NHS Finance, Performance and Operations

# Section 11: Other operational issues

## MFF payments

415. The MFF payment for the mandatory tariff associated with activity within the scope of PbR is paid directly by the responsible commissioning PCT

416. The MFF element for mandatory tariff activity must be included as part of the agreement of activity levels for 2010-11 between commissioners and providers included in contract values. For example, if NHS provider A undertakes £500,000 worth of mandatory tariff activity with PCT B, the value of the contract includes the relevant MFF payment index. Table 24 illustrates this.

Table 24: MFF payment

| Column A | Column B | Column C | Column D | Column E |
|---|---|---|---|---|
| Annual contract value @ national tariff | MFF Index | MFF payment | Total contract value | Monthly invoice amount for PCT B[84] |
| | | Col A*(Col B-1) | Col B + Col C | Col C/12 |
| 500 | 1.20 | 100 | 600 | 50 |

417. The MFF payable in respect of the tariff value is non-negotiable and will be calculated based on the value of tariff activity, including any tariff adjustments (e.g. specialised service top-ups).

418. The MFF payment resulting from changes to planned activity (agreed in contract at the start of the year) should be agreed between commissioners and providers as part of the monthly reconciliation stages and the year-end process. Any changes to the MFF charges because of an increase or decrease in tariff activity should be resolved promptly.

419. In order to facilitate this process, the MFF element of the amounts payable should be itemised separately on the contract value and the monthly reconciliation accounts. SUS PbR includes the final tariff value to facilitate this process.

420. The same MFF at the appropriate rate for the provider organisation is also payable for:

    (a) non-contract activity
    (b) non-mandatory prices

[84] initial monthly instalments will be subject to change based on reconciliation process

421. Where prices have been negotiated locally, as a result of local flexibilities including unbundling, commissioners and providers should agree whether an MFF payment is appropriate.

422. Table 25 below provides a summary of the arrangements for MFF payments by provider type.

Table 25: Arrangements for MFF payments

| Provider type | Payment arrangements | MFF value | MFF payment mechanism |
|---|---|---|---|
| NHS acute or foundation trusts | National tariff | NHS acute or foundation trusts | MFF paid directly to provider by PCT |
| PCT as provider | National tariff[85] | PCT provider | |
| IS (extended choice network and free choice network providers) | National tariff | MFF of the NHS acute or foundation trust nearest to the location where the care was delivered | |
| ISTCs | As per local agreement or ISTC contract | | |

## MFF payment index

423. Organisations should use the relevant PbR MFF payment index, which is shown in the *2010-11 tariff information spreadsheet*. The underlying MFF index is that implemented in PbR and PCT allocations in 2009-10 on the recommendation of the Advisory Committee on Resource Allocation (ACRA) in their December 2008 report[86].

424. We are continuing with the 2% capping policy of the MFF underlying index in 2010-11. By this we mean that the underlying MFF index value of an organisation will move towards the target value, but by no more than a 2% change from the 2009-10 value. The intention behind this policy is to limit the change to +/-2% in overall PbR income for organisations from the introduction in 2009-10 of the revised MFF index. 357 out of 389 organisations (92%) have reached their target MFF.

425. The change in overall income for organisations is the net effect of changes to the MFF payments and the effect that the revised MFF has on tariff prices, around a 3.5% increase in 2009-10. In 2010-11 there is a negligible

[85] National tariff where defined as 'hospital based services' or equivalent – otherwise payment based on local practice based commissioning arrangement
[86] Available at www.dh.gov.uk/allocations

effect on tariff prices because the majority of organisations moved to target in 2009-10 so the only effect on income will be the change in MFF payments, limited to +/-2%. Table 24 illustrates the capping policy.

Table 26: MFF 2% capping policy

| | 2008-09 | Target | 2009-10 | 2010-11 |
|---|---|---|---|---|
| MFF underlying index | 1.200000 | 1.100000 | 1.176000 | 1.152480 |
| % change on previous year | | -8% | -2% | -2% |

426. The MFF policy for mergers is changing in 2010-11. Previously, a new MFF was calculated for the merged organisation which was then applicable from the official date of the merger. With immediate effect, for organisations merging between now and the end of the financial year 2010-11 the new MFF will apply from 1 April 2011. SHAs should agree arrangements for MFF payments to achieve a neutral impact on the health economy in 2010-11.

427. From 1 April 2011, organisations merging at the start of the financial year will have the new MFF applied from the official date of the merger. For those that merge in-year the new MFF will apply from 1 April of the next financial year. In the meantime, SHAs should put in place arrangements to ensure a neutral impact across the health economy.

428. The intention behind the new policy is to help the health economy manage the financial impact of any merger. The methodology by which a new MFF value is derived means that for the same activity, the associated MFF payments for the single entity could be different to the sum of MFF payments for the separate organisations. This has an impact on the merging organisations as well as the commissioning organisations. In order to ensure fairness, the calculation of the MFF value must be consistent across all organisations.

429. Organisations should notify us of any planned mergers so that the new MFF value can be calculated and confirmed.

430. The calculation of the MFF and its operation in PbR is further explained in *PbR and the Market Forces Factor 2010-11*.

## Monthly reporting

431. The 2010-11 standard NHS contract for acute services[87] sets out the terms for providers to submit national data sets to SUS. The four key stages in the process are as follows:

[87] Available at http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Systemmanagement/DH_085048

(a) inclusion date – means date by which the provider needs to submit data for the month in question for inclusion in the report available for monthly reconciliation.
(b) first reconciliation point – means date when the PbR activity is available to the commissioner to facilitate reconciliation between provider and commissioner.
(c) post-reconciliation inclusion date – means date by which the provider and the commissioner need to have resolved any issues relating to the data submission for the month in question. The time between the inclusion date and post-reconciliation inclusion date can be used by providers to submit any late or amended data
(d) final reconciliation point – means date when the final reconciliation report is available for the month in question.

432. Table 27 sets out the timetable for monthly activity reporting and report availability for 2010-11.

Table 27: Monthly reporting dates

| Month | Inclusion date | First reconciliation point | Post-reconciliation inclusion date | Final reconciliation point |
|---|---|---|---|---|
| April 2010 | Mon 24 May | Wed 2 Jun | Wed 23 Jun | Thu 1 Jul |
| May 2010 | Wed 23 Jun | Thu 1 Jul | Fri 23 Jul | Mon 2 Aug |
| June 2010 | Fri 23 Jul | Mon 2 Aug | Mon 23 Aug | Wed 1 Sep |
| July 2010 | Mon 23 Aug | Wed 1 Sep | Thu 23 Sep | Fri 1 Oct |
| August 2010 | Thu 23 Sep | Fri 1 Oct | Fri 22 Oct | Mon 1 Nov |
| September 2010 | Fri 22 Oct | Mon 1 Nov | Tue 23 Nov | Wed 1 Dec |
| October 2010 | Tue 23 Nov | Wed 1 Dec | Wed 22 Dec | Tue 4 Jan |
| November 2010 | Wed 22 Dec | Tue 4 Jan | Mon 24 Jan | Tue 1 Feb |
| December 2010 | Mon 24 Jan | Tue 1 Feb | Mon 21 Feb | Tue 1 Mar |
| January 2011 | Mon 21 Feb | Tue 1 Mar | Fri 25 Mar | Mon 4 Apr |
| February 2011 | Fri 25 Mar | Mon 4 Apr | Thu 21 Apr | Wed 4 May |
| March 2011 | Thu 21 Apr | Wed 4 May | Mon 23 May | Wed 1 Jun |

## Non-contract activity

433. *Who pays? Establishing the responsible commissioner*[88] sets out the arrangements for payment for non-contract activity (NCA), and states[89], "the prices for NCA will be based, as far as possible, on the national tariff and

[88] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466
[89] Paragraphs 50 and 51

determined in accordance with PbR guidance for the relevant financial year. Disputes over payment for NCA should be resolved bilaterally, between provider and commissioner and may be referred to mediation or adjudication at the request of either party and in line with the provisions of the national model contract."

434. The prices for NCA in 2010-11 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 2007-08 national average reference costs multiplied by 1.04, where 1.04 reflects the compound tariff uplifts of 2.3% (2008-09), 1.7% (2009-10) and 0.0% (2010-11) to account for the difference between 2007-08 and 2010-11 prices.

435. Reporting, billing and payment for non-contract activity (NCA) needs to be in line with paragraphs 46 to 52 of *Who Pays? Establishing the Responsible Commissioner*.

436. Monthly reporting of data will apply to NCA as well as contract activity, though the expectation is that billing for NCA will be on a quarterly basis. More regular data flows should allow commissioners an opportunity to identify and challenge provider activity which they feel is the responsibility of another commissioner prior to invoicing, which will hopefully result in fewer disputed invoices.

437. Management of reporting, billing and payment for NCA should include a period of 31 calendar days for commissioners to validate activity invoiced to them by providers after which payment shall be made within 31 calendar days of agreement of activity between commissioner and provider.

438. Disputes over payment for NCA should be resolved locally between commissioners and providers. The expectation is that only material disputes should result in a formal resolution process.

439. Providers should make every effort to ensure quarterly 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 outside the standard timescales. Where part of an invoice is in dispute, then payment should be made for the non-disputed activity, again within 31 calendar days of agreement of activity between commissioner and provider.

## Devolved administrations

440. Flows of patients between commissioners and providers in England and Wales are governed by the *Interim protocol on cross border commissioning between England and Wales,* which is effective until 31 March 2011. The protocol applies to patients in Gloucestershire, Herefordshire, Shropshire County and West Cheshire Primary Care Trusts (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.

441. 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 nation. Under these arrangements, the treating provider invoices the responsible commissioner without the need for pre-treatment agreement. In addition to non-elective (emergency) 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, otherwise requests for payment may be refused. English providers should charge at mandatory national tariff rates for these patients.

442. These arrangements are further described in *Cross-border emergency treatment: agreement between England, Scotland, Wales and Northern Ireland*[90]*,* (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' for 2006-07,* which continue to apply for activity commissioned by devolved administrations in 2010-11 and until further notice.

