PAYMENT BY RESULTS

Implementation Support Guide 2006/07

(Technical Guidance)

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Document Version Control

The table below details updates made to this guidance following initial publication.

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Original	22/03/2006	-
Original	29/03/2006	Minor update to references to annexes in paragraph 23
Version 2	16/06/2006	1. New paragraphs inserted at 55-58 describing handling of long stay outliers. These paras confirm the rolling forward of the previous policy. 2. Update to paragraphs in support of indicative tariffs and critical care.
Version 3	16/08/2006	1. Update to paragraph 60 indicating release of NCA guidance. 2. Update to paragraph 98 clarifying what activity the in-year MFF payments to trusts covers.

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For Recipient's Use			

Contents

1. Introduction

Introduction

1. This document follows on from the executive summary technical guidance document for 2006/07 published in January 2006.

2. The executive summary provided a high level explanation of the operation of payment by results (PbR) in 2006/07 and summarised the key developments to the tariff and the rationale behind these. This document aims to cover issues required to plan and implement PbR in 2006/07.

3. The implementation of PbR marks a significant change to the way that funds flow through the health care system and to the basis on which services are commissioned. However, this change should not alter the basic principles that will underpin the effective commissioning and provision of healthcare services within local health economies.

4. To support these principles the '*Code of Conduct for Payment by Results'* was published in January 2006. This code establishes core principles and expectations as to how the system should operate. It makes clear that organisations operating under PbR must put the interests of patients first. This document should be read in conjunction with the code of conduct for guidance on expected behaviours with the implementation of PbR.

5. A PbR assurance framework will also be implemented in 2006/07, focused on improving the quality of patient-level data that underpins the effective operation of payment by results.

Development of new PbR arrangements

6. The development of PbR for 2006/07 has been supported by expert groups from a wide range of stakeholders, including:

- NHS Trusts;
- NHS Foundation Trusts;
- Primary Care Trusts;
- Strategic Health Authorities;
- clinical/commissioning networks;
- professional bodies;
- regulatory bodies;
- independent sector;
- industry.

2. Scope and Structure of PbR in 2006/07

Aims and principles underpinning developments to PbR scope and structure

7. The aims of developing the tariff are:

    - to ensure services are appropriately rewarded;
    - to create appropriate financial incentives;
    - to support wider system reform.

8. The principles underpinning developments to the tariff are:

    - tariff structure should be as stable as possible;
    - structure should be as simple as possible given the complex nature of healthcare provision;
    - structure should be based on services and not organisations;
    - NHS and other interested parties should be involved in the development process;
    - the 2006/07 tariff continues to be based on reference costs.

Scope of the National Tariff

9. In 2006/07 the tariff will cover admitted patient care, outpatients and accident & emergency services. It continues to apply to services provided by NHS Trusts, Foundation Trusts and Primary Care Trusts which are directly commissioned from PCTs and all forms of consortia, including specialised commissioners. The following table lists those services excluded from the scope of the mandatory tariff:

Services excluded from tariff
Community services
Mental health services
Ambulance services (other than patient transport services)
Well babies*
Private patients in NHS hospitals
Chemotherapy
Learning disabilities
Critical care
Continuing/intermediate care
Respite care
Regular attenders
Radiotherapy
Direct access radiology and pathology
Renal dialysis
Rehabilitation in discrete rehabilitation ward or unit or activity coded to specialty 314
Primary Care Services
Walk in Centres

*Included in the cost of the mother's care

10. The following table summarises the structure of the tariff. **Changes that have been made from 2005/06 are highlighted in bold:**

	Admitted patients	***Outpatients***	***A&E***
Currency	V3.5 HRG Spell	Attendance by specialty or outpatient procedure	Attendance
Structure	Tariffs for: • Electives • Non-Electives • **Differential tariffs for emergency admissions** • Single tariff for day cases and inpatients combined • **Short-stay emergencies**	Tariff for: • First attendance • Follow-up attendance • **9 specified procedures (see para 43)**	Tariff for: • High cost attendance • Standard attendance • **Combined Minor A&E/Minor Injuries Unit attendance** • Differential tariffs for reductions in activity.
Specialised service adjustments	• **Top-up payment for specific specialised and children's activity** • **Exclusions (see Annex A)**	• Separate tariff for children in some specialties • **Exclusions (see Annex A)**	Not applicable
Outliers	• Long stay outlier payment triggered at pre-determined length of stay (dependent on HRG). • Per diem rate specific to HRG.	• No outlier policy	• No outlier policy
Flexibilities - subject to advance agreement by both providers and commissioners	• Unbundling of care pathway subject to local agreement • Local 'pass through' payments for new technology • Emergency readmissions- local arrangements for determining appropriate reimbursement and criteria	• Unbundling of care pathway subject to local agreement • Procedures carried out in outpatient setting • Local 'pass through' payments for new technology • **Multi-professional outpatient attendances**	• No flexibilities

Differential tariffs for emergency admissions

Rationale

11. In 2005/06 those providers who are subject to PbR for emergency inpatient care services (mainly NHS Foundation Trusts) are paid at full tariff for all the activity they undertake. Paying the full tariff for growth in admitted emergency admissions places all of the financial risk on PCTs. Conversely, all the risk is with providers should activity levels fall.

