National tariff proposals for 2017/18 and 2018/19

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1. How to use this document

1. This engagement document seeks your views on certain proposals by NHS England and NHS Improvement[i] for changes to the national tariff, along with other proposals relating to the pricing system. The feedback we receive will be used to develop the proposals that we include in the statutory consultation on the next national tariff. The statutory consultation will take place later this year.

2. In this document we are engaging on national price relativities (the weighting of prices relative to each other) not the final level of proposed national prices.

3. This document includes the following sections:

    a. Policy proposals for the next national tariff, which we propose to set for two financial years (2017/18 and 2018/19).

    b. Changes to the currencies used to set national prices.

    c. Changes to the method used to calculate national prices.

    d. Changes to national variations.

    e. Changes to locally determined prices.

4. We may consider further changes to the national tariff outside of the policies contained within this document.

5. We have structured this document differently to previous years. Each proposed change is explained in a table. Where there is more than one change proposed to a policy, each change is presented in individual tables. We have moved all graphs and charts to the end of the document and added hyperlinks to aid navigation for readers on a computer or tablet. We have included all references as endnotes. There is no commentary contained in these notes.

6. Alongside this document, we have published the following.

Annexes and supporting documents
Preliminary assessment: National tariff proposals for 2017/18 and 2018/19
Annex A: National tariff workbook
Annex B: Price relativities response template
Annex C: Price setting models
Annex D: Rationale for adopting HRG4+ phase 3

[i] In this context, 'NHS Improvement' refers to Monitor, the body on which statutory national tariff functions are conferred by the Health and Social Care Act 2012 (the 2012 Act).

Annexes and supporting documents
Annex E: Developing the approach to setting the 2018/19 national tariff
Proposals for the 2017/19 national tariff: Further areas for specific policy development
Additional Information: Best practice tariff proposals for 2017/18 and 2018/19
Metrics engine
How mental health payment proposals support more efficient and effective care
How mental health payment proposals support better care

7. We have published an online survey to gather feedback on the proposals. This is available here: www.surveymonkey.co.uk/r/2017to2019NationalTariff

8. The deadline for feedback is **12:00 noon on 26 August 2016.**

9. To help you collate responses within your organisation, we have published a word version of the survey which is available on the same webpage as this document.

10. Please use the online system to provide feedback if possible, as this will help us to analyse your responses. If you are unable to use the online system you can download the word version of the form and email it to us at pricing@improvement.nhs.uk.

11. We intend to publish the responses to this engagement. If you are sending your response to us by email, and you do not want your name or your response shared, please include that at the top of your response.

2. Overview to our proposals

2.1. Background

13. In *Reforming the Payment System: Supporting the Five Year Forward View* NHS England and Monitor (now part of NHS Improvement) explained our vision for payment system reform based on new models of care and consistent improvements to currency design, the inputs to pricing and the methodology for setting prices.

14. Based on feedback from the service, we adopted an approach for 2016/17 that offered the service stability. We set a tariff based on prices that were in use by 88% of providers in 2015/16 with adjustments for efficiency, inflation and the Clinical Negligence Scheme for Trusts (CNST).

15. We believe that it is now appropriate to consider the introduction of some new policies to move the payment system towards the vision set out in *Reforming the Payment System*. However, we also believe that the changes we propose must not destabilise the service. This means that, where necessary, we may need to mitigate the impact of proposals on services.

16. We do not propose to change the principles used to determine national prices from previous years. Please see section 7 of the 2016/17 National Tariff Payment System statutory consultation[1] for further details.

2.2. Summary of our proposals

17. We are proposing two major changes this year.

    a. We propose to set a national tariff for two years. This would include two price lists, one for 2017/18 and the second for 2018/19.

    b. We propose to move from using HRG4 currency design to using phase 3 of HRG4+. HRG4+ is more detailed than HRG4, and better accounts for different levels of complexity. It also better reflects current clinical practice because the design is based on more recent cost and activity data. We propose to retain the same currency design for the second year.

18. We are proposing a number of other changes to complement the move to HRG4+ currency design. These include an update to top-up payments for specialised services, removing the interventional radiology best practice tariff (BPT), and adding four new national prices.

19. We propose to model prices for 2017/18 (based on HRG4+) by using the same method adopted by the Department of Health for the 2013/14 Payment by Results (PbR) tariff, with updated inputs and further adjustments. For the

second year of the proposed two year tariff (2018/19) we propose to roll these prices over with some adjustments.

20. We are considering options to limit financial volatility for providers and commissioners that may arise from a change of currency, or from inadequacies in costing data, particularly for orthopaedic services. We are working with clinicians and representative bodies to address this.

21. The prices published alongside this document are the prices for 2017/18 scaled to 2016/17 levels. This means we equalise the funds that would be paid for the same group of patients under both years' prices prior to overall adjustments (for example, for inflation or efficiency). This is to allow providers and commissioners to develop a clear understanding of how the proposals in this document would affect them when benchmarked against 2016/17 levels.

22. Our other proposals for currency design include updating the maternity pathway, updating the high cost drugs and devices lists, and introducing, changing and removing certain BPTs. We also propose to simplify the method for calculating BPTs. Again, we propose that these aspects of currency would remain the same in the second year of the tariff (2018/19).

23. For locally determined prices, we propose to require commissioners and providers to link a proportion of payment for mental health services to locally agreed quality and outcome measures or agree an alternative payment approach consistent with the rules for local pricing.

24. Prior to the statutory consultation, we will work with the service through our enhanced impact assessment to identify unplanned or undesirable effects from the proposals in this document. We will also continue to work with a range of stakeholders to develop final policies and resolve known issues with our proposals.

3. Proposal to set a national tariff for 2017 to 2019

26. During previous consultations on the national tariff and at engagement events on the payment system, providers and commissioners have consistently told us that they would like more predictability on the national tariff to aid long-term planning and investment.

27. We have listened to your feedback and considered options for providing greater certainty on the tariff in future years. The paper at Annex E, on developing the approach to setting the 2018/19 tariff, shows that we considered three options for achieving this. We have identified that our preferred option is to set a national tariff for two years (2017/18 and 2018/19).

28. The paper explains the options we assessed and why we prefer the two year tariff option. It also provides information on how we propose to deal with individual elements of the tariff (such as currency design, national variations) under each of the three options.

29. Sections 3.1 and 3.2 summarise the proposed changes, but should be read together with the paper at Annex E. We welcome your views on the proposals.

3.1. Proposal to set a tariff from April 2017 to March 2019

1. Existing policy	2. Proposed change
a. To date, NHS Improvement and NHS England have set the national tariff annually. We do this in a three stage process by: ○ engaging on the policies we propose to include in the statutory consultation ○ publishing a statutory consultation notice on the proposed tariff ○ publishing a national tariff.	a. We propose to set a national tariff that would last from April 2017 to March 2019. b. We propose to publish a statutory consultation on proposals for a national tariff covering 2017-19. This would include two price lists, one for 2017/18 and another for 2018/19, as well as a set of currencies, national variations and rules which would apply to both years.
3. Rationale	**4. What does this mean?**
a. Each year we receive feedback that the service does not have the certainty required at an early enough stage to plan effectively. b. Prices and policies would be set for two years, providing stability and certainty that could support strategic, long-term planning and investment. This approach would also remove the need to conduct a separate consultation on the 2018/19 tariff. c. We considered other options (see Annex E) and felt that they did not offer the level of certainty that the service expected or required.	a. We would propose two sets of prices, and rules and national variations that would apply for two financial years, in our upcoming statutory consultation on the national tariff.

3.2. Policy design for a two year tariff

1. Existing policy	2. Proposed change
a. Setting the national tariff annually allows us to review the policies each year. This includes policies on: ○ currency design, including best practice tariffs ○ the scope of national prices ○ local price setting rules ○ national variations.	a. The national tariff and its policies would be set for two years. b. We propose to publish two price lists, one for each financial year. The difference between the price lists would, for example, reflect adjustments for inflation, efficiency, CNST and service development. c. We are considering introducing a local pricing rule for 2017/2018 to support the introduction of payment models for Improving Access to Psychological Therapies (IAPT). Further details are set out below. Other than in respect of these proposals, we propose that the national tariff would be in the same form for both years. d. Where a transition path has been identified, for example, for top-ups for specialised services, we are considering how to implement this.
3. Rationale	**4. What does this mean?**
a. Setting a two year tariff would mean that any issues that arise would persist for two years. b. We would not be able to change or develop any aspects of tariff policies until the next statutory consultation, which would be for the 2019/20 tariff. c. However, we believe that the benefits of certainty outweigh the disadvantages at the present time.	a. National tariff policies and content would be set for two years. b. We would not be able to change any aspects of the national tariff until 2019/20 without consulting on, and introducing, a new national tariff.

4. Proposed changes to currency design and scope of prices

30. A currency is a unit of healthcare for which a payment is made. The currencies used for admitted patient care, outpatient procedures and A&E attendances are called Healthcare Resource Groups (HRGs). HRGs are clinically meaningful groups of diagnoses and treatments that may typically occur during a spell of care, and use similar levels of resources.

31. We propose to:

    a. Move to using phase 3 of the HRG4+ currency design for admitted patient care.

    b. Introduce national prices for cochlear implant procedures, complex computerised tomography scans, complex therapeutic endoscopic gastrointestinal tract procedures and photodynamic therapy.

    c. Make changes to the maternity pathway to update casemix assumptions.

    d. Add and remove items from the high cost drugs and devices lists to reflect changes in the market, clinical practice and HRG design.

32. The proposed introduction of HRG4+ is a significant change. We are proposing a number of associated changes, including changing the rates for top-up payments for specialised services (section 7.1), and removing the interventional radiology BPT. We are considering how to manage volatility that may arise.