443. The only change to this guidance is in *Cross-border emergency treatment,* table 1, category 4, where the price for this activity will now be 2007-08 national average reference costs multiplied by 1.04, representing three years of compound tariff uplifts to account for the difference between 2007-08 and 2010-11 prices.

[90] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139150

## Dehosting

444. Dehosting for services previously provided on an all-comers basis, mainly A&E and GUM services, continues to apply in England in 2010-11. 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 PCT in England, and vice versa.

# Annex A: Summary of changes to PbR in 2010-11

| | Status | Details | Para ref |
|---|---|---|---|
| Scope and structure | | | |
| Organisations within the scope of tariff | No change from 2009-10 | The mandatory PbR tariff remains payable for activity carried out by NHS trusts, NHS foundation trusts, PCTs as providers, independent sector extended choice network and independent sector free choice network providers | 7 |
| Services within the scope of the tariff | Change from 2009-10 | The mandatory tariff will be payable for elective and non-elective admitted patient care, outpatient attendances, 49 outpatient procedures and A&E services. | 8 |
| Currency underlying the tariff | No change from 2009-10 | HRG4 (and HRGv3.2 for A&E) | 10 |
| MFF | Change from 2009-10 | Change over 2009-10 towards revised MFF payment indices capped at 2%. Impact of MFF for merging organisations will be financially neutral in-year. | 415 |
| Mandatory tariff | | | |
| Admitted patients | | | |
| Admitted patient activity | Substantial change from 2009-10 | There will be tariffs for:<br>• combined day case and ordinary electives (except for a small number of HRGs where there is a separate ordinary elective and day case tariff)<br>• ordinary non-electives | 50 |
| Marginal rate emergency tariff | Substantial change from 2009-10 | A marginal rate of 30% of the published tariff price will apply to all emergency activity above a baseline set at the outturn of contract income from 2008-09. | 63 |
| Short stay emergency tariff | Change from 2009-10 | New percentage reductions for lengths of stay less than two days. | 82 |
| Long stay payments | No change from 2009-10 | Paid on a daily rate to all HRGs where the spell length of stay exceeds a trim point specific to the HRG. | 85 |
| Specialised service top-up payments | Change from 2009-10 | Top-up payments for specialised orthopaedic (moves from 14% to 30%, all organisations) and children's services (remains at 78%, eligible organisations). Both based on revised SSNDSs. | 90 |
| Short stay elective tariff | Substantial change from 2009-10 | With the removal of the new PSD tariff, the short stay elective tariff has also been removed. | 59 |
| Alteplase adjustment | No change from 2009-10 | Use of the drug alteplase for stroke continues to receive a targeted adjustment in certain circumstances. | 97 |
| Best practice tariffs | Substantial change from 2009-10 | Four best practice tariffs for cataracts, cholecystectomy (gall bladder removal), fragility hip fracture and stroke | 160 |
| Planned same day | | | |
| Planned same day (PSD) tariff | Substantial change from 2009-10 | The PSD tariff has been removed. | 59 |

| | Status | Details | Para ref |
|---|---|---|---|
| Outpatients | | | |
| Outpatient attendances | Substantial change from 2009-10 | The costs of non-direct access diagnostic imaging have been rebundled into outpatient attendances. | 146 |
| Outpatient procedures | Substantial change from 2009-10 | Mandatory tariffs for 49 HRGs. Remaining outpatient procedures reimbursed as part of the outpatient attendance tariffs. | 119 |
| Accident & emergency | | | |
| A&E | No change from 2009-10 | HRGv3.2 remains the currency for A&E services. | 154 |
| Exclusions | | | |
| High cost drug, device, procedure and service exclusions | Change from 2009-10 | Planned procedures not carried out (WA14Z) will be excluded.<br><br>The NHS element of the patient's stay where patients pay amenity charges will be included in PbR. Only the amenity charge itself will be excluded.<br><br>Other changes to the exclusions list in line with advice from relevant stakeholders. | 275<br><br>264<br><br>261 |
| Non-mandatory prices | | | |
| Non-mandatory prices | Change from 2009-10 | New non-mandatory prices for:<br>• adult renal dialysis<br>• direct access spirometry<br>• paediatric diabetes<br><br>The following will no longer have non-mandatory prices:<br><br>• non-direct access diagnostic imaging<br>• outpatient procedures | 313<br><br>316 |
| Flexibilities | | | |
| Flexibilities | Change from 2009-10 | New flexibilities for:<br><br>• additional outpatient procedure HRGs<br>• antenatal admissions<br>• complex diagnostic imaging<br>• hospital at home<br>• suspension by an SHA of contractual arrangements within a health economy in extreme circumstances and with the approval of the Department | 394 |
| Currencies | | | |
| Mental health | Substantial change from 2009-10 | A new currency for adult mental health services to be used in shadow form with the expectation that it will be mandated at some point in the future. | 347 |

# Annex B: Grouper changes

Tables B1 and B2 summarise the main changes from the 2009-10 Local Payment Grouper to the 2010-11 Road Test Grouper, and anticipated changes from the 2010-11 Road Test Grouper to the 2010-11 Local Payment Grouper. The changes are iterative and any change made to the Sense Check Grouper is carried over into the Road Test Grouper automatically. This is not an exhaustive list of all changes, but covers those changes that are likely to have an impact upon grouping results or outputs. Table B3 summarises handling of the best practice tariffs in the 2010-11 Local Payment Grouper.

Table B1: Changes from 2009-10 Local Payment Grouper to 2010-11 Road Test Grouper

| When | Type | Description |
|---|---|---|
| SC | OPCS/ICD Grouping | Remap 3 OPCS codes from UZ01Z to a valid HRG;<br>a. M6543, Radial styloid tenosynovitis [de Quervain]-Forearm to HB91<br>b. M5463, Pain in thoracic spine-Cervicothoracic to HC24<br>c. M2133, Wrist or foot drop (acquired)-Forearm to HD24 |
| SC | Grouping/Output | Spell Grouping Method data item has been added to all Spell outputs. This will be calculated as per the FCE Grouping Method but applied at Spell level |
| SC | Grouping/Output | The Provider spell number field has been amended to accept up to 24 characters. The whole of the field will also be used in all functionality - including sorting |
| SC | Grouping/Output | Neonatal Critical Care & Paediatric Critical Care grouping have been included in the payment groupers |
| SC | Grouping/Output | The input Provider Code and Provider Spell Number have been added to the spell based output files. |
| SC | OPCS/ICD Hierarchies | Hierarchies for a number of cardiac procedures have been adjusted as follows:-<br>K222 to 8, L264 to 4, T031 to 3, T032 to 3, T033 to 3, T034 to 3, T038 to 3, T039 to 3, T162 to 5, T838 to 3 |
| SC | Grouping/Output | The spell primary diagnosis will be populated for Multiple Trauma spells. |
| SC | Grouping/Output | Incomplete error reporting has been amended - to include when a record has both procedure and diagnosis grouping errors |
| SC | OPCS/ICD Grouping | When carried out together, CABG and valve now map to EA20 Other Complex Surgery and Redos |
| SC | Grouping/Output | Database Version to be included in Summary Output (All) via a new column to all summary file outputs. Column Heading "Database version". |
| SC | OPCS/ICD Grouping | Identified arthroscopic codes have been moved from major to intermediate knee HRGs as this activity is felt to be diluting the resources of major knee procedures. |
| SC | OPCS/ICD Grouping | To support unbundling policy, the design of echos has been amended: complex echoes remain and contain U202, U205, U206 as a core HRG; simple echoes containing U201, U208, U209 are to be unbundled as RA60 (procedure hierarchies to be changed accordingly); U308 and U308 to move to EA47 (core HRG). |
| SC & RT | Best Practice Tariffs & Specialised Services | Ensure specialised service functionality is 'generic'. The age areas are adults, children and all ages.<br>This is specifically required for the frailty SSC 88 for fracture neck of femur, which is generated from:<br>1. Procedure from list and diagnosis from list and<br>2. Age and<br>3. Admission method = fractured neck of femur flag<br>To note requirement of diagnosis in any field - not just primary |
| SC | Best Practice Tariffs | New Cholesystectomy HRGs for best practice tariffs have been added (Table B3) |
| RT | OPCS/ICD | The hierarchies for sentinel lymph node biopsy and mastectomy have been |

| When | Type | Description |
|---|---|---|
| | Hierarchies | adjusted to be the same |
| RT | Grouping/Output | Planned procedures not carried out logic used in spelling has been amended. This should allow planned procedures carried out to be appropriately grouped |
| RT | Grouping/Output | Output field name 'UnbundleHRGs' has been amended to be 'UnbundledHRGs' (d was missing) |
| RT | Grouping/Output | The value for GroupingMethodFlag field in the FCE output file will now be populated for Multiple Trauma HRGs (sub-chapter VA) - previously these were blank. The 'M' will be used for these records |
| RT | Grouping/Output | The specialised service trigger lists have been updated to accommodate the latest specialised service national definition sets |
| RT | OPCS/ICD Grouping | The list of UZ04 has been reviewed. M6543 has been removed from the list and M6544 has been put on the list (reversal of current design). |
| RT | Grouping/Output | Adult Critical Care (ACC) grouping now includes liver support |
| RT | OPCS/ICD Grouping | OPCS code W402 now maps to HA21/HB21 |
| RT | OPCS/ICD Grouping | OPCS code W052 now maps to HA01 |
| RT | OPCS/ICD Grouping | OPCS code S242 has had some updated orthopaedic logic applied to it |
| RT | OPCS/ICD Grouping | OPCS codeW192 has had site code logic added to match the rest of the rubric |
| RT | OPCS/ICD Grouping | OPCS code N159 has been taken out of UZ06 and now maps to LB34 as Epididymectomy is coded using N159 |
| RT | OPCS/ICD Grouping | The following combinations now map to pain management (AB03) rather than Neurology<br>P A521+Y Y381 Therapeutic lumbar epidural injection + Continuous injection of therapeutic substance into organ NOC<br>P A521+Y Y531 Therapeutic lumbar epidural injection under radiological control<br>P A522+Y Y531 Therapeutic sacral epidural injection under radiological control |
| RT | OPCS/ICD Hierarchies | The procedure hierarchies for OPCS code K59* have been adjusted, following an issue that was identified when venography is coded within ICD implantation. The changes are follows:<br>K591 Implantation of cardioverter defibrillator using one electrode lead to 7<br>K592 Implantation of cardioverter defibrillator using two electrode leads to 7<br>K593 Resiting of lead of cardioverter defibrillator to 3<br>K594 Renewal of cardioverter defibrillator to 7<br>K595 Removal of cardioverter defibrillator to 7<br>K596 Implantation of cardioverter defibrillator using three electrode leads to 7<br>K598 Other specified cardioverter defibrillator introduced through the vein to 7<br>K599 Unspecified cardioverter defibrillator introduced through the vein to 7<br>This will prevent Venography taking precedence (except for resiting of lead). |
| RT | HRG Label | The word "technical" has been removed from the labels for LB05 |
| RT | HRG Label | The labels of the renal transplant HRGs have been amended to ensure that it is clear that the age split relates to the recipient and not the donor |
| RT | HRG Label | "(Without treatment episode)" has been removed from the rehabilitation HRG labels |
| RT | HRG Label | The label of KA06 has been changed to Non Pituitary Endocrine Neoplasia and Hypoplasia |
| RT | HRG Label | HRGs PA56B and WA18Y have had their labels amended to distinguish between children and adults |
| RT | HRG Label | The labels of NZ04 to NZ09 have been amended for further clarification |