12. Without any change to the tariff structure, the risks faced would be exacerbated in 2006/07 as all NHS providers move into PbR for emergency care. During 2006/07 the NHS will also face some significant structural changes at SHA and PCT level.

Differential Rate

13. In order to better share the risk between providers and commissioners, a reduced rate tariff of 50% will apply to all emergency spells above a set threshold. If the threshold level of activity is not met, 50% of tariff will be withdrawn for the difference between actual and threshold. The differential rate should be applied to the tariff and include any national adjustments for short stay spells, specialised service top ups and excess bed days.

14. Emergency spells are defined by reference to the admission method of the patient. Only spells with the following admission methods should be treated as emergencies in relation to the application of the differential rate tariff:

Admission code	Description
21	Accident and emergency or dental casualty department of the Health Care Provider
22	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 GENERAL PRACTITIONER or deputy
23	Bed bureau
24	Consultant clinic, of this or another Health Care Provider
28	Other means, examples are: - admitted from the Accident And Emergency Department of another provider where they had not been admitted - transfer of an admitted PATIENT from another Hospital Provider in an emergency - baby born at home as intended

15. This threshold for 2006/07 will be set at the level of 2004/05 outturn plus 3.2%. 3.2% is the estimated national level of growth in emergency care in 2005/06 based on half-year returns. Therefore, target, planned or actual activity levels in 2005/06 will have no bearing on the setting of the thresholds for 2006/07.

16. The threshold is set on the basis of activity. The threshold activity is then priced at the 2006/07 national tariff. Specialised service top-ups and excess bed day income should be included in the calculation of the final threshold. This should be done using the 2006/07 tariff structure, trim points and specialised top up rates.

17. Thresholds should be set for each PCT provider relationship. Where services are commissioned by lead commissioners or consortia, the threshold should be set at between the lead PCT or consortium and provider. The threshold applies to total contract value but is calculated using HRG level information.

18. Work examples in Annexes B1 and B2 are very simplified, but attempt to illustrate the principles involved in calculating the thresholds and making quarterly adjustments. Annex B1 illustrates the situation where the contracted (plan or target level) for 2006/07 is higher than the threshold for 2006/07. Annex B2 illustrates the situation where the contracted (plan or target level) for 2006/07 is lower than the threshold for 2006/07.

Short Stay Emergencies

19. Short stay emergency tariff cases apply to medical HRGs where actual length of stay is less than two days. Feedback during 2005/06 has indicated that the targeting of the HRGs to which the short stay tariff applied and the level of reduction in the tariff needed to be re-examined. Therefore, three major changes have been made in this area:

- The reduction will now only apply to HRGs where the assignment of the HRG is based on diagnosis rather than procedure code.
- The reduction will not apply to spells delivered to children (aged <17 on date of admission)
- Rather than having a flat rate reduction, the level of reduction will now depend of the national average length of stay of the HRG as follows:

HRGs with average length of stay	Short stay tariff (% of tariff applied)
0-1	100% - ie. full tariff applies
2 days	50%
3-4 days	35%
5 or more days	20%

20. Details of this at HRG level are provided with the 2006/07 national tariff.

21. There has been no change to the short stay threshold, which remains at spells with a length of stay of less than two days.

22. The short stay tariff applies to emergency admissions (defined by codes 21-24 and 28). The criteria that determine whether the short stay tariff applies are those set out in paragraph 19. If these criteria are met then the short stay tariff applies regardless of whether the patient is admitted under a medical or a surgical specialty. The reduction applies to all elements of the tariff including specialised top-ups.

Specialised Services

Specialised top-ups

23. For a number of services, specialised activity for admitted patients will attract a tariff top-up. These top-ups are a percentage of the relevant HRG tariff. Details of these top-ups are shown in the table below. The procedure and diagnosis codes that attract the top-up are given in Annexes D-G. These codes are based on the Specialised Services National Definition Set, 2nd edition (December 2002). The list of codes was refined during the course of 2005 to take account of comments from specialised commissioners, providers and clinicians. Non-applicable HRGs are listed with the 2006/07 tariff. Some HRGs that are specialised characteristically, have their tariff calculated to reflect this and do not qualify for specialised top-ups. This also applies to HRGs that apply only to children.

Specialised Service and Paediatric Admitted Patient Tariff top-ups

Specialty	% Top-up
Cardiology and Cardiac Surgery	16%
Children Non-specialised	11%
Children Specialised	69%
Colorectal	35%
Hepatology, Hepatobiliary and Pancreatic Surgery	9%
Neurosciences	24%
Orthopaedic	70%
Respiratory	17%
Spinal surgery	24%

24. Statistical analysis was undertaken to estimate the impact of specialised activity on providers' costs. This analysis has been updated from last year to use more recent HES and reference cost data. The procedure and diagnosis codes drawn from the Specialised Services National Definition Set were determined as indicators of specialised activity. Where the impact was found to be statistically significant, a specialised top-up was calculated, with the level of the top-up determined by the statistical analysis.