4.1. Moving to HRG4+ phase 3 currency design

1. Existing policy	2. Proposed change
a. We currently use HRG4 currency design to set national prices. This currency design relies on cost and activity data from 2011/12. b. HRG4 currency does not reflect the latest clinical practice in terms of the mix of care that is delivered to patients and recent innovations in the way that services are delivered.	a. We propose to implement phase 3 of the HRG4+ currency design. Further information on the proposed change from HRG4 to HRG4+ can be found here.[2] b. HRG4+ phase 3 takes existing HRGs and splits them up to allow more levels of complexity. Figure 1 shows an example of this. c. HRG4+ phase 3 also introduces a complexity and comorbidity score to allocate the appropriate HRG to the relative complexity of treating the patient.
3. Rationale	**4. What does this mean?**
a. HRG4+ phase 3 provides a more granular currency design. This means it's better able to identify and pay for the resources used to treat patients with different levels of complexity. b. Moving to HRG4+ phase 3 would allow us to use the latest available data, from 2014/15, to set prices. c. We have evidence to show that data variation between providers for HRG4+ phase 3 is lower than for HRG4 or HRG4+ phase 2. This suggests that reference costs are better defined within HRG4+ phase 3. We have published a supporting document (Annex D) with our evidence. d. Introducing HRG4+phase 3 would be a big change. Retaining this design for 2018/19 would give certainty and stability to the service.	a. Moving to HRG4+ phase 3 would change the structure of national prices, chapters and subchapters. b. It is important that commissioners and providers consider the effect that this move would have on them. We welcome your feedback on these effects as part of this consultation. c. HRG4+ phase 3 would mean that providers are more accurately paid for the care they provide. The extra detail within this currency design would help providers to plan more effectively with commissioners to deliver better care for patients.

4.2. Changes to the scope of prices

1. Existing policy	2. Proposed change
a. National prices do not cover all healthcare services commissioned by the NHS. b. Each year NHS Improvement and NHS England must consider the scope of services that we consider should be priced nationally. c. National prices bring greater consistency to commissioning arrangements and provide a benchmark against which inefficient providers can reduce their costs. d. We will consider setting new prices where currency design and information quality allows us to group services together to form an HRG or to set prices to existing HRGs with no national price.	a. We propose to introduce four new national prices for the 2017-19 national tariff: ○ Cochlear implants (CA41Z, CA42Z) ○ Complex Computerised Tomography scans (RD28Z) ○ Complex therapeutic endoscopic, upper or lower gastrointestinal procedures (FZ89Z) ○ Photodynamic therapy (JC41Z, JC42A and JC42B). b. If we adopt a two year tariff, we would not review the scope of prices for 2018/19.
3. Rationale	**4. What does this mean?**
a. We believe that it is appropriate to introduce these prices to bring consistency to commissioning arrangements for these services. b. We engaged on the first three of these prices in 2016/17. The majority of responses we received supported introducing them. However, they were not introduced because of the decision to keep HRG4 in 2016/17. c. Following advice from the Health and Social Care Information Centre's (HSCIC) Expert Working Groups, we believe we have the information required to set prices for photodynamic therapy and that this is of sufficient quality.	a. Implementing these national prices would not create an administrative burden on the service as HSCIC would update the grouper so payments will be made automatically. b. Introducing new national prices for these services should reduce the burden related to locally agreeing these prices. c. Any decision to vary from the national prices would need to be made in line with the local pricing rules. d. If this proposal is accepted, it would continue to apply to the scope of prices in 2018/19.

4.3. Creating incentives to reduce inappropriate outpatient follow-ups

1. Existing policy	2. Proposed change
a. There are national prices for consultant-led outpatient attendances covering most Treatment Function Codes. b. Prices differentiate between first and follow-up attendances. c. Prices are the same whether the referral is by a GP or another source. d. Some outpatient procedures have separate prices.	a. We propose to change the way that consultant-led outpatient follow-up attendances are reimbursed. b. We will also consider how to encourage the use of the NHS e-Referral Service for GP outpatient referrals and more appropriate use of consultant to consultant referral routes. c. We propose to remove the nationally mandated prices for outpatient follow-ups and set a new local pricing rule under which providers and commissioners would agree a single payment for all outpatient follow-ups.
3. Rationale	**4. What does this mean?**
a. Providers are currently reimbursed for every consultant-led face-to-face first and follow-up outpatient attendance. There is no incentive to reduce inappropriate attendances or to move to new ways of providing outpatient care, such as by telephone, electronically or in groups. b. Removing the nationally mandated prices for outpatient follow-ups, and introducing a local pricing rule to agree a single price for all outpatient follow-ups, would create a strong incentive on providers to reduce unnecessary attendances.	a. The national prices for outpatient follow-ups would be removed. b. We would introduce a new local pricing rule to agree a single payment for each provider/commissioner contract for outpatient follow-ups. c. We would still publish non-mandatory prices that could be used to inform the development of local prices. d. We welcome your views on how the local pricing rule could be designed.

4.4. Updates to the maternity pathway

1. Existing policy	2. Proposed change
a. The maternity pathway[3] has three stages for payment: antenatal, delivery and postnatal. The antenatal and postnatal stages contain standard, intermediate and intensive levels, with higher prices for greater complexity. b. The price for each level is informed by our understanding of the mix of cases that are assigned to each level. c. In 2015, we collected updated casemix information that demonstrated that a higher proportion of cases are allocated to the intermediate and intensive antenatal pathway than we had assumed. This means that relative to each other, standard prices are higher, and intermediate and intensive prices lower, than they should be.	a. We propose to update the casemix assumptions for the antenatal stage of the maternity pathway to increase the activity allocated to intermediate and intensive levels. The allocation at standard level would be reduced. b. This would change the relative weightings between the standard, intermediate and intensive prices. The policy would not increase or decrease the total amount of money allocated to the antenatal stage. c. The proposed percentage changes to the casemix assumptions for antenatal care are shown in Table 1.
3. Rationale	**4. What does this mean?**
a. We consider it appropriate to update the assumptions to reflect new information. This would mean that providers are more accurately paid for the care they provide. b. We engaged on this policy in August 2015[4] and received significant support for this change. c. We also considered introducing a three-level payment structure for the delivery phase, rather than the current two-level structure, but consider that it is not yet ready to be introduced. d. The mapping of the NZ HRGs to the two part payment is shown in Table 2.	a. Income received by individual providers would be determined by their maternity casemix. b. If we adopt a two year tariff, there would be no updates or changes to the maternity pathway for 2018/19. c. Before publication of the next national tariff, we plan to review payment for maternity services, to ensure that it compensates providers for high quality care, while supporting commissioners to commission for personalisation, safety and choice. As with all nationally priced services, local variations can be made where there is agreement to move to alternative arrangements that benefit patients.

4.5. Changes to the high cost device list

1. Existing policy	2. Proposed change
a. The high cost devices list contains devices that are not subject to national prices but are negotiated locally in accordance with the rules on locally determined prices. b. These devices are not used consistently across all providers or for all procedures within a HRG. If they were included in national prices, they would create prices that overpay some providers and underpay others. c. There are currently 28 categories of devices on the list. d. The high cost devices group[5] considers whether to propose adding or removing devices from the list. Anyone can propose a device to be added to the list via the NHS England portal.[6]	a. We propose to remove 10 out of 28 categories of devices from the high cost list (shown in Table 3). b. We propose to remove all devices from the stents category, except for bifurcated stents. c. We propose to remove devices for percutaneous ablation procedure from the 'radiofrequency, cryotherapy and microwave ablation probes and catheters' category. d. We propose to clarify that the category for lengthening nails includes nails for limb reconstruction.
3. Rationale	**4. What does this mean?**
a. We consider this appropriate because the additional detail within HRG4+ phase 3 improves the identification of high cost devices by mapping them to an appropriate HRG. b. The high cost devices group reviewed requests for additions to the list and reviewed the current list for potential removals. As part of the manual adjustment process, the experts were asked if they believed the prices reflected the cost of the device. c. Where we have proposed to remove categories of devices, we would adjust the HRGs either through the calculation process or a subsequent manual adjustment.	a. High cost devices removed from the list will be reimbursed through national prices. b. Under this proposal, we would adjust the national tariff to make sure that payment for procedures using devices removed from the list reflects their cost. c. This list would not change in 2018/19.

4.6. Changes to the high cost drug list

1. Existing policy	2. Proposed change
a. The high cost drugs list contains drugs that are not reimbursed through national prices. The prices for these are negotiated locally in accordance with the rules on locally determined prices. b. These drugs are not used consistently across all providers or for all procedures within a HRG. If they were included in national prices, they would create prices that overpay some providers and underpay others. c. There are currently 344 drugs on the high cost list. d. A high cost drugs group considers whether to propose adding or removing drugs from the list. Anyone can propose a drug to be added to the list via the NHS England portal.[7]	a. We propose to add 2 drugs into existing categories on the list. b. We propose to add 9 new categories of drugs to the list. There are 10 drugs distributed across these categories. These are shown in Annex A. c. We propose to remove fibrin sealants from the blood products category.
3. Rationale	**4. What does this mean?**
a. The high cost drugs group reviewed requests for additions to the list and reviewed the current list for potential removals. These changes are based on the expert advice we have received from the high cost drugs group.	a. Drugs removed from the list would be reimbursed through national prices. b. Drugs added to the list would not be reimbursed through national prices but under local pricing rules. c. This list would not change in 2018/19.

5. Incentivising best practice through currency design

33. A best practice tariff (BPT) is an alternative currency and national price for a service that is designed to incentivise quality and cost-effective care. The price difference between best practice and usual care is calculated to create an incentive for providers to adopt best practice.

34. Clinicians and national clinical leaders have suggested areas where they felt the development of a BPT would benefit patients. In reviewing these suggestions we have considered the following criteria.

Criteria for best practice tariffs
Quality improvement
Clinical area and target population
Activity levels
Evidence base (eg NICE accredited guidelines)
Variation in current practice
Data source to support measurement of the BPT (eg clinical audit)
Affordability and cost impact
Impact on health inequalities
Implementation timelines
Risk of unintended consequences.

35. We are proposing to add 4 new BPTs, amend 4 existing BPTs and remove 1.

36. Unless otherwise stated, all new proposals for BPTs adopt the pricing methodology set out in Section 6.4.

37. We are also introducing an innovation and technology tariff to accelerate the adoption of new practice through the tariff.

38. We had planned to amend the scope of the BPT for early inflammatory arthritis to extend beyond the first year of care. Following discussions with the British Society of Rheumatology and the Health Quality Improvement Partnership, we have decided to postpone this. We will work to align the next stage of the BPT to the Rheumatoid and Early Inflammatory Arthritis National Clinical Audit.

39. NHS England has produced a document which provides information on the BPT changes being proposed (*Additional Information: Best practice tariff proposals for 2017/18 and 2018/19*). This is available at https://improvement.nhs.uk/resources/national-tariff-policy-proposals-1718-and-1819. Please note that if the service accepts the proposal to set a two year tariff, we would not make any further changes to BPTs until 2019/20.