| When | Type | Description |
|---|---|---|
| RT | HRG Label | The HRG HD22 has been removed (the logic was removed in LP 09-10 but the HRG still remains, so this is a cosmetic tidy up) |
| RT | Documentation | The ICD10 descriptions will be shown in full in the chapter listings [MALCOLM] reports |
| RT | Documentation | The HRG header has been modified in chapter listings [MALCOLM] outputs where the list of codes are split over multiple pages |
| RT | Documentation | All chapter listings [MALCOLM] documentation will include:<br>The name of the grouper<br>The lozenge for the grouper |
| RT | Documentation | Critical care grouper documentation has been updated |

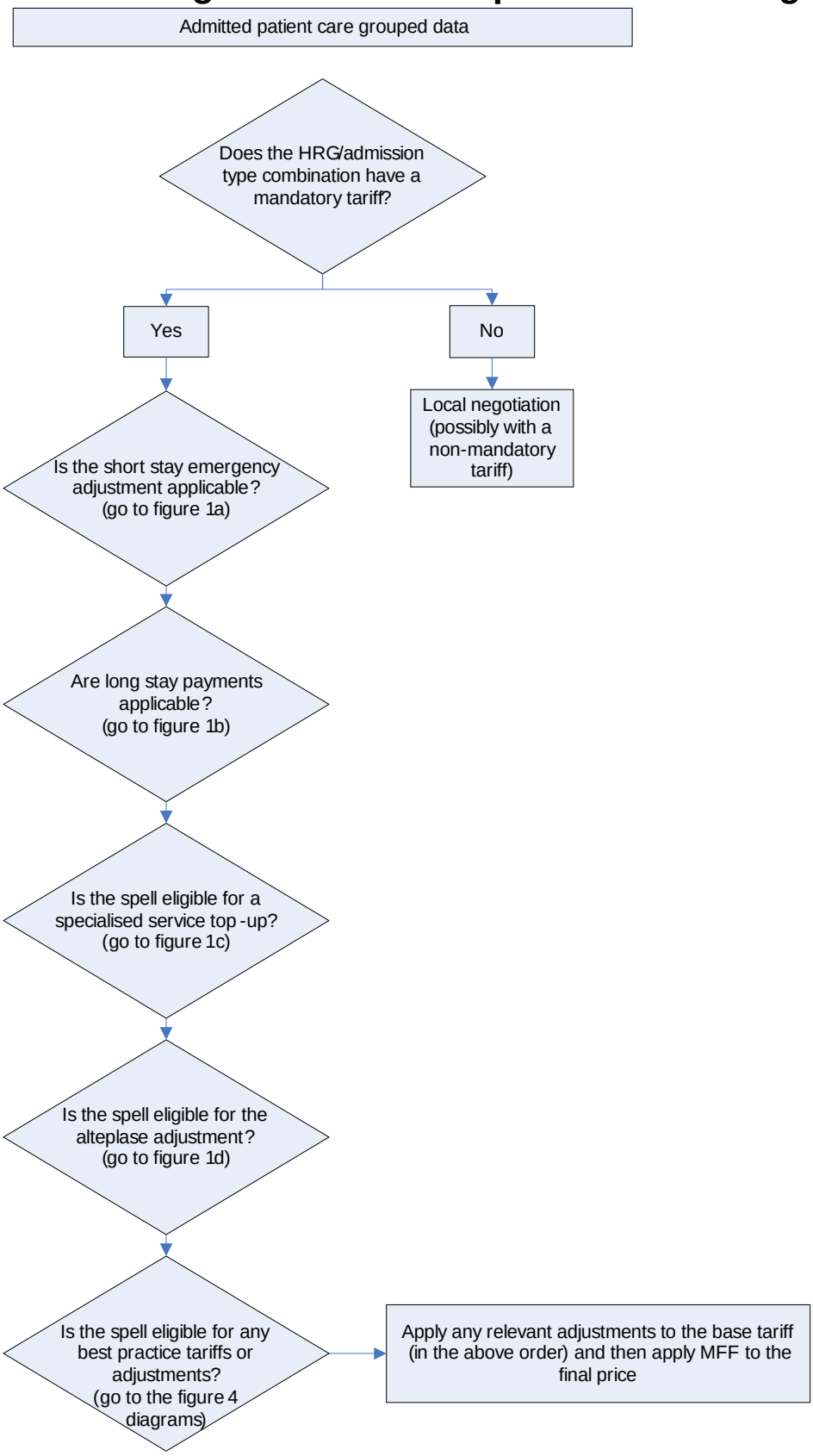
Table B2: Anticipated changes between 2010-11 Road Test Grouper and 2010-11 Local Payment Grouper

| When | Type | Description |
|---|---|---|
| LP | Documentation | Insert wording (as per 09/10 LP grouper) when selecting the type of data to group to indicate which version of A&E is for payment and which is for information |
| LP | OPCS/ICD Grouping | Remap W403 & W413 from HB/HA 21 to HA05 |
| LP | OPCS/ICD Grouping | Remap W414 from HB/HA 21 to HA05 |
| LP | Best Practice Tariffs | Introduce SSC55 for the stroke best practice tariff |
| LP | Specialised Services | Update to the trigger lists for the orthopaedic and children specialised service code trigger lists |
| LP | Best Practice Tariffs | Update SSC88 admission method to include transfers |

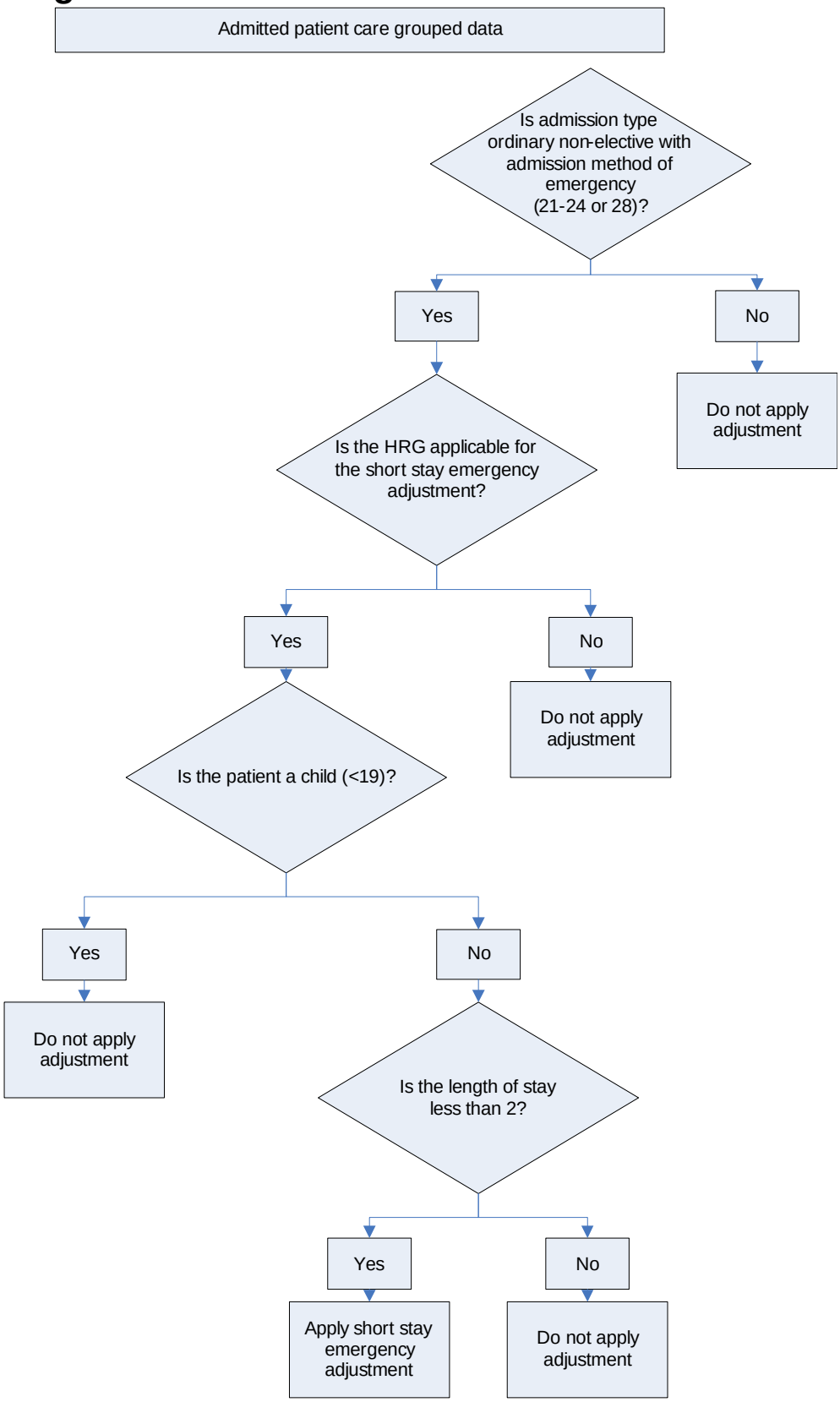
Table B3: 2010-11 Local Payment Grouper and best practice tariffs