Specialised exclusions

25. For 2006/07, a number of specific HRGs and outpatient specialites have been excluded from the mandatory scope of the tariff because they have low volumes, volatile costs, and/or are of a specialised nature. These HRGs/specialties are listed in the table of exclusions in Annex A.

26. The tariff for cochlear implants (HRG C60) covers all the costs associated with the admitted patient spell in which the device is implanted. It does not cover subsequent programming and maintenance of the device. Commissioners and providers should agree a local price for such maintenance.

High cost drug, device and procedure exclusions

27. Existing classifications will not necessarily allow for fair reimbursement of these items because the numbers are low and unpredictable or the relevant HRG includes more routine treatment and the distribution of different activity within the HRG is not even across providers**.** Therefore a number of high cost drugs, devices, procedures and products have been excluded from the scope of tariff. Details of these exclusions are given in Annex A. The list of exclusions was determined after wide-ranging consultation with providers and commissioners of specialised services. Only those items explicitly named are excluded.

28. The following criteria were used to identify the exclusions:

    - Costs are high relative to the rest of the activity within the relevant HRG
    - A sub-set of Trusts within the HRG disproportionately provides the high cost item (the benchmark we have used is that fewer than 20 providers are carrying out half of all activity).

29. In each case, cost and national volume for the item to be excluded were estimated, and tariffs were adjusted for the relevant HRGs and outpatient specialties, so as to ensure that the effect of the exclusions was cost neutral.

30. The costs of Implantable Cardioverter Defibrillator (ICD) devices (which can apply to patients in several different Chapter E HRGs) were collected separately in the 2004/05 reference costs collection. These device costs were excluded from the appropriate HRG costs and therefore the relevant tariff calculation. Therefore, where providers use an ICD, an addition to the national tariff to cover the cost of the device only will need to be locally determined, along with any accompanying information flows.

31. For all excluded drugs, devices, and blood products, commissioners and providers should agree local prices, and local arrangements for monitoring activity. These local prices should be paid as an additional payment to the relevant HRG or outpatient tariff. To give an example, if a patient is admitted to hospital for a procedure involving an aortic stent, the normal HRG-based tariff should be paid for the admitted patient spell, with a additional payment to cover the additional cost of the stent itself. This additional payment is the only part of the total cost that will be subject to local determination.

32. In most cases, the additional payment should cover only the cost of the excluded drug, product, device and associated consumables. However some procedures may entail additional costs over and above the cost of any device used, 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. The additional payment should only be payable for activity that meets this definition. Activity that meets the definition should be agreed between commissioners and providers, with the involvement of clinicians as appropriate.

33. In all cases, commissioners and providers will need to determine whether they wish to agree volumes and prices as part of SLAs, or to operate on a case-by-case basis. For some excluded items, such as spinal cord stimulators or insulin pumps, it may be most appropriate to agree volumes and prices in advance within a SLA, while for others such as Enzyme Replacement Therapy, 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 relevant clinical guidance and guidelines (eg. from NICE).

34. In the case of bespoke orthopaedic prostheses, the relevant HRG tariff will generally include the cost of a standard prosthesis. In these instances, the top-up should cover only the difference in cost between the bespoke prosthesis, and a standard prosthesis. For example, a Trust providing a bespoke knee replacement will receive the standard HRG-based tariff for the admitted patient spell. This will generally include the cost of a standard prosthesis. The commissioner and provider should therefore agree an additional payment to cover the additional cost of the bespoke prosthesis, over and above the cost of the standard prosthesis.

Outpatients

35. For the purposes of reference costs, an outpatient attendance is defined as ‘a pre-booked appointment for which a consultant is clinically responsible whether they are present at the clinic or not’. The same definition should be used to determine whether the outpatient tariff applies. According to the NHS data dictionary, the clinic does not have to take

place in Trust premises and so clinics held off-site are included in the scope of PbR.

36. In addition, the ante-natal visits and obstetric outpatient categories collected as part of the reference costs have been grouped to treatment function 501 Obstetrics. If the appointment has been booked and is either hospital based or a consultant clinic within a GP surgery, the Obstetrics outpatient tariffs apply. If the activity involves a pre- or post-natal visit to a patient's home, this is a community attendance and is excluded from PbR in 2006/07.

37. A first attendance is the first or only attendance in a series in respect of one referral. Follow-up attendances are those that are not first attendances. 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 and the patient returns to the clinic run by the same consultant, this is a new episode i.e. the attendance is classified as a first attendance.

38. 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 6 months apart or where the patient attends having been given a further appointment at their last attendance, the follow-up tariff applies.