5.1. New BPT for straight-to-test for patients requiring lower gastrointestinal investigation

1. Existing policy	2. Proposed change
a. 307,714 flexible sigmoidoscopies and 564,665 colonoscopies were undertaken in England in 2014/15. b. The cancer survival rate in England, including for bowel cancer, is poorer than in many comparable countries[8] and rates of endoscopy are much lower.[9] c. 20% of bowel cancers are diagnosed following a non-elective admission, when the disease is too advanced for a positive outcome.[10] d. Endoscopy is responsible for over 50% of all diagnostic breaches of the six week wait target.	a. We propose to introduce a pathway to offer diagnostic tests to patients without an initial outpatient appointment: ○ The GP refers the patient onto the two week referral pathway or six week diagnostic pathway. ○ The provider contacts the patient via a triage hub, aided by an algorithm, to decide on the most appropriate test. ○ If the approach is not suitable for the patient they would be referred for an appointment as normal. ○ Following the test, the diagnostic service is responsible for deciding the most appropriate clinical steps. b. We propose to assign the BPT price against colonoscopy and flexible sigmoidoscopy HRGs. The price may also take into account the number of triage appointments that will not progress to a diagnostic test.
3. Rationale	**4. What does this mean?**
a. This BPT would improve access to testing, enabling earlier diagnosis and treatment, and improving patient outcomes. Improved outcomes[11] and fewer outpatient appointments would save money.[12] b. Evidence from the NHS shows that straight to test pathways can reduce diagnostic and/or treatment waiting times for patients with colorectal cancer.[13] c. Evidence from Guy's and St Thomas'[14], Barts Health[15] and Dorset County Hospitals[16] show that straight to test pathways result in high patient and GP satisfaction.	a. Providers that do not achieve the best practice standard will receive less income for the service. b. If introduced this policy should improve efficiency and patient experience c. This would not cover CT pneumocolon and plain CT. We are unable to assign a BPT price for these services as they do not have specific national prices. We will continue to work with the National Casemix Office on this issue.

5.2. New BPT for chronic obstructive pulmonary disease (COPD)

1. Existing policy	2. Proposed change
a. COPD is a long term respiratory condition characterised by airflow obstruction that is not fully reversible. COPD causes 115,000 emergency admissions per year, 24,000 deaths per year and 16,000 deaths within 90 days of admission. Type 2 respiratory failure occurs in a quarter of COPD admissions. b. Specialist input, and adherence to evidence based care processes, have been shown to improve outcomes in the management of COPD exacerbations. However only 57% of COPD patients admitted to secondary care receive specialist input within 24 hours. Only 68% of providers report offering discharge bundles to patients.	a. We would like to encourage providers to improve the proportion of patients receiving specialist input within 24 hours and a discharge bundle prior to leaving hospital. b. We would consider best practice achieved when: ○ a percentage of patients with a primary diagnosis of COPD, admitted for an exacerbation of COPD, receive specialist input into their care within 24 hours of admission, and ○ where they receive a discharge bundle prior to discharge. c. We have not proposed a BPT target rate as we would like your feedback on this. Table 4 shows various options alongside current achievement rates. d. Table 5 shows the possible activities that could be included within a discharge bundle.
3. Rationale	**4. What does this mean?**
a. This policy would bring the management of COPD in line with NICE guidelines.[17] b. The COPD audit is a national dataset that can be used to collect data for the proposed BPT. c. Current compliance rates are so low that we believe it is necessary to set financial incentives to improve the care offered to COPD patients.	a. Providers that do not achieve the best practice standard will receive less income for the service. Compliance against the BPT would be measured through the national COPD audit. Commissioners and providers would need to use this dataset. b. Specialist input would be defined as 'a respiratory health professional deemed competent at reviewing and managing patients with acute exacerbation of COPD'. This is the same definition used by the COPD audit. c. We expect the BPT would require some providers to make investments to meet the target rate. We welcome feedback from the service on the impact of this aspect of the proposal.

5.3. New BPT for cardiac rehabilitation for myocardial infarction (MI)

Existing policy	**Proposed change**
a. Cardiac rehabilitation is a coordinated and structured programme designed to remove or reduce the underlying causes of cardiovascular disease. b. It is second only to aspirin and beta blockers in terms of cost effectiveness in the management of cardiovascular disease.	a. We propose to introduce a BPT to encourage providers to refer appropriate post-MI patients to cardiac rehabilitation within 3 days of an initiating event, and prior to discharge. b. The target population would be calculated locally. Actual referrals would be measured using the National Audit of Cardiac Rehabilitation. c. We propose a target achievement rate of 45%. d. Table 6 shows the primary diagnosis codes that would be eligible for the BPT, excluding ICD10 code I214. Table 7 shows the HRGs that would be covered by the BPT, where there is also a primary diagnosis from Table 6.
Rationale	**What does this mean?**
a. This policy is designed to encourage providers to bring practice into line with the NICE quality standard QS99. b. The target rate accounts for the fact that the method for calculating the total number of eligible patients is likely to overestimate the number of people needing cardiac rehabilitation. Not all MI patients will be eligible for cardiac rehabilitation due, for example, to poor health.	a. Providers that do not achieve the best practice standard will receive less income for the service b. Providers and commissioners would need to extract the target population. This should be calculated locally through the Secondary Uses Service (SUS), based on admissions, discharged to their usual place of residence, whose admission was an emergency admission with a primary diagnosis from Table 7. c. We expect that there would be an increase in referrals to cardiac rehabilitation services and we would work with the service to quantify this impact.

5.4. New BPT for non-ST segment elevation myocardial infarction (NSTEMI)

Existing policy	**Proposed change**
a. NSTEMI is a type of myocardial infarction generally caused by complete and persisting blockage of the coronary artery. b. According to the Myocardial Ischaemia National Audit Project (MINAP) database, there were 49,242 admissions for NSTEMI in 2013/14. c. NICE clinical guideline 94 states that timely access to angioplasty for NSTEMI patients is clinically effective and cost effective. Earlier angiography is likely to lead to earlier discharge.	a. We propose to introduce a new BPT for NSTEMI to improve the time from a patient being admitted to them receiving coronary angioplasty. b. We would measure achievement through the MINAP database. This collects data on time from admission to coronary angioplasty for NSTEMI patients. c. We propose to set a target rate of 60% of NSTEMI patients having coronary angiography within 72 hours of admission. d. For patients transferred from one hospital to another to have coronary angiography, the time for achieving the BPT would be calculated from the time of admission to the first hospital. e. The BPT would apply where the primary diagnosis on admission is ICD10 code I214 'acute subendocardial myocardial infarction'. Table 8 lists the HRGs within scope.
Rationale	**What does this mean?**
a. This policy is designed to create a financial incentive for providers to meet NICE clinical guideline 94. It would do this by paying a higher price for care that meets these standards relative to care that does not. b. Data shows that currently, 55% of NSTEMI patients (excluding transfers) receive coronary angiography within 72 hours of being admitted. This suggests that a BPT achievement rate of 60% is reasonable.	a. Providers that do not achieve the best practice standard will receive less income for the service b. This proposal could cause providers to incur additional costs to meet the BPT target. It would also create a small administrative burden in terms of monitoring and confirming compliance. c. The BPT would be flagged as it applies at a sub-HRG level to a group of HRGs. Providers should share trust-level MINAP data with commissioners so that progress can be monitored against the best practice criteria.

5.5. Changing the day case BPT by adding 19 procedures

Existing policy	**Proposed change**
a. The day case BPT aims to increase the proportion of elective activity performed as a day case, where clinically appropriate. b. It currently covers 15 procedures selected from the British Association of Day Surgery's (BADS) directory of procedures that are suitable for day case admissions. c. This directory contains a list of procedures alongside percentages that BADS considers could be delivered as day cases. d. The BPT is made up of a pair of prices for each procedure: one applied to day-case admissions and one applied to ordinary elective admissions. In all cases SUS PbR will automate payment of the appropriate price.	a. We propose to include a further 19 procedures within the day case BPT. b. Table 9 identifies these procedures alongside the average day case rate we have observed providers meeting, the rate that BADS considers is achievable, and our proposed rate at which providers would receive the BPT price in 2017/18 and 2018/19.
Rationale	**What does this mean for you?**
a. We consider it appropriate to add these 19 procedures to the BPT based on the guidance provided by the BADS directory. b. Day case procedures are safer and more convenient for many patients and performing more procedures as a day case helps providers to reduce pressure on inpatient beds. c. We are proposing rates below the BADS directory recommended rates, as we want to set a realistic target but also to encourage providers to move towards the BADS rates. We would seek to revise this target in future.	a. We have assumed a rate for each procedure that would be cost neutral across all providers. b. Providers achieving the BPT rate would receive a higher price for their activity than the current price. Those who do not achieve the BPT rate would receive a lower price than currently.

5.6. Changing the day case BPT by increasing the target rates for two procedures

Existing policy	**Proposed change**
a. The day case BPT aims to increase the proportion of elective activity performed as a day case, where clinically appropriate. b. It currently covers 15 procedures selected from the British Association of Day Surgery's (BADS) directory of procedures that are suitable for day case admissions. c. This directory contains a list of procedures alongside percentages that BADS considers could be delivered as day cases. d. The BPT is made up of two prices for each procedure. There is a higher price for day case admissions and a lower price for ordinary elective admissions.	a. We propose to increase the target rates for two procedures within the day case BPT: operations to manage female incontinence and tympanoplasty. b. Table 10 identifies the existing BPT target rate for these procedures and the proposed new rate at which providers would receive the BPT price in 2017/18 and 2018/19.
Rationale	**What does this mean for you?**
a. We have made this proposal as the observed rates are at, or close, to the target rate. The target rates are below the BADS rates and we consider that the service should continue to move towards the BADS rates. b. Day case procedures are safer and more convenient for many patients and performing more procedures as a day case helps providers to reduce pressure on inpatient beds.	a. Providers that do not achieve the target would not receive the best practice payment.

5.7. Changing the fragility hip fracture BPT

1. Existing policy	2. Proposed change
a. The fragility hip fracture BPT is an existing tariff that encourages providers to treat hip fracture patients in line with NICE clinical guideline CG124 and quality standard QS16. b. The purpose is to promote best practice across the care pathway from admission to discharge. c. The service has achieved two of the measures under the current design of the BPT. A further measure has been found to have limited clinical or prognostic value.	a. We propose to remove three measures from the existing BPT and replace them with four new measures: ○ A nutritional assessment during the admission. ○ Persistence with bone treatment after discharge. ○ A delirium assessment during the admission. ○ Assessed by physiotherapist the day following surgery. b. Tables 11 and 12 give more information on the measures we propose to remove and to add. c. We propose that the full BPT price would only be paid if all criteria are met and a follow-up appointment takes place 120 (+/-60) days after discharge.
3. Rationale	**4. What does this mean?**
a. We consider it appropriate to remove measures that have become standard clinical practice as no longer offer the desired incentive. b. In considering which measures to introduce we consulted clinical leads, the National Hip Fracture Database (NHFD) team and Healthcare Quality Improvement Partnership. c. The proposed new measures will encourage best practice and there is data available to measure performance.	a. Data on the new proposed measures would be collected by the NHFD. Providers and commissioners would need to use this data to validate achievement. b. The BPT would be paid in two stages: a standard price, followed by a top-up to achieve the BPT price once the criteria are met. This would include the follow-up appointment. c. We welcome your views regarding any issues that may arise, particularly in terms of payment reconciliation.