| Service area | Can the best practice tariff be generated in the Grouper? | What the Grouper does |
|---|---|---|
| Cataracts | No | Generates the base HRGs and outpatient TFC attendances but not the bundled pathway. |
| Cholecystectomy | Yes | Groups activity to the new cholecystectomy HRGs (GA10C-E) which have best practice tariff prices. |
| Fragility hip fracture | No | Applies an SSC flag of 88 to spells that group to one of the HRGs HA11-14 that have the relevant age, admission method, diagnosis and procedure codes. Does not identify whether they have received best practice care. |
| Stroke | No | Applies an SSC flag of 55 to spell that group to HRGs AA22Z or AA23Z and have a primary diagnosis of either I61, I63 or I64 (including the various subsets of codes for these main codes). Does not identify whether they have received best practice care. |

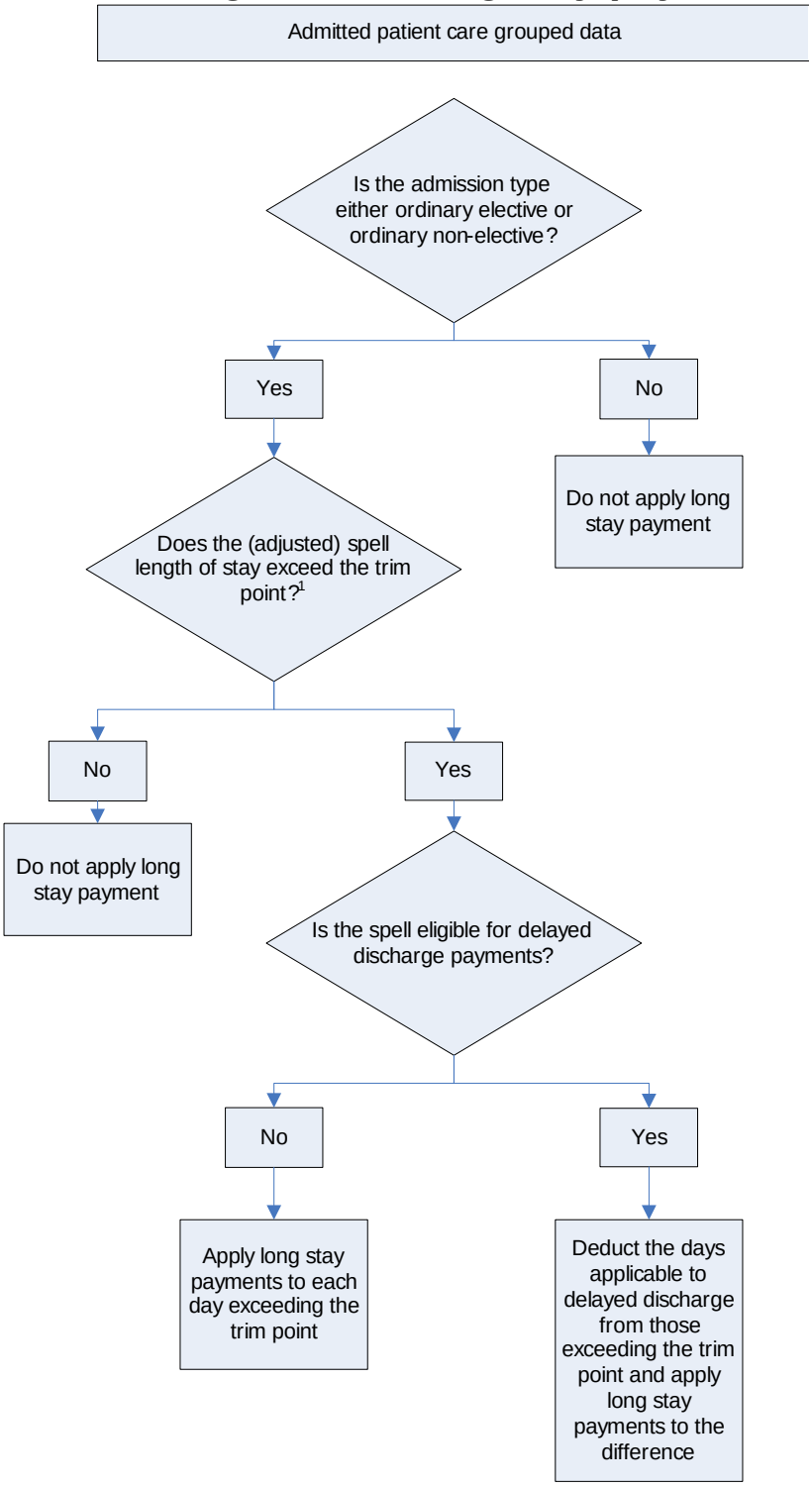
# Annex C Figure 1: Admitted patients flow diagram