39. The outpatient tariff is based on attendance by specialty. Reference cost categories were mapped to the appropriate outpatient tariff specialty. There were some instances where one reference cost category contained many outpatient tariff specialties. In these cases a tariff was calculated using the reference cost category and the same tariff was given to each of the outpatient specialties.

40. So as to provide incentives to minimise follow-ups where these are not necessary, the tariff has been structured to 'front-load' the reimbursement so that follow-ups have a relatively low reimbursement rate compared with a first attendance. This front-loading has been set at 10% of the follow-up costs. This means that 10% of the costs of follow-up attendances have been added to the first attendance costs making the tariff for first attendance relatively higher.

41. Where a provider offers the services of a number of specialties in a single outpatient visit, this will be recorded as just one outpatient attendance. The specialty that the activity is recorded to should be determined locally in consultation with commissioners where appropriate. To ensure that providers that offer a range of services in a single visit to a patient that otherwise would have had to visit each specialty separately are fairly reimbursed, we have allowed for a local funding flexibility for such attendances. This is described in Section 4 on local flexibilities.

42. The DSCN (32/2004) mandates non-face-to-face outpatient activity, e.g. telephone consultations, to be collected and transmitted. The data is being collected for the first time as part of the 2005/06 reference cost collection. Consequently, this activity is not covered by the 2006/07 outpatient tariff. On the basis of the robustness of the 2005/06 reference cost data, we will consider whether to set a tariff for this activity in 2007/08. Therefore the price for these will be subject to local negotiation in 2006/07.

Procedures in outpatients

43. For 2006/07 we have created a tariff for nine specific outpatient procedures. The procedure tariff is paid instead of the specialty based attendance tariffs (in line with the 2004/05 reference cost guidance). This is a first step towards creating a setting-independent tariff. The local flexibility, allowing commissioners and providers to negotiate a local price for other outpatient procedures, will remain in 2006/07, and is described in the section on local flexibilities. **The nine procedures, and the codes by which they are defined, are detailed in the table below:**

Table showing OPCS 4.3 Codes for outpatient procedures paid via tariff

Procedure	OPCS 4.3 Codes
Colposcopy	P27.3, Q55.4
Hysteroscopy	Q18.1,Q18.8, Q18.9
Flexible Sigmoidoscopy	H25.1, H25.8, H25.9
Rigid Sigmoidoscopy	H28.1, H28.8, H28.9
Epidural Injections (for Pain Services, specifically not to be used for Obstetrics)	A52.1, A52.2, A52.8, A52.9
Fine needle biopsy of breast	B37.1, B32.1, B32.3
Needle biopsy of prostate	M70.1, M70.2, M70.3
Laser Destruction of Lesion of Skin	S09.1, S09.2
Subcutaneous injection	X38.1, X38.2, X38.3, X38.4, X38.5, X38.6, X38.7,X38.8, X38.9

44. If more than one of these procedures is undertaken in a single outpatient attendance, each procedure attracts it's full tariff.

A&E/Minor Injury Units

45. There are three tariffs to cover services delivered in accident and emergency departments and minor injuries units. These are High Cost attendance, Standard attendance and Minor A&E/Minor Injuries Units (MIUs). Dead on Arrivals (DOAs) should be funded under the standard tariff. Costs and activity for U06 are not included. The table below provides a mapping of reference cost codes to tariff categories

Table showing mapping of A&E categories

Reference cost classification	Code label	A&E tariff payment
U06	Attendance disposal invalid for grouping	**No payment**
DOA	Dead on Arrival	**Standard**
V01	High cost imaging (Died/Admitted)	**High cost**
V02	High cost imaging (Referred/Discharged)	
V03	Other high cost investigation (Died/Admitted)	
V04	Other high cost investigation (Referred/Discharged)	
V05	Lower cost investigation (Died/Admitted)	**Standard**
V06	Lower cost investigation (Referred/Discharged)	
V07	No investigation (Died/Admitted)	**Minor A&E and Minor Injuries Unit**
V08	No investigation (Referred/Discharged)	
V100MC*	Non 24 hour A and E Department/Casualty Department	
V100MI*	Discrete Minor Injuries Unit	

***** Walk in centre activity continues to be excluded from the scope of PbR.

46. A&E attendances are reimbursed at the same rate regardless of whether a patient is subsequently admitted. The additional costs of those A&E attendances that lead to an admission have been added to the admitted patient care non-elective HRG tariff in proportion to the numbers of patients admitted through A&E. Patients who have died, or were admitted, are identified by the odd numbered V codes. Patients admitted through A&E should be reimbursed both for the A&E attendance and the relevant admitted patient HRG tariff.

47. As in 2005/06 A&E services are to be funded on an 80 per cent fixed and 20 per cent variable basis up to the planned level of activity. The split between the fixed and variable element to the tariff should not be interpreted as a measure of the prevailing fixed or variable costs. Rather, it provides a mechanism for ensuring that required capacity is funded regardless of actual activity. This is in recognition of the unpredictable nature of emergency services and the 'core service' features of A&E. A core level of A&E provision is required independently of the level of activity at any particular point in time.