5.8. Changing the primary hip and knee replacement BPT to increase the National Joint Registry (NJR) compliance rate

1. Existing policy	2. Proposed change
a. The primary hip and knee BPT aims to link payment to outcomes that are important for patients by collecting patient reported outcomes measures (PROMs) and data submissions. b. Submitting data to the NJR will allow the service to make decisions about hip and knee replacement over the longer term by understanding the outcomes achieved by brand of prosthesis, hospital and surgeon. c. Providers ask patients for consent to submit their details to the NJR. The current criteria for payment requires providers to submit data in at least 85% of cases and to have an unknown consent rate of below 15%.	a. We propose to increase the NJR compliance rate from 85% to either 90% or 95%.
3. Rationale	**4. What does this mean?**
a. This proposal would benefit patients by improving the information that they, and their clinicians, have to make decisions about their care.	a. Providers would need to improve their engagement with patients in order to meet the new target for the BPT. b. Obtaining patient consent to submit their details to the NJR is part of the overall pre-surgery consent. Therefore, we don't believe this would place an additional burden on providers. c. The expected impact of this change can be seen in Table 13. d. We welcome feedback from the service regarding the appropriate rate.

5.9. Changing the primary hip and knee replacement BPT to change the health gain criteria

1. Existing policy	2. Proposed change
a. Information on a patient's health state is collected via PROMs. Patients use the Oxford Hip Score and Oxford Knee Score to report any change in their health status following a hip or knee replacement procedure. b. The data is collected at three intervals: before surgery, after surgery and after six months. When the provider has a minimum of 30 collected questionnaires then they can be plotted against other providers in a funnel plot using a statistical analysis. This can be seen in Figure 2. c. Providers are not currently eligible for the BPT price if their patients' average health gain is below the lower 99.8% level.	a. We propose to change the significance criteria for health gain by changing the rate below which providers will not be paid from the lower 99.8% significance to the lower 95% significance. This would reduce the number of providers that are eligible for the BPT. b. This change is shown in Figure 2.
3. Rationale	**4. What does this mean?**
a. We believe this is appropriate because it would help strengthen incentives for providers to deliver high quality outcomes for hip and knee replacement. b. This will set a challenging target for providers and create competition to achieve greater health gain for patients.	a. As the data is cumulative, payment must be made when there is enough data available. The data is provisional until finalised in each year after the end of the year. This means that provisional data is used for payment. b. The change in the BPT rate would reduce the number of providers eligible for the BPT. c. The expected impact on eligible providers is shown in Table 13.

5.10. Changing the same day emergency care (SDEC) BPT

1. Existing policy	2. Proposed change
a. The SDEC BPT is designed to encourage providers to treat patients in an ambulatory care setting, where appropriate. b. The NHS Institute's 'Directory of Ambulatory Emergency Care in Adults'[18] lists 49 clinical scenarios that can be managed in ambulatory emergency care. c. There are 19 clinical scenarios in the existing SDEC BPT.	a. We propose to make seven more clinical scenarios eligible for the SDEC BPT. These are: ○ Abnormal liver function ○ Acutely hot painful joint ○ Chronic indwelling catheter related problems ○ Gastroenteritis ○ Transient ischaemic attack ○ Upper gastrointestinal haemorrhage ○ Urinary tract infections b. Table 14 shows the specific HRGs covered by this proposal and Table 15 shows our proposed target rates.
3. Rationale	**4. What does this mean?**
a. Adding these clinical scenarios would improve the use of resources by treating appropriate activity as ambulatory care and freeing up beds for high-need patients. b. We identified the scenarios, based on clinical codes from the directory, to pick those with a significant proportion of activity between one and three days length of stay. c. From the 26 scenarios identified, we excluded any that had fewer than 10,000 units of activity, were related to maternity services, already in scope of an existing BPT and were, following clinical advice, deemed inappropriate. d. We also limited the HRGs to include only those with low complications and comorbidity scores in line with the existing BPT	a. If this proposal is implemented, providers would be expected to consider changing patient pathways within the new clinical scenarios. b. If implemented, local health economies should see a reduction in average length of stage and a decrease in inappropriate short stay admissions.

5.11. Removing the interventional radiology BPT

1. Existing policy	2. Proposed change
a. The interventional radiology BPT was introduced in 2011/12 to ensure more appropriate reimbursement for a set of interventional radiology procedures. b. We are proposing to introduce HRG4+phase 3 currency design. Within this design there is a greater level of detail for the services covered by the BPT. These can be found in subchapter YR.	a. We propose to remove the interventional radiology BPT. b. Table 16 shows how the procedures from the BPT map to HRGs in the new currency design.
3. Rationale	**4. What does this mean for you?**
a. The HRG4+ currency design contains currencies for interventional radiology that resolve the issue the BPT was introduced to address. b. The introduction of HRG4+ would remove the need for this BPT.	a. The change would be implemented automatically via the HSCIC grouper.

5.12. Introducing an innovation and technology tariff

1. Current situation	2. Proposal

• To date, the NHS has been relatively slow at introducing and spreading innovations in medical technology in a timely manner.
• The NHS currently encourages the development of innovation through the NHS Innovation Accelerator, the NHS test beds, and the Commissioning through Evaluation programme.[19]
• The NHS Innovation Accelerator currently has 17 initiatives in the 2015 programme. The NHS test beds have 7 projects. The Commissioning through Evaluation programme has 6 active schemes.
	• We propose to encourage the uptake and spread of technology by identifying potential innovations that we could encourage via the tariff.
	• We propose to assess innovations to fit into one of the following five categories:
	  ○ suitable for the high cost list
	  ○ suitable for a best practice tariff
	  ○ suitable for an adjustment to a national price or group of prices
	  ○ suitable for another tariff incentive
	  ○ not suitable for inclusion in the tariff.

3. Rationale	**4. What does this mean**
• Currently the method for introducing new innovations is through local variation agreement between providers and commissioners. The adoption of new technology is hindered by the need for a number of local negotiations before it is considered for tariff. • This new approach would provide a national mechanism for the adoption of suitable new technology. • We believe that the rapid adoption of new innovation will have a significant positive impact on patient care.	• We welcome feedback on our proposed approach to the implementation of the innovation and technology tariff. • During the proposed two year tariff, we will continue to seek examples of innovations that could be incentivised via the tariff. We will look to promote adoption of these innovations, for example, through the use of local variations.

6. Our proposed method for setting prices in 2017/18 and 2018/19

40. In 2016/17, we set national prices for the national tariff by applying adjustments for efficiency, cost inflation and CNST to the local prices agreed under the 2015/16 Enhanced Tariff Option (ETO). These prices had been modelled for the statutory consultation on the 2015/16 national tariff.

41. For 2017/18, we propose to model prices from reference costs rather than roll over an existing price model. We are also planning to:

    a. use 2014/15 reference costs and Hospital Episode Statistics (HES) data to set prices

    b. simplify the approach to modelling BPTs

    c. apply manual adjustments to modelled prices.

42. To set national prices for 2018/19 we are proposing to roll over 2017/18 prices with adjustments such as for inflation, efficiency and CNST.

43. For other aspects of the method, we propose to use the same approach as last year for modelling 2017/18 prices. We have not published our full proposals for these areas at this stage, but at present this includes:

    a. Cost uplifts in relation to inflation (see section 4.2.1 of the 2016/17 National Tariff Payment System).

    b. Adjustments for CNST. There are differences in the structure of the chapters between HRG4 and HRG4+ phase 3. But allowing for these, we propose to use the same methodology to determine the uplift. (See section 4.2.2 of the 2016/17 National Tariff Payment System).

    c. Efficiency. We propose to use the same method for setting the efficiency factor (see section 4.3 of the 2016/17 National Tariff Payment System).

44. We are considering how we would set the adjustments for prices for 2018/19.

45. We are not engaging on the elements of the method that determine final price levels at this stage. This includes our method for setting the final cost base. We will work on this policy before the statutory consultation.

46. The prices in this document have been scaled by reference to the total amount paid for nationally priced services in 2016/17. This allows for direct comparison of prices from one year to the next, so the sector can easily assess the impact of the proposals we have made in this document.

47. We recognise that a number of these policies may have a significant impact on services or providers in their current form. However, we are still developing the policies to determine the final price levels, which will include an approach to reduce financial volatility for providers and commissioners.

48. We realise that some providers may have concerns about the price relativities published alongside this document, particularly providers of orthopaedic services. We are working with clinicians and representative groups to understand the underlying issues with prices in orthopaedics, which appear to be caused by the systematic understatement of the costs of service provision in the way that costs are collected. In the short term, we are exploring how we might limit the impact of currency changes on revenue. We would like to clarify that this work is unrelated to the 'Getting It Right First Time' programme, which targets clinical efficiency.

49. To mitigate the impact of price changes in particular areas where this could destabilise services, we are proposing to limit the price change in some subchapters to 25% of the modelled change for that subchapter. These subchapters are H (orthopaedics), LD (renal dialysis), neonatal disorders (PB), chemotherapy (SB) and radiotherapy (SC). We propose to top-slice all other chapters to take account of this change. This means that the total amount of money allocated for payment under these scaled prices would be the same as in 2016/17.