# Annex C Figure 1a: Short stay emergency adjustment flow diagram

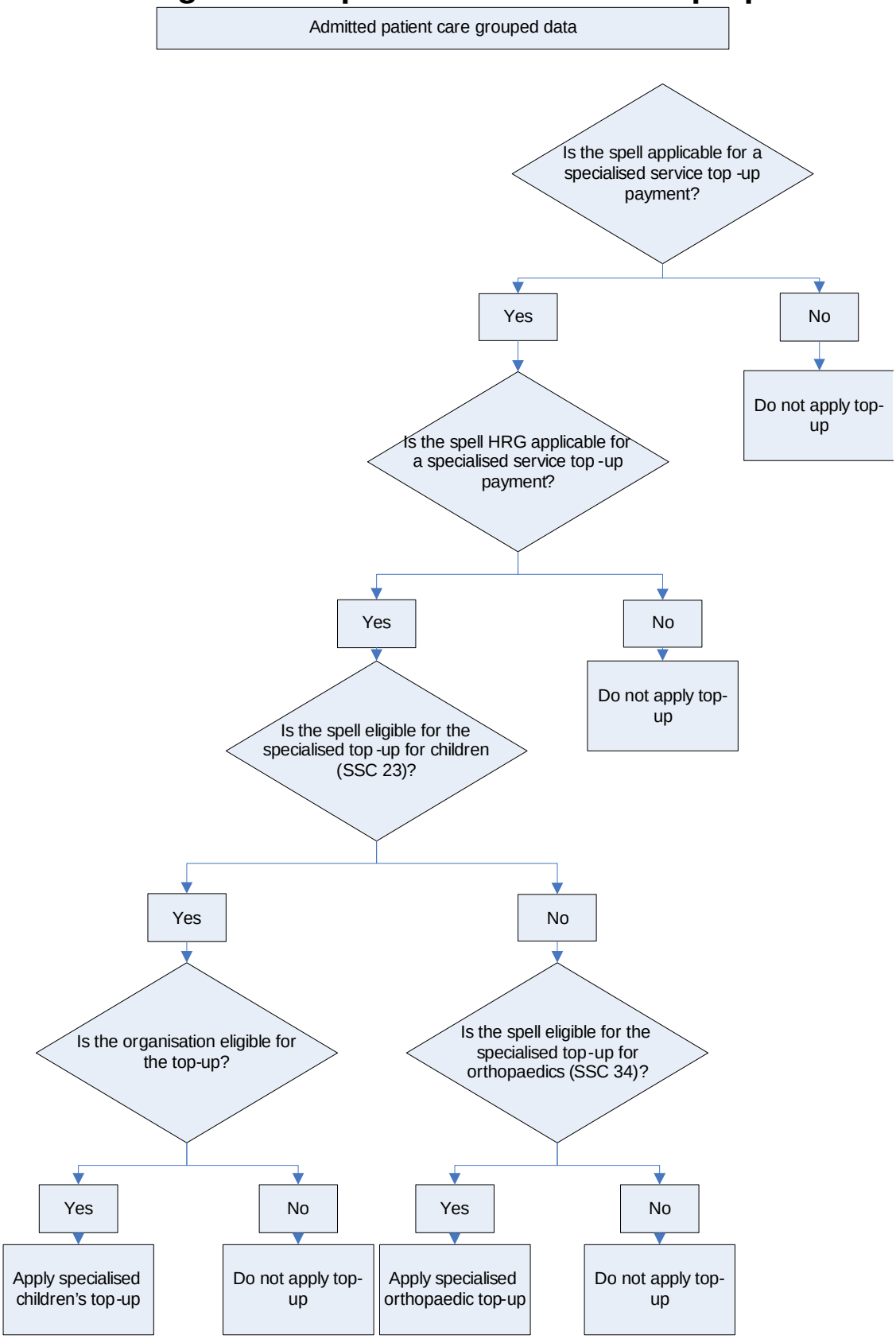


# Annex C Figure 1b: Long stay payment flow diagram

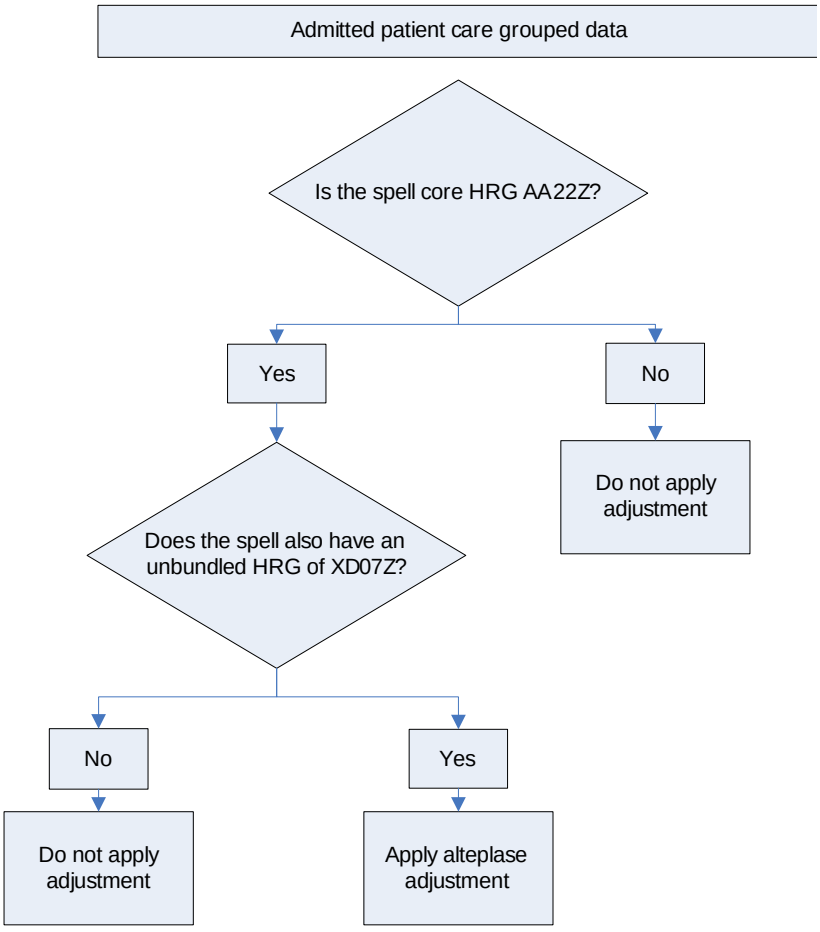



[1]Elective and non-elective admissions may have different trimpoints

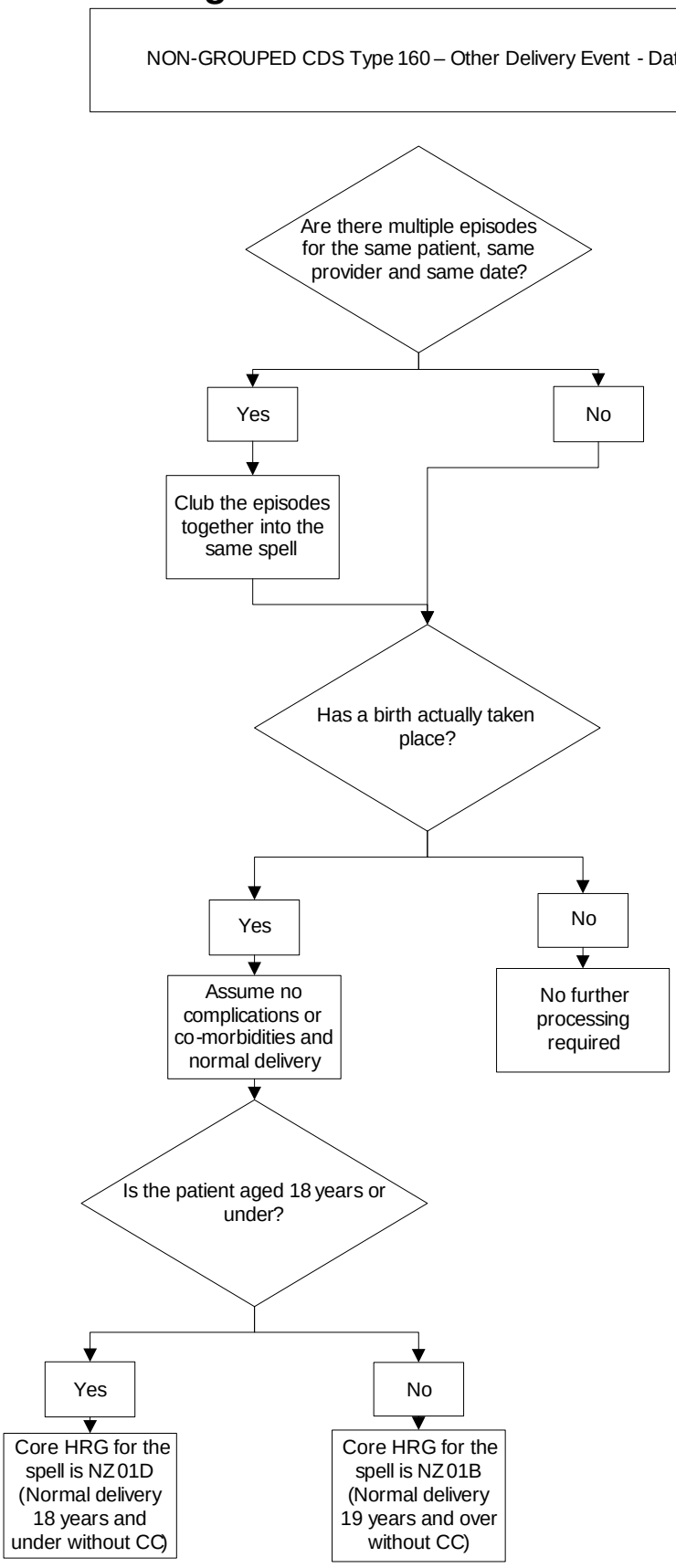
# Annex C Figure 1c: Specialised services top-ups flow diagram



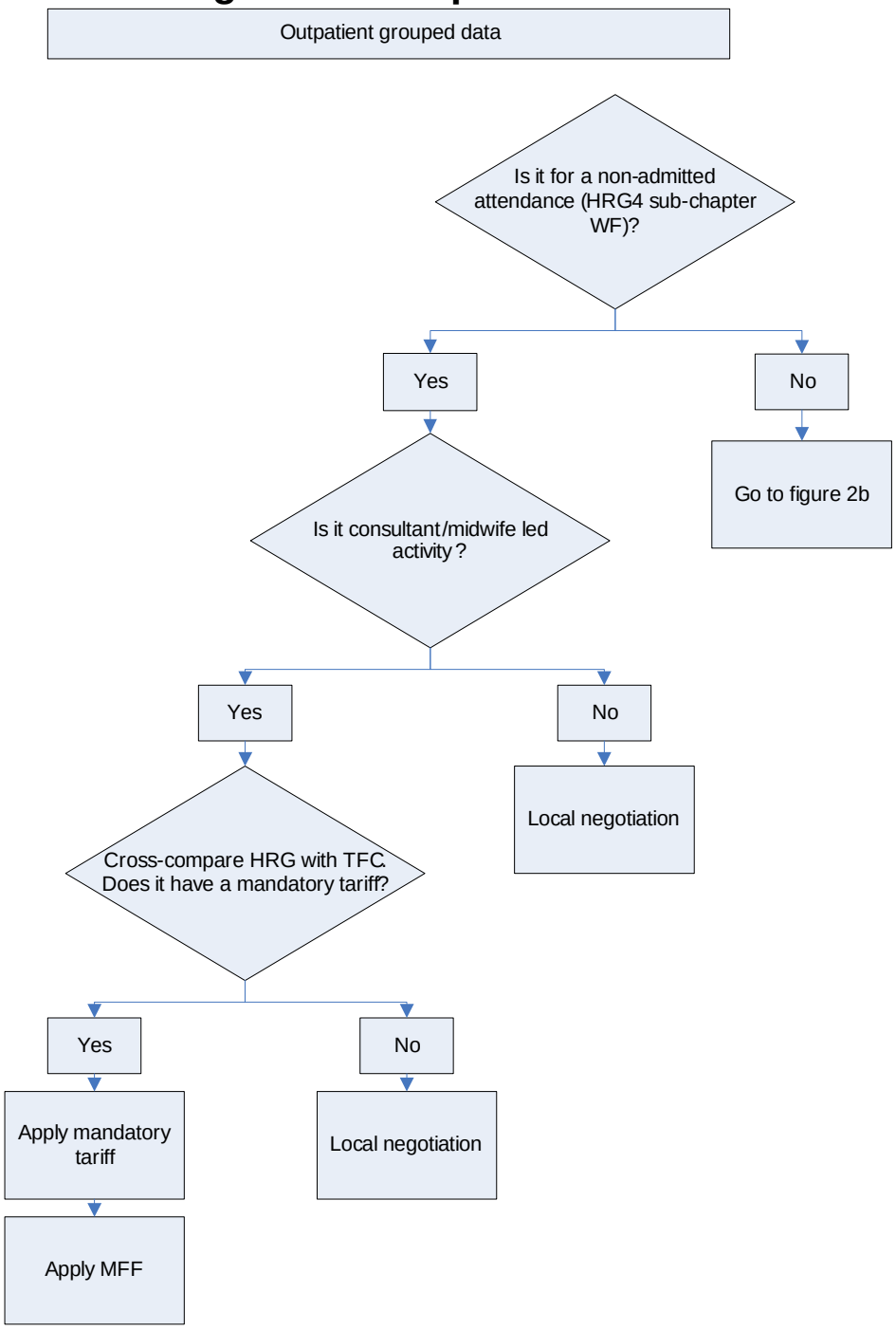
# Annex C Figure 1d: Alteplase adjustment flow diagram