48. Organisations will be funded at tariff for their planned weighted activity. Under- performance against this plan will then be withdrawn at 20% of tariff, whilst over performance will be funded at full tariff. For example:

    - If planned activity is 1,000 attendances at a tariff of £10. Planned income is therefore £10,000.
    - If outturn activity is 90% of plan ie. 900 attendances, with 100 shortfall, then income is reduced by 100*20%*£10=£200.

- If outturn activity is 110% of plan ie. 1,100 attendances, with 100 over performance, then income is increased by 100*£10=£1,000.

Impact of NICE guidance

49. NICE produces three forms of clinical guidance: clinical guidelines (management of particular clinical conditions), technology appraisals (guidance on specific health interventions, including pharmaceuticals), and guidance on the safety and efficacy of interventional procedures.

50. The cost implications of NICE guidance for the NHS is taken account of in two main ways:

    - Through an adjustment within the national tariff uplift (dealing with pay and prices, pay reform and technical issues)
    - Through specific adjustments to the national tariff prices where appropriate.

51. The uplift adjustment includes an estimate of the cost implications of NICE guidance – both guidelines and technology appraisals. This is revised on an annual basis but the overall national uplift must be consistent with the overall funding settlement position. See also Annex C for further details of the national tariff uplift.

Impact of NICE Technology Appraisals

52. The criteria used to determine whether specific adjustment needs to be taken of NICE guidance are:

    - The guidance is subject to a funding direction and;
    - The impact is cost increasing in a material way and;
    - The costs will impact during the period from the relevant reference cost collection to the year in which the national tariff applies.

53. NICE technology appraisals due to be implemented during the period covered by the 2004/05 reference costs and up to and including the period when the tariff applies (2006/07), have been assessed for their potential impact on the national tariff. Where implementation of the appraisal recommendations would have a material impact on the relative casemix weight of any of the HRGs for 2006/07 then a prospective adjustment to the tariff has been made. Only new and reviewed technology appraisals have been considered. Technology appraisals where a cost saving is anticipated have not been included within specific HRGs but will be reflected in the overall uplift used in the national tariff uplift.

54. Recent and forthcoming technology appraisals were jointly reviewed with NICE to determine which would fall within the relevant time period and would have implications for the national tariff. Those that were identified

as requiring some action because they are both within scope of PbR and will make a cost impact are set out in the table below:

Table showing NICE technology appraisals meeting criteria for adjustment

Technology Appraisal	Detail	Date Due	Action for 2006/07 tariff
Psoriasis	efalizumab and etanercept (Anti-TNF drugs)	Jan-06	High cost drug exclusion
Hepatitis C	pegylated interferons, ribavarin and alpha interferon (interferons for Hepatitis C) for the treatment of mild to moderate disease	August 2006 review	High cost drug exclusion
		Use of the same drugs for more severe cases were appraised by in January 2004 and dealt with under high cost drugs in 2005/06	
Rheumatoid Arthritis	adalimumab, etanercept and infliximab (Anti-TNF drugs)	Jun-06	High cost drug exclusion
Renal transplantation	immunosuppressive regimens for children and adolescents	Jun-06	No action (outside scope)
Sepsis (severe)	drotecogin (xigris)	Sept 2004 (considered now as PbR being shadowed for critical care)	High cost drug exclusion
Ischaemic heart disease	coronary artery stents	June 2006 review	Adjust E15 (elective and non-elective) tariff by £25.5m Review once Technology Appraisal is published
Diabetes	Inhaled Insulin	Oct-06	No action-review when Technology Appraisal is published
Myocardial perfusion scintigraphy		Nov-03	Adjust E11, E12, E22 and E23 by £2m (as for 2005/06)
Laparoscopic surgery for inguinal hernia		Sep-04	No action

Long Stay Outliers

55. The HRG costs reported in the published 2004/05 reference costs do not include the cost of stays beyond a defined elective and non-elective "trimpoint" (these are listed separately as excess bed days). In many countries, specific payment systems for outliers are used to act as formal risk-sharing arrangements between a hospital and purchasers. The outlier payment will operate after a patient's length of stay exceeds the trimpoint. The trimpoint is defined in the same way as Reference costs, but is spell-based and there are separate elective and non- elective trimpoints. An HRG specific per diem rate will be applied beyond this trimpoint. The technical paper on the tariff includes information on how the trimpoints were calculated and tariffs adjusted for long stay outliers.

56. For spells that started before 2006/07, but finish in 2006/07, the 2006/07 tariff should apply on discharge. In these cases, the spell length of stay should be calculated from the actual admission date, if admission is in 2005/06. If admission was before 2005/06, for PbR purposes, the length of stay for should be calculated from the start of 2005/06. In both of these cases the 2006/07 trim points should be applied to this length of stay. The 2006/07 tariff should then be used for all excess beddays including those that occurred in 2005/06.

57. Note that the specialised services supplementary payments can be applied to the short-stay tariff but not to the long stay outlier payment.