6.1. Approach to modelling national prices for 2017/18

1. Existing policy	2. Proposed change
a. For 2016/17, we used locally varied prices agreed under the 2015/16 ETO with adjustments for efficiency, CNST and cost uplifts to set national prices. b. We adopted this approach to promote stability and to give the service the chance to focus on financial concerns. c. To do this, we retained HRG4 currency design and accepted that it was based on reference costs and activity data from 2011/12.	a. For 2017/18, we propose to model prices using the model initially proposed in 2016/17[20] with reference costs and Hospital Episode Statistics activity data from 2014/15. To determine final prices we would: ○ clean 2014/15 reference costs ○ model price relativities from costs and activity ○ adjust prices to 2016/17 levels ○ apply manual adjustments to prices ○ apply an adjustment to offset significant in-year volatility ○ adjust the final 2016/17 cost base ○ determine final price levels by making adjustments for efficiency, inflation and CNST.
3. Rationale	**4. What does this mean?**
a. We need a method for setting prices against the HRG4+ phase 3 currency design. The current model is an approach that the service is familiar with. b. This approach would allow us to use the latest costs and activity data. **c.** It would take at least two years to develop and test a new method for calculating prices with the service. This means that it's not possible to take this approach for the 2017/18 to 2018/19 tariff.	a. National prices for healthcare would be based on costs and activity data from 2014/15. b. The manual adjustments section contains more information on how we would offset data quality issues. c. We welcome any feedback you may have on this proposal.

6.2. Managing model inputs

1. Existing policy	2. Proposed change
a. For 2016/17, we used locally varied prices agreed under the 2015/16 ETO with adjustments for efficiency, CNST and cost uplifts to set prices. b. This means that we did not use reference costs and activity data as an input into the 2016/17 tariff although it informed the price list that it was based on.	a. We propose to use costs from the 2014/15 reference cost collection and activity data from the 2014/15 HES collection. b. We propose to clean the cost data by removing: ○ Outliers from the raw dataset detected using a statistical outlier test known as the Grubbs test. ○ Providers who submitted reference costs more than 50% below the national average for more than 25% of HRGs and who also submitted reference costs 50% higher than the national average for more than 25% of HRGs. ○ Providers who submitted reference costs containing more than 75% duplicate costs across HRGs and departments.
3. Rationale	**4. What does this mean?**
a. When we began the modelling process, the latest available reference costs and activity data were from 2014/15. b. The 2014/15 reference cost collection was designed to support HRG4+. c. The data cleaning approach is based on methodology proposed in a report that we commissioned from Deloitte.[21] We do not propose to adopt all of the methodology, particularly where there are technical issues or where we would exclude too many providers.	a. More recent data, with a method for reducing some of the issues within costs, should improve the accuracy of prices. b. We would manage any remaining quality issues with reference costs by making manual adjustments to fix price relativities.

6.3. Manual adjustments to relative prices

1. Existing policy	2. Proposed change
a. The national prices determined in 2016/17 included manual adjustments that had been made in proposing those prices as part of the statutory consultation on the 2015/16 national tariff. b. To mitigate the poor quality of reference cost data we test price relativities with the HSCIC expert working groups (EWGs), clinicians that use these HRGs on an ongoing basis. Where changes are recommended we make manual adjustments.	a. We have proposed a number of manual adjustments to price relativities, based on feedback we received, for example in workshops with clinicians. b. We have made a limited number of manual adjustments to trimpoints where prices were expressly equalised across specific settings, other than that we have only made adjustments to trimpoints if specifically requested (note: there were no such requests at this time). c. We are publishing the proposed manual adjustments in Annex B. The service is asked to provide further feedback on illogical or inappropriate price relativities. d. We have also made some adjustments at subchapter level to mitigate the impact of the proposed changes in national prices.
3. Rationale	**4. What does this mean?**
a. The use of dedicated engagement including workshops with EWGs will improve the quality of the manual adjustments recommended by allowing expert clinicians to reach a consensus on each change proposed. b. The EWGs do not comprehensively represent the clinicians or wider expertise within a specialty. By providing the wider service with an opportunity to comment we believe that further appropriate adjustments can be made.	a. The prices published this year should be a more accurate representation of the relative resource use between procedures. b. These price relativities would not change from 2017/18 to 2018/19. There would be no further manual adjustments made for 2018/19.

6.4. Simplifying the method for setting prices for BPTs

1. Existing policy	2. Proposed change
a. When a BPT is introduced, we develop a new model to calculate the price. At present there are 17 BPTs, each with its own price calculation model. b. These models must be updated when we set the national tariff each year. Some of these models are very complex, meaning that a disproportionate amount of resource is required to update BPT prices.	a. We propose to simplify and standardise the method for setting prices for BPTs by: ○ Using the modelled price without adjustments as the starting point. ○ Setting a fixed differential between the BPT and non-BPT price (either a percentage or absolute value). ○ Setting an expected compliance rate that would be used to determine final prices. This would reflect our expectations of compliance at a national level. At this rate, the BPT would not add to or reduce the total amount paid to providers at an aggregate level. b. We propose to apply this method to all but eight BPTs, which are shown in Table 18.
3. Rationale	**4. What does this mean?**
a. Simplifying the method for calculating BPTs would reduce the time it takes to calculate national prices. b. We have made assumptions about compliance rates based on the best available evidence in each case.	a. If providers do not achieve the BPT, then they will receive the lower price. If they achieve it then they will receive the higher price b. If the assumptions we have made on compliance rates are very different to actual rates, the amount paid may impose a cost pressure on commissioners or providers. A cost pressure on providers would act as an incentive to achieve best practice. c. This proposal would reduce the non-BPT price compared to the normal HRG price. This creates the incentive to deliver best practice care.

6.5. Proposed method for a two year tariff

1. Existing policy	2. Proposed change
a. To date we have proposed to publish the national tariff annually**.**	a. We propose to publish a national tariff to cover 2017/18 and 2018/19. For the 2018/19 financial year, we propose to model prices using the 2017/18 price list as a base and then: ○ determining final price levels by applying adjustments for expected efficiency, inflation and CNST ○ adjusting the method for setting inflation, efficiency and CNST to base them on longer term projections rather than the most recent available data. b. We are considering how any approach to managing volatility would transition into 2018/19.
3. Rationale	**4. What does this mean?**
a. We could model two sets of prices but as the starting point for modelling would be the same costs, we believe that it is simpler to use the 2017/18 price list and adjust as necessary. b. We believe it is appropriate to change the method for efficiency, inflation and CNST because the current method is based on more recent data, for example, pay settlements or clinical negligence. c. We believe it is appropriate to include transitions within the method for calculating prices for 2018/19, to move the service towards full adoption of specialist top-ups and prices under HRG4+.	a. Forecasting inflation is tricky. There is a possibility that any inflation figures we set in 2016 for 2018 will not be accurate. b. Under this approach, it would not be possible to make changes to the policies for the second year of the two year tariff without consulting on, and introducing, a new national tariff. c. National prices for healthcare for 2018/19, as well as 2017/18, would be based on costs and activity data from 2014/15.

7. National variations

50. For the 2017-19 national tariff, we are considering changes to one national variation: top-up payments for specialised services.

51. We propose to retain the existing approach for the following national variations:

    a. market forces factor

    b. 30 day readmission rule

    c. marginal rate emergency rule

    d. primary hip and knee

7.1. Top-up payments for specialised services

1. Existing policy	2. Proposed changes
a. Specialised services are accessed by comparatively few patients from a small number of providers with the right expertise. They are relatively expensive and account for around 14% of the total NHS budget. b. Top-up payments for specialised services were introduced in 2005 to reflect the additional costs of complexity. Table 18 shows the current top-ups. c. Our proposal to move to HRG4+ phase 3, combined with new definitions for specialised services,[22] changes the need for top-up payments.	a. We propose to: ○ Move to top-ups based on the Prescribed Specialised Services (PSS) definition of specialised services (Table 19). ○ Move to top-up payments for 2017/18 that adopt the recommendations from the University of York.[23] ○ Mitigate the impact by transitioning to the new rates over four years for services that would lose income from the new rates. Other rates will be scaled pro-rata to maintain a total payment amount of around £415 million.
3. Rationale	**4. What does this mean?**
a. We have reviewed specialised top-ups to reflect the new specialised service definitions and the HRG4+ currency design. b. This change would use the latest reference costs and HES data, and a methodology developed by the University of York with input from the service and the Specialist and Complex Care Advisory Group. c. Moving straight to the new top-up rates could destabilise providers. We are also analysing how complexity is captured by the national tariff. As we will not conclude this analysis in time for proposals to be included for the 2017 to 2019 national tariff, we believe that is appropriate to transition to the new top-up levels.	a. If we moved straight to the PSS flags the total top-ups would increase from about £320 million to about £415 million. Given the other changes proposed within the system, we consider it appropriate to transition areas that see significant reductions under the new approach (paediatrics and orthopaedics) over a period of four years. b. We remain committed to exploring the reasons for cost variation in specialised and complex care with the service, and to develop policies that address your concerns. c. We would move to the second year of the transition path for 2018/19.

8. Locally determined prices

52. We propose to make changes to the arrangements for locally determined prices in 2017/18 by requiring mental health commissioners and providers to agree contracts based on episode of care or capitation.

53. We propose no other changes at this stage, but we are reviewing policies that relate to local modifications and locally determined prices and may consult on further proposals at a later stage. If we adopted a two year tariff as we propose, the rules for local pricing and the method for local modifications would be the same for 2017/18 and 2018/19.

54. As part of the development of new models of care we are looking to develop local variation templates:

    a. To support changes to the way emergency care is provided locally. The local variation would support moving towards a payment approach where providers and commissioners would agree an overall level of activity and spend on emergency activity that could be overlaid with a gain and loss share. Payment would also be linked to achieving system wide quality and outcomes metrics decided locally and aligned with Sustainability and Transformation Plan (STP) objectives.

    b. To support CCGs in commissioning evidence-based services from care homes that help to reduce admissions to hospital.

    c. For mental health services to align incentives between secondary and tertiary services.

    d. For advice and guidance from a consultant to a GP.

55. Any local variation would need to be agreed by providers and commissioners. To assist these local agreements, we will look to develop a template that local organisations could use or adapt based on individual circumstances. More detail of this local variation would be published alongside the statutory consultation.