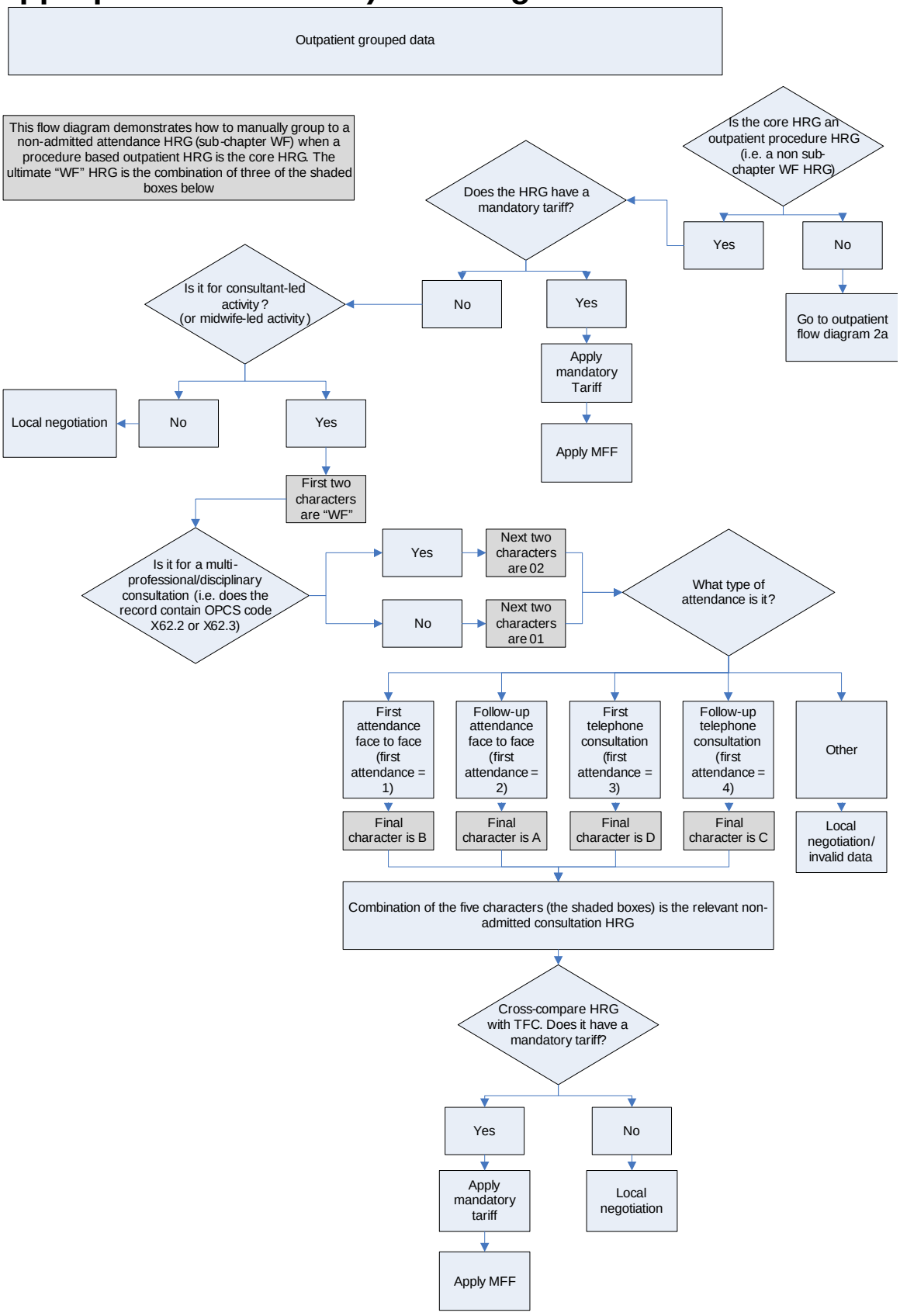
# Annex C Figure 1e: Home births flow diagram



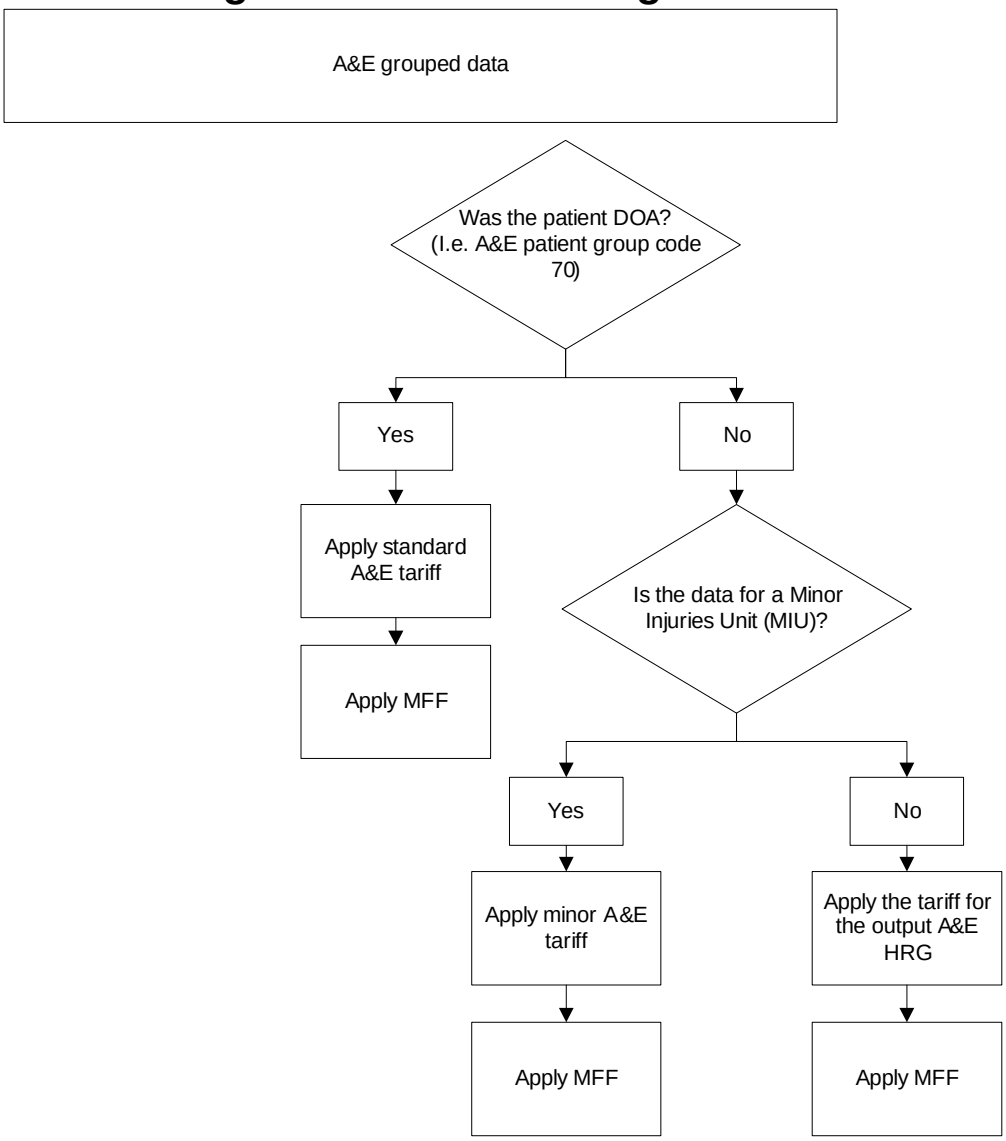
# Annex C Figure 2a: Outpatient attendance flow diagram



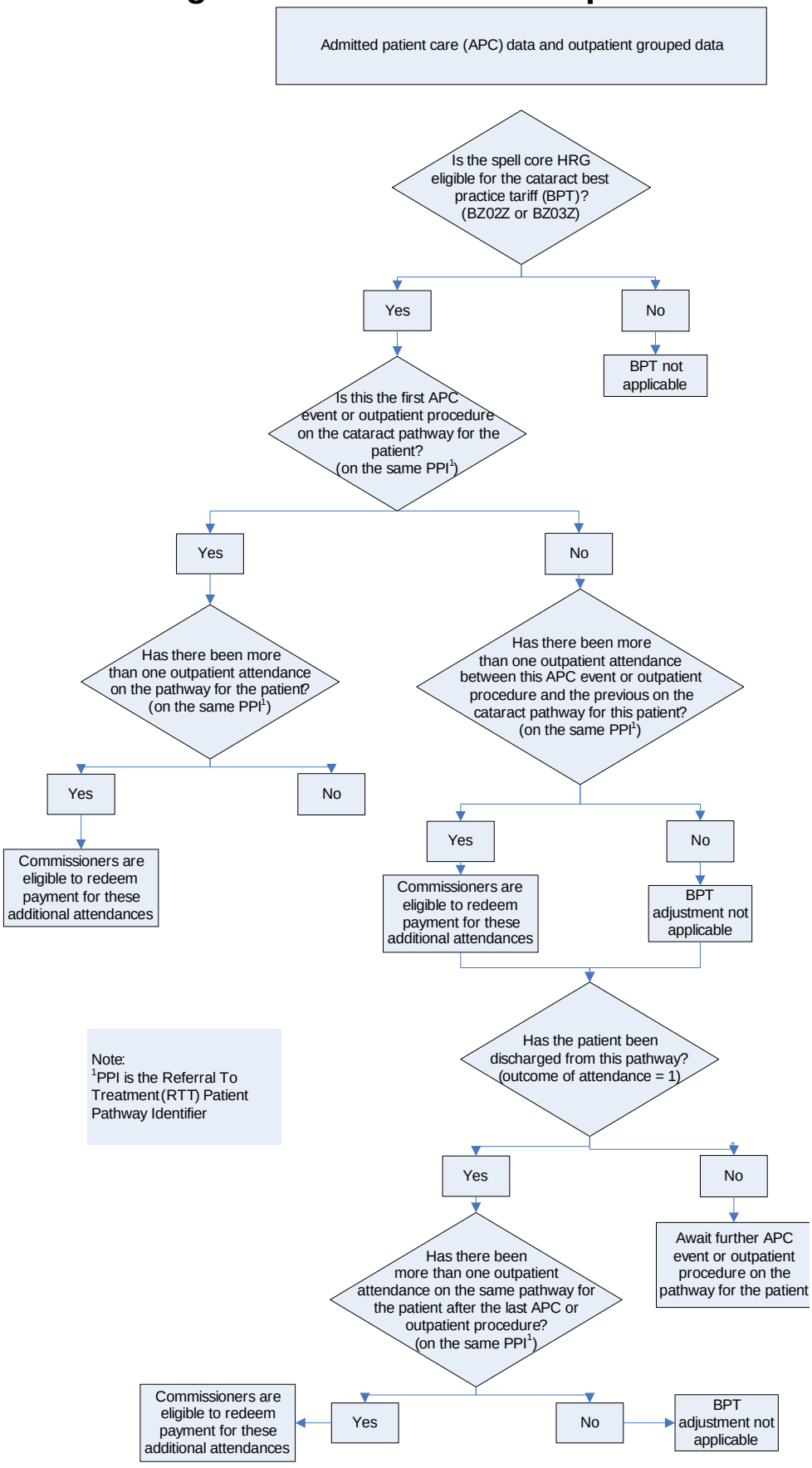
# Annex C Figure 2b: Outpatient procedure (and determining appropriate attendance) flow diagram