58. If a patient is deemed fit for discharge and fines have been imposed on local authorities under the Delayed Discharge arrangements then PCTs should not be liable for any further outlier payment.

3. Other Operational Factors

Cross Border activity with Wales

59. For 2006/07, as in 2005/06, English providers should continue to charge Welsh Local Health Boards (LHBs) at local prices. This is consistent with guidance issued to LHBs in Welsh Health Circular 'WHC (2006)12' issued on March 8 2006. English providers should not inflate local prices over and above any expected inflationary uplift.

Non-Contract Activity

60. Guidance on non-contract activity (NCA) for 2006/07 has been issued on the DH website.

Indicative Tariffs

61. Indicative tariffs have been made available for the following number of services which remain outside the scope of PbR.

- Admitted patient care outside scope of PbR
- Bone Marrow Transplant
- Cystic Fibrosis
- Chemotherapy
- Kidney Transplant
- Outpatients outside scope of PbR
- Pathology
- Radiology
- Radiotherapy
- Regular Attenders
- Renal Dialysis

62. These indicative tariffs can be used in cases where both the provider and commissioner agree to do so. Where these tariffs are adopted, separate data flows between providers and commissioners will need to be established for the purposes of local SLA monitoring. These services are not within the mandatory scope of PbR and prices can still be locally determined.

63. Retrospective price adjustments cannot be imposed by one party. The indicative tariffs will have been adjusted to remove the MFF. If these tariffs are used for commissioning purposes then a suitable adjustment to take account of the MFF will be required.

64. The indicative tariffs were released on June 16 2006 and can be found at the following address on DHs website;

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/NHSFinancialReformsArticle/fs/en?CONTENT_ID=4127039&chk=bypVXH

Adult Critical Care

65. During 2005/06 it was not possible for the NHS to start collecting the new data that is needed to support the critical care tariff. This data collection will commence on 1 April 2006. Therefore, 2006/07 will act as a shadow year for critical care. This will involve;

- Collecting and reporting Critical Care Minimum Data Set (CCMDS) as the basis for critical care activity contracting on a cost and volume basis with appropriate casemix adjustments
- Using HRGs as a casemix adjustment
- Using local prices to attach to casemix weighted activity.

66. 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 produce HRGs for adult critical care services (further work is being undertaken by the Health and Social Care Information Centre to develop HRGs for children's critical care services). A new dataset – the (CCMDS)- has been mandated for collection from 1st April 2006. This new data collection will support the new HRGs that have been developed for adult critical care services. The critical care HRGs apply to patients receiving level 2 or level 3 care.

67. In the future the tariff for adult critical care will be payable for patients receiving level 2 or level 3 care. Reimbursement will depend on the care received, rather than the designation of the bed or unit in which the patient receives care. Level 1 and Outreach Services will be funded as overheads to the critical care tariff.

68. Specialist burns units, spinal units and liver units should be excluded from the shadowing of the tariff in 2006/07. Liver and spinal patients in general units should be included in the shadowing of the tariff.

69. Each admission to critical care should be reimbursed separately and be the subject of a separate HRG.

70. Treatment of children in adult units should be funded using the adult critical care HRGs.

71. The shadowing should assume a fixed and variable funding model for adult critical care. Initially, the fixed element should be set at 80% of the expected level of critical care expenditure.

72. SLAs between commissioners and providers should specify an expected level of expenditure on adult critical care, derived from an expected level of casemix-adjusted annual activity.

73. The DSCNs relating to critical care are 01/2005 (HRGs) and 13/2005 (CCMDS). These set out the data requirements and describe the HRGs. The HRGs are based upon the total number of organs supported during a critical care stay. Reimbursement will depend upon the total number of organs supported, and the length of stay in critical care.

74. Cost weights derived from the HRG development work are to form the basis of a set of indicative tariffs for critical care. However, further work is required to validate these and these will not be made available for use during 2006/07.

75. From 2005/06 PCTs should have agreed SLAs with providers that are based on cost and volume commissioning. Casemix weighting will be possible for units that are able to begin collecting the minimum dataset from 1st April 2006. The cost and volume arrangements should include agreed local prices for each unit of activity (either bedday or per case basis). Fixed and variable funding arrangements should be used where PCTs would be expected to guarantee 80 per cent of the agreed SLA value and reimburse the additional 20 per cent in line with activity. Any activity above the agreed level will be reimbursed at 100 per cent of the agreed local tariff SLA activity levels should generally be in line with outturn. Where this is not the case there should be clear plans in place to manage the expected activity and a shared understanding of why activity is expected to deviate from outturn levels.

76. The CCMDS will 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 being 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.

Patient Transport Services

77. In 2006/07 PTS will be treated in the same way as 2005/06 contrary to 'Implementing payment by results Technical Guidance 2006/07: Executive Summary'. For details of flexibilities relating to PTS see paragraph 84.

Major new capital investment and PFI

78. Under PbR, tariff income will be the main funding source for Trusts, with additional local income being received from PCTs only for services outside of the tariff.