8.1. Mental health payment proposals

1. Existing policy	2. Proposed change
a. Payment for mental health services is subject to local payment arrangements. b. In the 2016/17 national tariff we required providers to move away from poorly specified contracts. c. In October 2015 we engaged on the adoption of new payment approaches, capitation or episode of care, and the response from the service suggested that there was a desire to adopt these approaches but that they were not ready for implementation in April 2016. d. A payment model for IAPT services is available for local adoption.[24] Further testing of the payment models for IAPT services continues.	a. We propose to change the local payment rules for mental health to link prices to locally agreed quality and outcome measures and the delivery of access and waits standards. b. We propose to require local use of one of the following options: ○ Episode of treatment or year of care, as appropriate to each mental healthcare cluster. ○ Capitation, informed by care cluster data and other evidence, or ○ An alternative payment approach consistent with the rules for local pricing and existing policy to move away from poorly specified and evidenced contracts. c. We propose to mandate the use of the IAPT payment model from April 2018.
3. Rationale	**4. What does this mean?**
a. Linking payment to the achievement of outcomes will encourage providers and commissioners to deliver safe and effective care that is in the best interest of patients. b. We believe that these proposals offer the service a balance between flexibility over local payment development to meet local needs and national payment system reform to support transformation of care.	a. When moving to any new payment approach providers and commissioners should consider managing change by developing an MOU and risk sharing agreement. b. We welcome feedback on the proposal to mandate the payment model for IAPT services from April 2018. c. These proposals do not include CAMHS or Secure & Forensic services, as currencies for these areas are under development and will be covered by separate arrangements. Providers and commissioners may choose to include these services within the scope of one of the payment approaches – consistent with the Local Payment Rules and principles. d. There would be no further changes to the rules for 2018/19.

9. Changes outside of the scope of national prices

56. Alongside the national tariff we also publish non-mandatory prices and non-mandatory currencies. These are intended to inform local negotiation under the local payment rules.

57. We publish this information for two main purposes:

    a. To enable testing as part of the development of potential national prices. This allows us to seek feedback from the service and to understand any issues with currency design and cost collection before mandating these changes.

    b. To offer the service a starting point in local price setting when we do not have appropriate information to set mandatory prices.

58. The following section contains our proposed changes to non-mandatory currencies and non-mandatory prices.

59. Non mandatory currencies and prices will not be included within the national tariff document. This means that changes could be made to non-mandatory currencies or non-mandatory prices during the period that the proposed two year tariff would be in force.

9.1. New non-mandatory prices for national currencies

1. Existing policy	2. Proposed change
a. We are not confident that we have enough information to set a national price in some areas. But we recognise that there would be benefit in setting a non-mandatory price that local health systems could use. b. Setting a non-mandatory price will give us the opportunity to seek feedback from the service ahead of any proposal to introduce a new mandatory price.	a. Introduce non-mandatory prices for the following treatment function codes (TFCs): ○ TFC317 – allergy ○ TFC331 – congenital heart disease service. ○ TFC323 – spinal cord injury b. Introduce non-mandatory prices for the following HRGs: ○ LE02A – peritoneal dialysis for acute kidney injury ○ LA01, LA02, LA03, LA10Z , LA11Z, LA12A, LA13A, LA14Z LA46Z – renal transplantation. c. Introduce a non-mandatory price for HIV outpatients with data collected and validated by Public Health England
3. Rationale	**4. What does this mean?**
a. We proposed to introduce a mandatory price for LE02A in 2016/17, but feedback suggested that reference costs were not of sufficient quality to do so. With a non-mandatory price we can receive feedback while we seek to understand the issues with reference costs. b. The non-mandatory price for renal transplantation is based on reference costs and bottom up costing. We propose to introduce a non-mandatory price to ensure that the approach can be implemented practically and to give providers the chance to test its impact. c. Due to concern about variation in service at the eight major spinal cord injury centres we have developed a clinical currency and are proposing a non-mandatory price.	a. Non-mandatory prices are not national prices, and their use is not required by the national tariff. Providers and commissioners would still need to agree a price locally, in line with the rules for local pricing. b. Providers would be required to submit completed local pricing templates for these currencies. c. We would seek feedback from providers and commissioners over the course of the year regarding the appropriateness of these prices. d. If we adopt a two year tariff, introduction of new national prices in these areas would not take place until 2019/20. In the interim, we may consider changes to the non-mandatory price for 2018/19 in response to feedback.

9.2. New non-mandatory currencies

1. Existing policy	2. Proposed change
a. We would make non-mandatory currencies available for services where we would like to test the currency design before implementing mandatory currencies. b. Where we do this, we will seek feedback and evidence from the service on whether the currencies are appropriate. c. We may pilot a set of currencies with a small group of providers before making these available to the wider service. d. In 2015 we ran pilots of wheelchair service currencies and palliative care currencies.	a. We propose to introduce non-mandatory currencies for ○ Wheelchair services (Table 20) ○ Palliative care (Figure 3) ○ Prosthetics ○ Cleft lip and palate ○ Paediatric critical care ○ Bone marrow transplant. b. In addition, we will investigate the possibility of developing an outcome-based non-mandatory currency for IVF services which could be made available for use locally.
3. Rationale	**4. What does this mean?**
• We consider it appropriate to introduce non-mandatory currencies in this way for the service to test. • The feedback we receive will determine the future of currency design for these services.	a. Non-mandatory currencies are not subject to the national tariff. Providers and commissioners would still need to agree a price locally, in line with the rules for local pricing in section 6 of the national tariff. b. We will seek feedback from providers and commissioners over the course of the year regarding the appropriateness of these currencies. c. If we adopt a two year national tariff, the introduction of a new mandatory currency in these areas would not take place until 2019/20. In the interim, we may consider changes to the non-mandatory currency for 2018/19 in response to feedback.

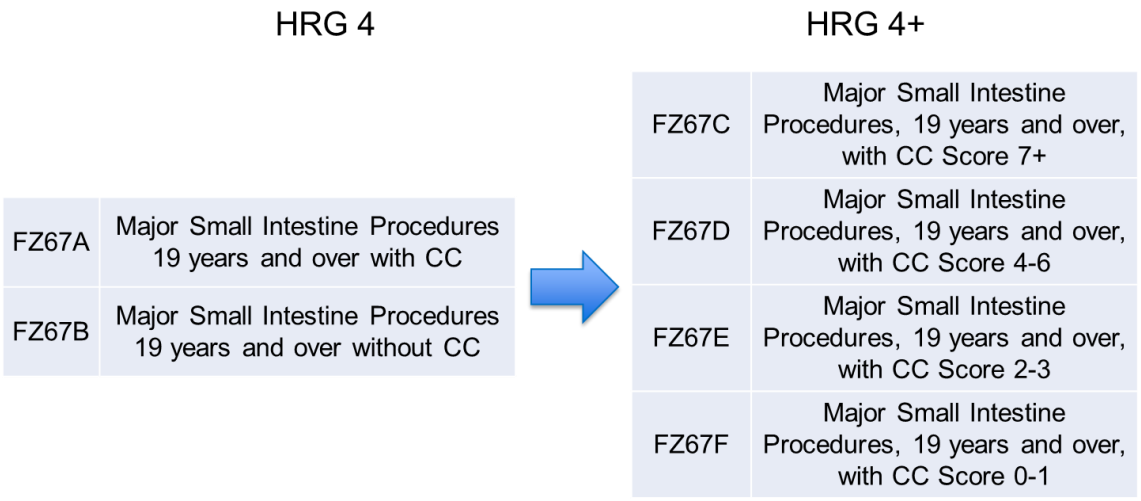
9.3. Removing the non-mandatory cataracts BPT

1. Existing policy	2. Proposed change
a. The cataract BPT was introduced to encourage the provision of a streamlined pathway, to improve patient experience and encourage efficient care. The pathway is in line with the Royal College of Ophthalmologists' guidelines[25]. b. The cataracts BPT applies to adults only. The price applies to the entire elective cataract pathway by covering the sum of the costs of the individual outpatient attendances as well as the surgical procedure. c. Because of low uptake and the issues with implementation, this was made non-mandatory in 2013/14.	a. We propose to completely remove the non-mandatory cataracts BPT. b. If providers and commissioners have successfully implemented it and wish to retain it, they can do so.
3. Rationale	**4. What does this mean?**
a. There is low uptake for this BPT. This is because the data required to process the BPT was not collected and processed automatically, and requires providers and commissioners to reach local agreement. b. Because of the low uptake, we believe that there is no longer a purpose in retaining the non-mandatory BPT.	a. Commissioners and providers are still able to agree a pathway for cataracts locally. Because of the low uptake of the existing policy we believe it will have a limited impact on the service.

10. Figures and tables

10.1. An example of moving to HRG4+ currency design

Figure 1: Taking account of complexity and comorbidities in HRG4+



To return to the proposal to move to HRG4+ please click here.

10.2. New to the maternity pathway

Table 1: Casemix assumptions for antenatal care

Pathway	Current allocations	Allocations based on proposed changes
Standard	65.5%	50.0%
Intermediate	27.3%	38.7%
Intensive	7.1%	11.3%

Table 2: Mapping the new currency design to the delivery stage of the maternity pathway

HRG	Description	Current Mapping
NZ30A	Normal Delivery with CC Score 2+	with CC
NZ30B	Normal Delivery with CC Score 1	with CC
NZ30C	Normal Delivery with CC Score 0	without CC
NZ31A	Normal Delivery, with Epidural or Induction, with CC Score 2+	with CC
NZ31B	Normal Delivery, with Epidural or Induction, with CC Score 1	with CC
NZ31C	Normal Delivery, with Epidural or Induction, with CC Score 0	without CC
NZ32A	Normal Delivery, with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 2+	with CC
NZ32B	Normal Delivery, with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 1	with CC
NZ32C	Normal Delivery, with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 0	without CC
NZ33A	Normal Delivery, with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 2+	with CC
NZ33B	Normal Delivery, with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 1	with CC
NZ33C	Normal Delivery, with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 0	without CC
NZ34A	Normal Delivery, with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 2+	with CC
NZ34B	Normal Delivery, with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 1	with CC
NZ34C	Normal Delivery, with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 0	without CC
NZ40A	Assisted Delivery with CC Score 2+	with CC
NZ40B	Assisted Delivery with CC Score 1	with CC
NZ40C	Assisted Delivery with CC Score 0	without CC
NZ41A	Assisted Delivery, with Epidural or Induction, with CC Score 2+	with CC

HRG	Description	Current Mapping
NZ41B	Assisted Delivery, with Epidural or Induction, with CC Score 1	with CC
NZ41C	Assisted Delivery, with Epidural or Induction, with CC Score 0	without CC
NZ42A	Assisted Delivery, with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 2+	with CC
NZ42B	Assisted Delivery, with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 1	with CC
NZ42C	Assisted Delivery, with Epidural and Induction, or with Post-Partum Surgical Intervention, with CC Score 0	without CC
NZ43A	Assisted Delivery, with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 2+	with CC
NZ43B	Assisted Delivery, with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 1	with CC
NZ43C	Assisted Delivery, with Epidural or Induction, and with Post-Partum Surgical Intervention, with CC Score 0	without CC
NZ44A	Assisted Delivery, with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 2+	with CC
NZ44B	Assisted Delivery, with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 1	with CC
NZ44C	Assisted Delivery, with Epidural, Induction and Post-Partum Surgical Intervention, with CC Score 0	without CC
NZ50A	Planned Caesarean Section with CC Score 4+	with CC
NZ50B	Planned Caesarean Section with CC Score 2-3	with CC
NZ50C	Planned Caesarean Section with CC Score 0-1	without CC
NZ51A	Emergency Caesarean Section with CC Score 4+	with CC
NZ51B	Emergency Caesarean Section with CC Score 2-3	with CC
NZ51C	Emergency Caesarean Section with CC Score 0-1	without CC

To return to the proposal to update the maternity pathway please click here.