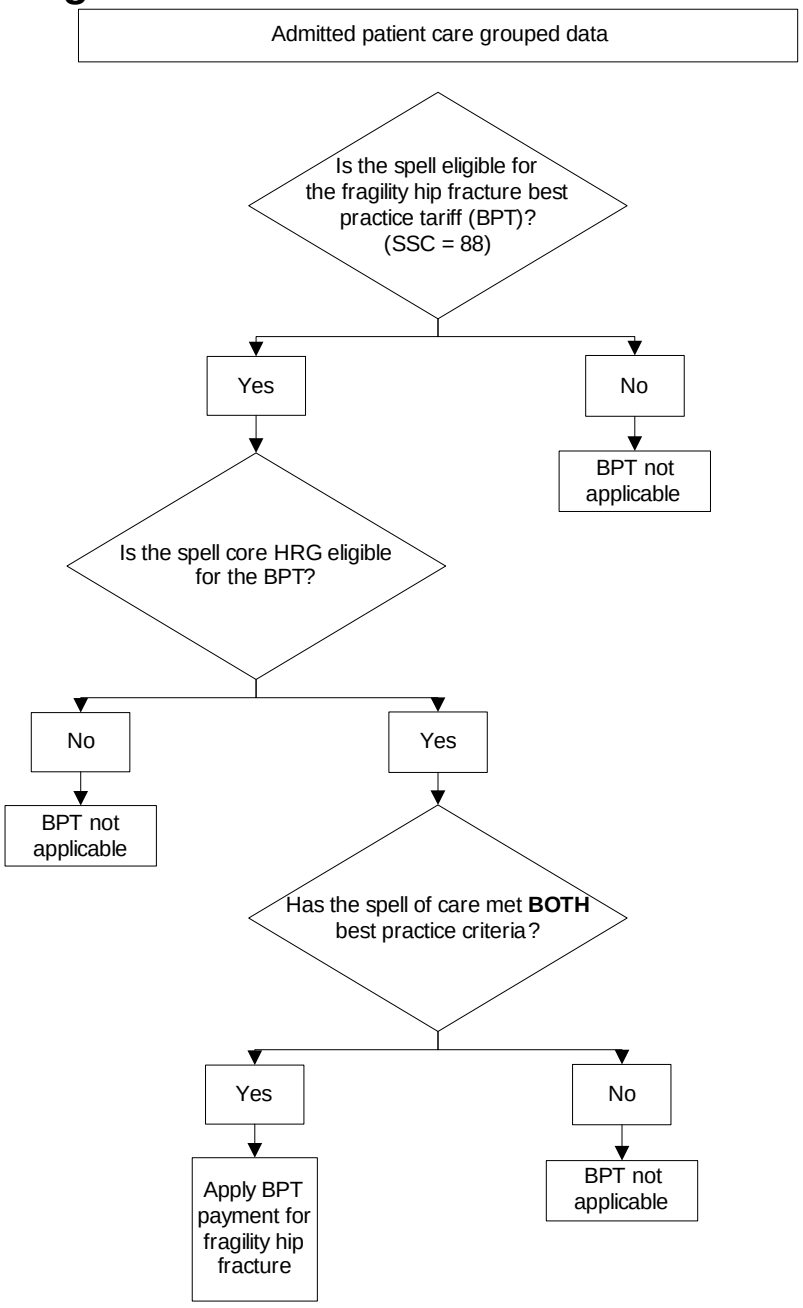
# Annex C Figure 3: A&E flow diagram



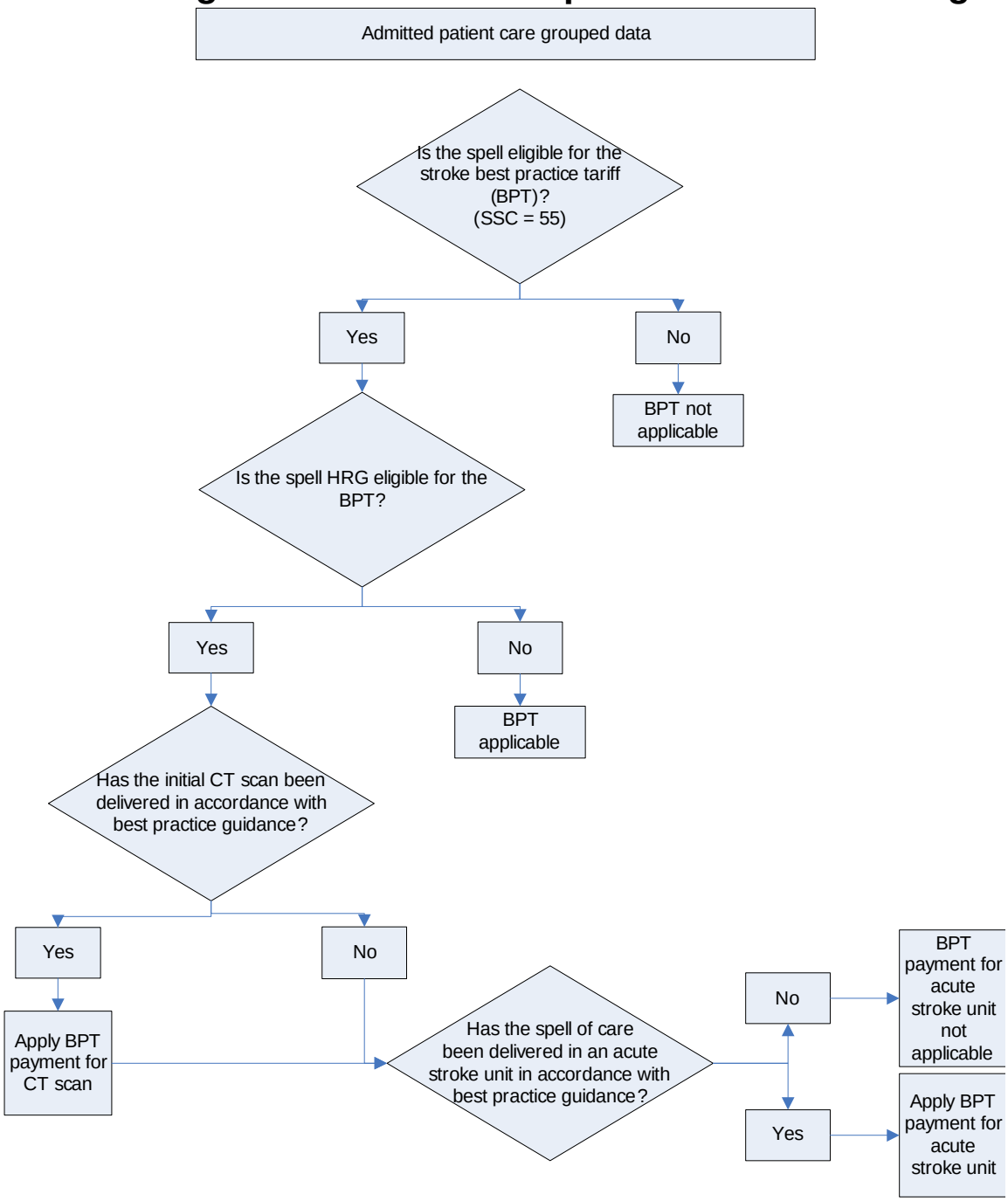
# Annex C Figure 4a: Cataracts best practice tariff flow diagram