79. Over and above this, a central supplement, managed by the NHS Bank, has contributed to the revenue costs of capital development and we envisage that this existing support will continue for 2006/07. The following costs, associated with major new capital schemes (defined as those over £25m),will be covered:

- procurement costs up to a maximum of 2% of the capital value of the project
- support in the early years of operation equivalent to 2.5% of capital value in year 1, 2% in year 2, tapering to 0% over 5 years.

4. Local Flexibilities

80. The tariff is a fixed price and should not be subject to local negotiation. However, certain 'local flexibilities' are provided for under PbR guidance and should be used to support technical innovation and/or improved access to services in the interest of NHS patients. Such arrangements should only occur if they:

    - are agreed in advance and;
    - have agreed quantified outcomes and;
    - define who carries the financial risk if planned changes are not delivered with standard tariff applying in default.

Pass through payments

81. Pass-through payments are additional payments for use of a particular device, technology or drug and can be made to providers over and above the relevant tariff reimbursement. PCTs and providers must agree payment is intended primarily for new devices, drugs, treatments or technologies or to new applications of existing technology. However, there may be a limited number of technologies which may not be new but are:

    - Coded to a relatively high volume HRG where the activity within the HRG is heterogeneous in nature and;
    - Delivered in a limited number of centres and;
    - Of disproportionate cost relative to the HRG tariff.

82. Where the above three conditions are all met then PCTs can agree pass-through payment in the same way as for new technology.

83. For any pass-through payment arrangements, the following criteria and conditions should apply:

    - The pass-through arrangement should be fixed for a maximum period of 2 years only from the date at which the pass-through funding arrangement first applies (this could be mid-way through a financial year). The earliest date this could apply is 1st April 2005.
    - PCTs should have regard to the existing cost effectiveness evidence including any NICE guidance, health technology assessments (HTAs), DES evaluation reports or other relevant national guidance.
    - The price to be attached to the pass-through funding should be agreed in advance and the price 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.
    - If appropriate, the device, technology or procedure should be included on the NICE list of Interventional Procedures.

- PCTs should have due regard to the procurement arrangements for these drugs, devices, technologies or treatments identified as being suitable for pass-through funding.
- DH to be informed of these arrangements via PbRComms@dh.gsi.gov.uk

Patient Transport Services

84. In general, PTS is included within the tariff. However, in cases where PCTs are contracting PTS directly with PTS providers, a locally agreed adjustment should be made to the contract with the relevant healthcare provider.

Service redesign and application of the tariff

85. Local health communities are developing various local schemes that deliver services in new ways and in new settings. Examples include PCTs providing diagnostic services prior to attending out-patient appointments and hospital-at-home schemes following joint replacements. Over time, as more of the NHS changes care pathways and re-designs services, these changes will be captured in reference costs and tariff prices. Moreover, the version 4 HRGs planned for the future will help address these issues directly.

86. In the short-term, pathology, diagnostics and non-discrete rehabilitation remain "bundled" within the tariff prices rather than separately identified. The expectation is that commissioners should not have to pay twice for part of a care pathway. Where an alternative provider is used for part of a service that is included with a single tariff price, there are three potential arrangements that could apply: sub-contracting of activity at local price; tariff splitting; or unbundling. These arrangements are set out in more detail below:

i) ***Sub-contracting***
Where one part of the care pathway is commissioned **by a main provider** from another provider as part of an outpatient attendance or inpatient stay, the main provider is responsible for the remainder of the patient's care and they should be responsible for funding the unbundled element of the care pathway. There is no need for PCTs to split the tariff – the tariff that has been paid to the main provider will include all elements of the care pathway. The Trust is sub-contracting the activity and this is currently outside the scope of PbR and can be locally negotiated. This arrangement should be used to support policy on choice of scan, but does not apply to ISTC contracts. The use of sub-contracting ensures that money follows the patient, and the commissioning Trust is incentivised to be cost-effective in its use of other services.

ii) ***Tariff splitting***

Where the main provider has not been responsible for commissioning an element of the care pathway (eg. where they are delivered in primary care prior to referral) and in the case of ISTC contracts, the tariff should be split. [(i)] The tariff should be split using the indicative tariffs published for direct access services, where these are available. The tariff should be reduced by the direct access tariff or locally determined price multiplied by the average proportion of patients in the HRG/outpatient speciality requiring a test. For example:

- A PCT refers 100 patients to an outpatient speciality with a tariff of £200, 25 of which are expected to require a scan costing £160 (but which are carried out either by an ISTC or in primary care). The outpatient tariff can be reduced by 25/100 * £160 = £40, for the 100 patients to which the new pattern of provision applies. £4,000 is released from the acute provider to fund the tests.

iii) ***Unbundling based on length of stay***

Where services are being provided in a way that significantly reduces average length of stay compared to the national average for an HRG (eg. through step-down provision in a community hospital), then again the tariff can be split. For this purpose, 60% of the tariff is assumed to relate to length of stay, and can reduced by the proportion reduction in length of stay. For example:

- A PCT uses community hospital provision to reduce length of stay by 2 days from 10 days to 8 days, and this is significantly different to the national pattern of provision that is reflected in reference costs. The inpatient tariff is £1,000. The tariff can be reduced by 60% of 1,000 * 2/10 = £120.