10.3. Changes to the high cost device list

Table 3: Changes to the high cost device list: Device categories proposed for removal

Device name	HRG to be change	How the change will be processed
3 dimensional mapping and linear ablation catheters used for complex cardiac ablation procedures	EA29A, EA29B and EA29C - Percutaneous Complex Ablation, including for Atrial Fibrillation and Ventricular Tachycardia	Manual Adjustment
Radiofrequency, cryotherapy and microwave ablation probes and catheters – for cardiac only.	EA29A, EA29B, EA29C - Percutaneous Complex Ablation, including for Atrial Fibrillation and Ventricular Tachycardia	Manual Adjustment
Aneurysm coils	Chapter AA	Manual Adjustment
Carotid, iliac and renal stents	Various	Manual Adjustment
Cochlear Prosthesis	Chapter C	Manual Adjustment
Consumables for robotic surgery	Chapter LB	Manual Adjustment
Deep brain, vagal, sacral, spinal cord and occipital nerve stimulators	Chapter AY and YQ	Manual Adjustment
Endovascular stent graft	Chapter Y	Manual Adjustment
Flow diverters for intracranial aneurysms	Chapter AA	Manual Adjustment
Intracranial stents	Chapter AA and Y	Manual Adjustment
Percutaneous valve repair and replacement devices	Chapter E	Manual Adjustment

To return to the proposal to change the high cost device list please click here.

10.4. New BPT for chronic obstructive pulmonary disease (COPD)

Table 4: Options for the BPT compliance rate

Specialist input rate	Percentage of providers meeting criteria (specialist input)	Percentage of providers meeting criteria (specialist input and discharge bundle)
60%	35%	28%
65%	26%	21%
70%	21%	16%
75%	11%	8%

Table 5: Possible activities within a discharge bundle[26]

Activity
Inhaler technique checked and medications reviewed
Written self-management plan and emergency drug pack in place, where appropriate
Smoking status and assistance to quit where appropriate
Suitability for pulmonary rehabilitation assessed and PR offered, where appropriate
Follow-up (by phone or in person) within 72 hours of discharge

To return to the proposal to introduce a new BPT for COPD please click here.

10.5. New BPT for cardiac rehabilitation for myocardial infarction (MI)

Table 6: ICD10 primary diagnosis codes

ICD10 code	Description
I210	Acute transmural myocardial infarction of anterior wall
I211	Acute transmural myocardial infarction of inferior wall
I212	Acute transmural myocardial infarction of other sites
I213	Acute transmural myocardial infarction of unspecified site
I214	Acute subendocardial myocardial infarction
I219	Acute myocardial infarction, unspecified
I220	Subsequent myocardial infarction of anterior wall
I221	Subsequent myocardial infarction of inferior wall
I228	Subsequent myocardial infarction of other sites
I229	Subsequent myocardial infarction of unspecified site

Table 7: HRGs that would fall in scope of the cardiac rehabilitation for MI BPT

HRG	Description
EB10A	Actual or Suspected Myocardial Infarction, with CC Score 13+
EB10B	Actual or Suspected Myocardial Infarction, with CC Score 10-12
EB10C	Actual or Suspected Myocardial Infarction, with CC Score 7-9
EB10D	Actual or Suspected Myocardial Infarction, with CC Score 4-6
EB10E	Actual or Suspected Myocardial Infarction, with CC Score 0-3
EY40A	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 12+
EY40B	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 8-11
EY40C	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 4-7
EY40D	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 0-3
EY41A	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 12+
EY41B	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 8-11
EY41C	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 4-7
EY41D	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 0-3
EY42A	Complex Cardiac Catheterisation with CC Score 7+
EY42B	Complex Cardiac Catheterisation with CC Score 4-6
EY42C	Complex Cardiac Catheterisation with CC Score 2-3
EY42D	Complex Cardiac Catheterisation with CC Score 0-1
EY43A	Standard Cardiac Catheterisation with CC Score 13+
EY43B	Standard Cardiac Catheterisation with CC Score 10-12
EY43C	Standard Cardiac Catheterisation with CC Score 7-9
EY43D	Standard Cardiac Catheterisation with CC Score 4-6
EY43E	Standard Cardiac Catheterisation with CC Score 2-3
EY43F	Standard Cardiac Catheterisation with CC Score 0-1

To return to the proposal to introduce a new BPT for cardiac rehabilitation for MI please click here.

10.6. New BPT for non-ST segment elevation myocardial infarction (NSTEMI)

Table 8: HRGs that would fall in scope of the NSTEMI BPT

HRG	Description
EY40A	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 12+
EY40B	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 8-11
EY40C	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 4-7
EY40D	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 0-3
EY41A	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 12+
EY41B	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 8-11
EY41C	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 4-7
EY41D	Standard Percutaneous Transluminal Coronary Angioplasty with CC Score 0-3
EY42A	Complex Cardiac Catheterisation with CC Score 7+
EY42B	Complex Cardiac Catheterisation with CC Score 4-6
EY42C	Complex Cardiac Catheterisation with CC Score 2-3
EY42D	Complex Cardiac Catheterisation with CC Score 0-1
EY43A	Standard Cardiac Catheterisation with CC Score 13+
EY43B	Standard Cardiac Catheterisation with CC Score 10-12
EY43C	Standard Cardiac Catheterisation with CC Score 7-9
EY43D	Standard Cardiac Catheterisation with CC Score 4-6
EY43E	Standard Cardiac Catheterisation with CC Score 2-3
EY43F	Standard Cardiac Catheterisation with CC Score 0-1

To return to the proposal to introduce a new BPT for NSTEMI please click here.

10.7. Changing the day case BPT by adding 19 procedures

Table 9: Proposed new day case BPTs

Clinical Area	BADS rate	Current observed rate	Proposed BPT target rate
Day Surgical Procedures			
Anterior or posterior colporrhaphy	40%	7%	20%
Autograft anterior cruciate ligament reconstruction	40%	26%	40%
Biopsy / sampling of cervical lymph nodes	80%	71%	80%
Creation of arteriovenous fistula for dialysis	80%	60%	70%
Dacryocysto-rhinostomy including insertion of tube	90%	64%	75%
Endoscopic insertion of prosthesis into ureter	90%	47%	60%
Endoscopic resection / destruction of lesion of bladder	50%	9%	20%
Excision biopsy of lymph node for diagnosis (cervical, inguinal, axillary)	80%	64%	80%
Excision of lesion of parathyroids	30%	10%	20%
Implantation of cardiac pacemaker	90%	34%	45%
Laparascopic Oophorectomy and salpingectomy (including bilateral)	70%	17%	30%
Optical Urethrotomy	90%	42%	55%
Polypectomy of internal nose	90%	54%	65%
Repair of other abdominal hernia	85%	67%	85%
Transluminal operations procedures on femoral artery	70%	43%	55%
Ureteroscopic extraction of calculus of ureter	50%	28%	40%
Medical Procedures			
Bone marrow biopsy	95%	63%	75%
Liver Biopsy	90%	70%	80%
Renal Biopsy	95%	57%	65%

To return to the proposal to add additional procedures to the day case BPT please click here.

10.8. Changing the day case BPT by increasing the target rates for two procedures

Table 10: Proposed changes to existing day case BPTs

Clinical Area	BADS rate	2014/15 transition rate	Current observed rate	Proposed new BPT rate
Operations to manage female incontinence	60%	45%	45%	60%
Tympanoplasty	80%	50%	45%	65%

To return to the proposal to increase the target rates for two procedures within the day case BPT please click here.

10.9. Changing the fragility hip fracture BPT

Table 11: Measures we propose to remove from the fragility hip fracture BPT

Measure for removal	Description
Joint Admissions Protocol	The completion rate is nearly 100%. This is felt to have no further incentive value.
MDT working	The completion rate is nearly 100%. This is felt to have no further incentive value.
Post-op abbreviated mental test	This test is performed pre and post-surgery. The results of the first and second tests are so similar that it has no effect on the achievement of the BPT. We propose to remove the post-op abbreviated mental test.

Table 12: Measures we propose to add to the fragility hip fracture BPT

New measure	Description
A nutritional assessment during admission	This has been shown to significantly improve outcomes and nutritional supplementation, where appropriate, can help to reduce mortality.
Persistence with bone treatment after discharge	The current BPT ensures that patients are assessed and begin bone treatment in hospital, but long-term compliance is poor. Telephone follow-ups are effective and significantly increase long-term compliance with treatment. We propose that telephone appointments take place 120 (+/- 60) days from the date of discharge. The National Hip Fracture Database (NHFD) records this information. Deceased patients would be excluded from this measure but would still contribute towards the BPT if all other criteria in the NHFD are met.
A delirium assessment during admission	This would replace the post-op abbreviated mental test measurement and allow care to focus on the causes of delirium.
Assessed by physiotherapist the day after surgery	This would help ensure that all patients who are fit enough are mobilised the day after surgery. This should reduce complications, enhance recovery and improve outcomes.

To return to the proposal to change the fragility hip fracture BPT please click here.