# Annex C Figure 4b: Fragility hip fracture best practice tariff flow diagram



# Annex C Figure 4c: Stroke best practice tariff flow diagram



# Annex D: Interventional radiology HRGs

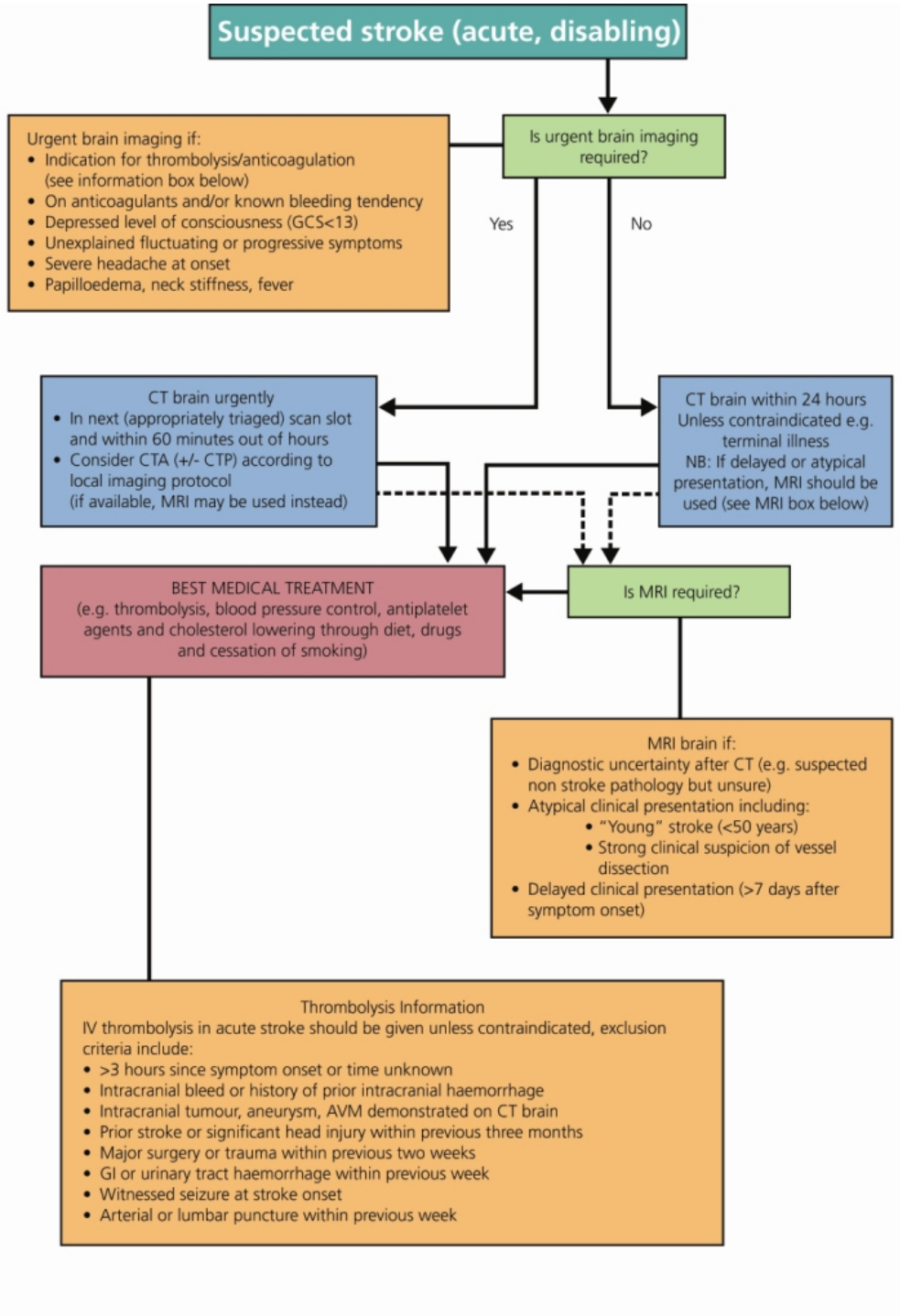
HRGs done entirely by interventional radiologists

| Code | Name |
|---|---|
| AA17Z | Intercranial Procedures Except Trauma with Haemorrhagic Cerebrovascular Disorders – category 1 or 2 |
| GB01Z | Endoscopic/Radiology category 4 |
| GB04A | Endoscopic/Radiology category 1 with Major CC |
| GB04B | Endoscopic/Radiology category 1 with Intermediate CC |
| GB04C | Endoscopic/Radiology category 1 without CC |
| LB01A | Percutaneous Nephrostomy with CC |
| LB01B | Percutaneous Nephrostomy without CC |
| LB05A | Kidney Intermediate Technical, Endoscopic and Percutaneous Interventions 19 years and over with Major CC |
| LB05B | Kidney Intermediate Technical, Endoscopic and Percutaneous Interventions 19 years and over with Intermediate CC |
| LB05C | Kidney Intermediate Technical, Endoscopic and Percutaneous Interventions 19 years and over without CC |
| LB05D | Kidney Intermediate Technical, Endoscopic and Percutaneous Interventions 18 years and under |
| LB42Z | Dynamic studies of Urinary Tract |
| QZ01A | Aortic or Abdominal Surgery with CC |
| QZ01B | Aortic or Abdominal Surgery without CC |
| QZ15A | Therapeutic Endovascular Procedures with Major CC |
| QZ15B | Therapeutic Endovascular Procedures with Intermediate CC |
| QZ15C | Therapeutic Endovascular Procedures without CC |
| QZ16A | Diagnostic Vascular Radiology and other transluminal Procedures with major CC |
| QZ16B | Diagnostic Vascular Radiology and other transluminal Procedures with intermediate CC |
| QZ16C | Diagnostic Vascular Radiology and other transluminal Procedures without CC |

HRGs done mainly by interventional radiologists

| | |
|---|---|
| GB02A | Endoscopic/Radiology category 3 with Major CC |
| GB02B | Endoscopic/Radiology category 3 with Intermediate CC |
| GB02C | Endoscopic/Radiology category 3 without CC |
| GB03A | Endoscopic/Radiology category 2 with CC |
| GB03B | Endoscopic/Radiology category 2 without CC |
| QZ13A | Vascular Access for Renal Replacement Therapy with CC |
| QZ13B | Vascular Access for Renal Replacement Therapy without CC |
| QZ14A | Vascular Access except for Renal Replacement Therapy with CC |
| QZ14B | Vascular Access except for Renal Replacement Therapy without CC |

# Annex E: Imaging for stroke




From page 13 of *Implementing the National Stroke Strategy – an imaging guide*, available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085146

# Annex F: Further reading on best practice care

**Cataracts**

- Delivering Quality and Value: High Volume Care Focus on: Cataracts. Published by the NHS Institute for Innovation and Improvement (May 2008). *Describes a best practice cataracts pathway, including key characteristics of high quality cataract care, measures for improvement and other resources.*

**Cholecystectomy (gall bladder removal)**

- Delivering Quality and Value: High Volume Care Focus on: Cholecystectomy. Published by the NHS Institute for Innovation and Improvement. *Describes a best practice cholecystectomy pathway, including key characteristics of high quality care, measures for improvement and other resources.*
- Delivering Quality and Value: High Volume Care Focus on: Cholecystectomy – A guide for commissioners. Published by the NHS Institute for Innovation and Improvement. *A supplementary guide to the above document, intending to help commissioners and local health communities improve the quality and value of care for cholecystectomy patients.*
- Day case laparoscopic cholecystectomy. Published by the British Association of Day Surgery (December 2004). *This booklet acts as an essential guide for those setting up or wishing to improve laparoscopic cholecystectomy services.*
- 'Transforming your Day Surgery Services: Focus on Cholecystectomy': *The NHS Institute for Innovation and Improvement is developing a toolkit 'Transforming your Day Surgery Services: Focus on Cholecystectomy' to be launched in April 2010. The toolkit enables trusts to review and assess their current practice in elective and emergency cholecystectomy and day surgery services in general against best practice identified in the NHS Institute's Focus On: Cholecystectomy document. The toolkit includes a blank process map and a set of stickers where trusts can identify where they are against best practice and provides a set of solutions and templates to support implementation. The toolkit will be available to order from* http://www.institute.nhs.uk/option,com_joomcart/Itemid,194/main_page,document_product_info/cPath,71/products_id,186.html

**Fragility Hip Fracture**

- Delivering Quality and Value: High Volume Care Focus on: Fractured neck of femur. Published by the NHS Institute for Innovation and Improvement (May 2008). *Describes a best practice fractured neck of femur pathway, including key characteristics of high quality care, measures for improvement and other resources*.

- The Blue Book Guide for the Care of Patients with Fragility Hip Fracture. Published by the British Orthopaedic Association in conjunction with the British Geriatrics Society (September 2007). *This book offers guidance, standards of care, and feedback on care and outcomes.*
- Metrics to help you view your current practice against optimal practice – Fractured neck of femur The NHS Institute for Innovation and Improvement is developing a set of metrics that allow trusts to review and assess their current practice against optimal practice set out in the NHS Institute's Focus On: Fractured Neck of Femur document. These metrics will be available from April 2010 via the website at http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,188.html. The metrics have been tested with sites across England as part of the NHS Institute's Rapid Improvement Programme for Orthopaedics 2008-09.

**Stroke**

- Delivering Quality and Value: High Volume Care Focus on: Acute Stroke. Published by the NHS Institute for Innovation and Improvement. *Describes a best practice acute stroke pathway, including key characteristics of high quality care, measures for improvement and other resources.*
- National Stroke Strategy. Published by the Department of Health (December 2007). *Describes the vision for stroke services, plus guidance and support to commissioners and strategic health authorities and social care, and inform the expectations of patients and their families.*
- Impact Assessment of the National Stroke Strategy. Published by the Department of Health (December 2007). *Describes the impact and costs of the National Stroke Strategy, including net savings accruable to the NHS and social services from following best practice stroke care, as well as estimates of lives and quality adjusted life years saved.*
- National Clinical Guidelines for Stroke. Published by the Royal College of Physicians on behalf of the Intercollegiate Working Party for Stroke (2008). *Provides definitions and guidance around best practice stroke care along the entire pathway, with information to support both clinicians and commissioners to improve services.*
- Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). NICE guideline CG68 July 2008. *Definitive guidelines on stroke symptoms and diagnoses, brain scanning, specialist care, drug treatments and surgery for people who have had a stroke.*
- Implementing the National Stroke Strategy – an imaging guide. Published by the Department of Health, June 2008. *Provides further detail on the recommendations set out in the National Stroke Strategy regarding imaging for transient ischaemic attack (TIA) and stroke. It sets out best practice and provides guidance on how imaging services may develop to provide gold standard TIA and stroke care.*
- Mending hearts and brains - clinical case for change: Report by Professor Roger Boyle, National Director for heart disease and stroke. Published by

the Department of Health, December 2006.
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsPolicyAndGuidance/DH_063282

# Annex G: Useful links

2010-11 Local Payment Grouper
http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment

Audit Commission pages on PbR
www.auditcommission.gov.uk/pbr

British National Formulary
www.bnf.org

HRG4
http://www.ic.nhs.uk/casemix

NHS Connecting for Health
www.connectingforhealth.nhs.uk

NHS Data Model and Dictionary
http://www.datadictionary.nhs.uk/

NHS Information Centre for health and social care
www.ic.nhs.uk

NHS standard contracts
http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Systemmanagement/DH_085048

Operating framework for the NHS in England 2010-11
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

PbR pages on the Department of Health website
www.dh.gov.uk/pbr

SUS PbR
http://www.connectingforhealth.nhs.uk/systemsandservices/sus/supports/pbr

Who pays? Establishing responsible commissioner
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634