(i) Note discrete episodes taking place solely for rehabilitation should be recorded with treatment function code 314. This ensures they can be eligible for funding under local prices rather than under the PbR tariff. Discrete rehab is effectively unbundled and the tariffs do not need to be split.

Emergency Readmissions

87. Unnecessary emergency readmissions should not attract full reimbursement if the provider did not provide sufficient quality of service or prepare patients adequately for discharge. Emergency readmissions have been recognised in the star ratings programme as a quality indicator for NHS trusts.

88. However, there are some services and groups of patients where open access arrangements are made. 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.

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

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

90. PCTs and providers should agree as part of SLA 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.

91. In the longer term, the intention is to find an appropriate way within HES data of flagging 'open access' or other ways of differentiating emergency readmissions from planned but unscheduled care.

Outpatient Multi-disciplinary attendances

92. In 2006/07 there is a new flexibility to negotiate a local price for multi-professional outpatient attendances. This includes multi-disciplinary or joint clinics where there are representatives from more than one specialty. This approach replaces the 2005/06 tariff approach whereby such attendances where paid at the tariff for the highest cost speciality plus half the tariff for the lowest cost speciality. Feedback suggested this approach was too rigid to recognise the way in which some services are being provided.

Outpatient Procedures

93. Where treatment is being delivered appropriately in an outpatient setting and the local cost of delivering this activity is more than twice the relevant specialty level tariff, the service can be funded at a locally negotiated rate. This is provided that it is with the agreement of both the provider and commissioner. This will apply to outpatient procedures other than those for which there are published tariffs (see para 43).

94. There may also be services that are either new or where the provider has been delivering the service in an outpatient setting. Where a provider is clearly delivering the service in a different setting compared with other providers and the local cost is more than twice the relevant specialty level tariff, the service can be funded at a locally negotiated rate. This can only happen with the explicit agreement of both provider and commissioner.

95. Should this approach be taken, the provider must record at least one diagnosis code and either an OPCS-4 procedure code or an outpatient HRG code (whichever best describes the procedure or investigation in question) in the Outpatient CDS record. This will ensure that commissioners can effectively monitor such occurrences and to inform both the next version of HRGs and future outpatient tariff arrangements.

Infectious Disease Isolation Units

96. Additional funding can be provided by PCTs for infectious disease isolation wards. The same arrangements as for the pass through flexibility applies.

5. Transitional Arrangements

Commissioner and Provider adjustments

97. Details of 2006/07 transitional and MFF adjustment for NHS providers and NHS commissioners were issued under cover of AWP(06-07)SHA15. This allocation working paper (AWP) confirmed the calculation of PbR provider and PbR commissioner transitional adjustments.

Market Forces Factor

98. AWP(06-07)SHA15 also confirmed the calculation of 2006/07 MFF adjustments for providers and commissioners. The funding associated with the MFF for PbR activity covered by the 2006/07 baseline exercise will be paid to Trusts from DH. PCTs will therefore pay the same tariff for the same activity to all providers they commission with, regardless of where they are located. An amount to reflect the MFF payments for 2006/07 will be removed non-recurrently from PCT baselines and paid directly to providers.

99. An AWP will be issued shortly giving details of how and when trust transitional payment and purchase orders and PCT RLA adjustments will be made.

100. For the 2006/07 national tariff the same market forces factor (MFF) as was used in 2005/06 is being retained. However, those providers whose MFF score was constrained by the 2% variation limit in 2005/06 will move toward their ‘target MFF’ subject to a further maximum 2% move. Only a small number of providers are not at their target MFF.

101. An AWP will be issued shortly giving details of how and when trust transitional payment and purchase orders and PCT RLA adjustments will be made.

6. Future scope of PbR

102. Currently, PbR extends to services provided by NHS Trusts and NHS Foundation Trusts. Further work is needed before PbR can be extended to other sectors, including the voluntary sector and the independent sector (IS).

103. This work will assess the different economic factors affecting each of the different sectors to inform the development of the national tariff in a way that is consistent with achieving a level playing field.

104. From the spring of this year a small number of IS providers will come within the scope of PbR with the introduction of the Extended Choice Network (ECN) which will offer greater choices to patients from NHSFTs and Wave 1 ISTC providers. In the Autumn of 2006 this will include IS providers who have bid under the phase 2 procurement to specifically be ECN providers.

105. As set out in *Health Reform in England: update and next steps* (Department of Health, December 2005), in Autumn 2006 we will publish proposals for developing PbR from 2007/08 and beyond.

7. Further information

106. Further information can be found at www.dh.gsi.gov.uk/paymentbyresults

107. Further details relating to the implementation of PbR will be issued via a series of technical papers. The appropriate NHS networks will be made aware of these upon release.