10.10. Changes to the primary hip and knee BPT

Table 13: Proposed changes to the rates for the primary hip and knee BPT

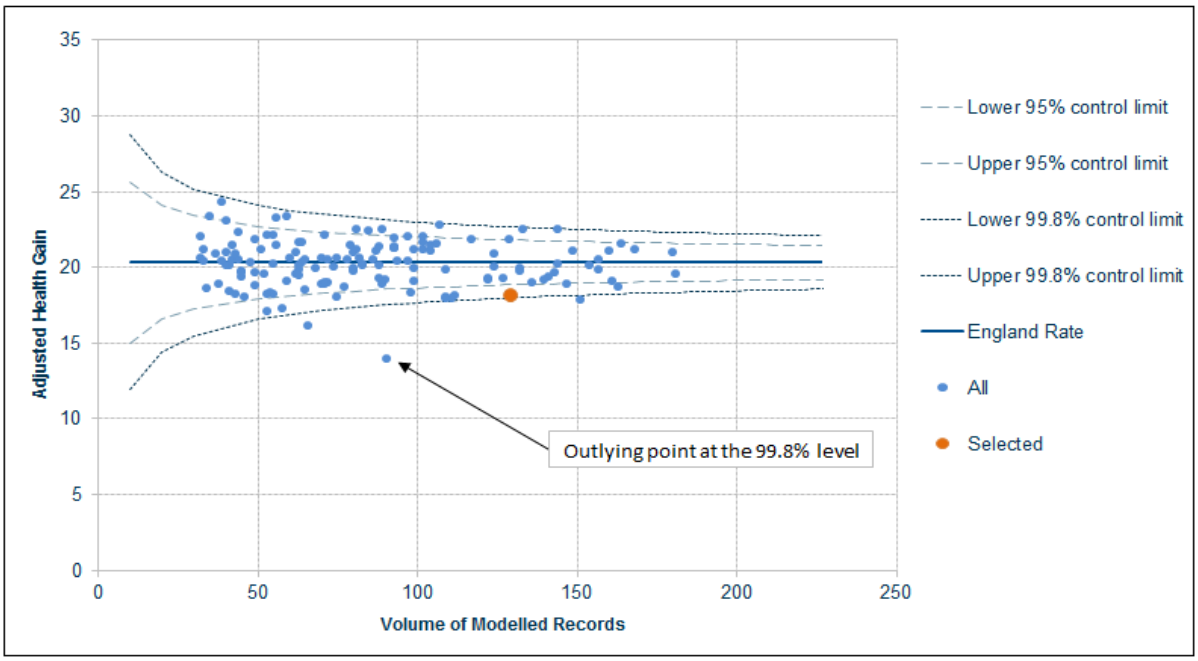
Outlier level	NJR 85%		NJR 90%		NJR 95%	
	Hip	Knee	Hip	Knee	Hip	Knee
99.8%	90%*	86%*	81%(-9%)	84% (-2%)	72%(-18%)	76%(-10%)
95%	86% (-4%)	84%(-2%)	78%(-12%)	82%(-4%)	71%(-29%)	74%(-12%)

*This is the current estimated eligibility

This table shows the expected impact in number of providers eligible to meet the BPT criteria from a change in outlier criteria and NJR compliance.

To return to the proposal to increase the NJR compliance rate for the primary hip and knee BPT please click here.

Figure 2: Outlier rates for the primary hip and knee BPT



To return to the proposal to change the health gain criteria for the primary hip and knee BPT please click here.

10.11. Changing the same day emergency care BPT

Table 14: HRGs covered by the proposal to extend the SDEC BPT

HRG	Description	Level	Proposed clinical scenario
GC17K	Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 0-1	SUB HRG	Abnormal Liver Function
HD26G	Musculoskeletal Signs or Symptoms, with CC Score 0-3	SUB HRG	Acutely hot painful joint
LB15E	Minor Bladder Procedures, 19 years and over	SUB HRG	Chronic indwelling catheter related problems
LB20F	Infection or Mechanical Problems Related to Genito-Urinary Prostheses, Implants or Grafts, without Interventions, with CC Score 2-6	HRG	Chronic indwelling catheter related problems
LB20G	Infection or Mechanical Problems Related to Genito-Urinary Prostheses, Implants or Grafts, without Interventions, with CC Score 0-1	HRG	Chronic indwelling catheter related problems
FZ36P	Gastrointestinal Infections without Interventions, with CC Score 2-4	HRG	Gastroenteritis
FZ36Q	Gastrointestinal Infections without Interventions, with CC Score 0-1	HRG	Gastroenteritis
AA29F	Transient Ischaemic Attack with CC Score 0-4	HRG	Transient Ischaemic Attack
LA04Q	Kidney or Urinary Tract Infections, without Interventions, with CC Score 4-7	HRG	Urinary tract infections
LA04R	Kidney or Urinary Tract Infections, without Interventions, with CC Score 2-3	HRG	Urinary tract infections
LA04S	Kidney or Urinary Tract Infections, without Interventions, with CC Score 0-1	HRG	Urinary tract infections
FZ38P	Gastrointestinal Bleed without Interventions, with CC Score 0-4	SUB HRG	Upper gastro-intestinal haemorrhage
FZ91M	Non-Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 0-2	SUB HRG	Upper gastro-intestinal haemorrhage

Table 15: Proposed target rates for new clinical scenarios

Proposed clinical scenario	75th percentile (HES 2013/14)	Current national average rate (HES 2013/14)
Abnormal liver function	30%	22%
Acutely hot painful joint	65%	55%
Chronic indwelling catheter related problems	65%	55%
Gastroenteritis	35%	26%
Transient Ischaemic Attack	40%	30%
Urinary tract infections	30%	21%
Upper gastro-intestinal haemorrhage	60%	50%

To return to the proposal to change the same day emergency care BPT please click here.

10.12. Removing the interventional radiology BPT

Table 16: Mapping procedures from the interventional radiology BPT to HRG4+

Procedure	Condition	Proposed HRGs[ii]
Angioplasty and stenting of the superficial femoral artery or iliac artery	Peripheral artery disease	• YR10 - Percutaneous Transluminal Angioplasty of Multiple Blood Vessels • YR11 - Percutaneous Transluminal Angioplasty of Single Blood Vessel
Angioplasty and stenting	Diabetic foot disease	• YR10 - Percutaneous Transluminal Angioplasty of Multiple Blood Vessels • YR11 - Percutaneous Transluminal Angioplasty of Single Blood Vessel • YR12 - Percutaneous Transluminal Angioplasty with Insertion of Stent Graft into Peripheral Blood Vessel
Thoracic endovascular aortic repair	Thoracic aneurysm	• YR01 - Complex Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm • YR02 - Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm
Transjugular intrahepatic portosystemic shunt	Portal hypertension	• YR16 - Transjugular Intrahepatic Creation of Portosystemic Shunt
Vacuum assisted percutaneous excision of benign breast lesions	Benign breast lesions	• JA43 - Unilateral Intermediate Breast Procedures
Abdominal endovascular aortic repair	Abdominal aortic aneurysms	• YR01 - Complex Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm • YR02 - Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm • YR03 - Complex Endovascular Repair of Abdominal Aortic Aneurysm • YR04 - Endovascular Repair of Abdominal Aortic Aneurysm
Uterine Fibroid Embolisation	Uterine fibroids (benign tumours of the uterus)	• YR55 - Uterine Artery Embolisation

To return to the proposal to remove the interventional radiology BPT please click here.

[ii] The proposed HRGs have been derived from regrouping historical HRG4 activity using the HRG4+ currency design grouper for 2017/18 and are provided only as a guide to the possible new HRGs for the specific interventional radiology procedures included in the BPT.

10.13. Simplifying the method for setting prices for BPTs

Table 17: BPTs not covered by the standardised method and how we propose to set prices for them

BPT	Proposed method
Early inflammatory arthritis	Roll over existing BPT. This is because we are not able to update the 2013/14 method and/or the inputs used.
Major trauma	
Paediatric diabetes year of care	
Parkinson's disease	
Renal Dialysis	Keep the 2013/14 method except that we propose to: • align the calculation process with that of the other BPTs • simplify calculation of peritoneal dialysis prices by basing them directly on reference costs.
Paediatric epilepsy	Set the national standard price as per the 2013/14 PbR method but set the BPT using the proposed standard methodology.
Pleural effusion	Keep the 2013/14 price relativities for this BPT but otherwise apply the proposed standardised methodology.
Transient ischaemic attack	Keep the additional payment as per the 2013/14 PbR method but otherwise apply the proposed standardised methodology.

To return to the proposal to simplify the method for setting prices for BPTs please click here.

10.14. Top-up payments for specialised services

Table 18: Specialised top-ups under SSNDS

SSNDS code	SSNDS description	Rate
SS06	Spinal surgery	32%
SS08	Neurosciences	28%
SS34	Orthopaedic	24%
SS91	Children Specialised - Low	44%
SS93	Children Specialised - High	64%

Table 19: Proposed top-up payments for specialised services

PSS Flag	Flag description	Top-up Area	Rate
NCBPS01L	Soft cell sarcoma	Cancer	37%
NCBPS01M	Head and Neck cancer	Cancer	6%
NCBPS01O	Bone sarcoma	Cancer	22%
NCBPS01T	Teenage and Young Adults Cancer	Cancer	6%
NCBPS01U	Upper GI Surgery - oesophageal and gastric cancer	Cancer	8%
NCBPS01X	Specialised Urology - Penile cancer	Cancer	24%
NCBPS01Y	Rare Cancers	Cancer	4%
NCBPS01Z	Specialised Urology - Testicular cancer	Cancer	21%
NCBPS03Z	Haemophilia	Other	27%
NCBPS06Z	Spinal - Spinal Surgery	Spinal	41%
NCBPS08O	Neurosciences - Neurology	Neuroscience	6%
NCBPS08S	Neurosciences - Neurosurgery	Neuroscience	29%
NCBPS13C	Cardiac - Inherited heart disorders	Cardiac	10%
NCBPS13E	Cardiac - Cardiac surgery	Cardiac	13%
NCBPS13F	Cardiac - PPCI and Structural Heart Disease (Complex Invasive Cardiology)	Cardiac	8%
NCBPS19V	Hepatobiliary - pancreatic cancer	Cancer	4%
NCBPS19Z	Hepatology & Pancreatic	Other	8%
NCBPS23A	Childrens services - Cancer	Paediatrics	27%
NCBPS23B	Childrens services - Cardiac	Paediatrics	101%
NCBPS23F	Childrens services - Gastroenterology	Paediatrics	15%
NCBPS23H	Childrens services - Haematology	Paediatrics	23%
NCBPS23M	Childrens services - Neurosciences	Paediatrics	65%
NCBPS23N	Childrens services - Ophthalmology	Paediatrics	94%
NCBPS23Q	Paediatric Surgery - Trauma and Orthopaedics	Paediatrics	31%
NCBPS23T	Childrens services - Respiratory	Paediatrics	94%
NCBPS23X	Childrens services - Surgery	Paediatrics	44%
NCBPS29B	Respiratory - Complex thoracic surgery	Respiratory	24%

NCBPS29E	Respiratory - Management of central airway obstruction	Respiratory	25%
NCBPS30Z	Vascular Services	Other	6%
NCBPS33C	Colorectal - Transanal Endoscopic Microsurgery	Other	38%
NCBPS34A	Orthopaedic Surgery	Orthopaedics	51%
NCBPS38S	Haemoglobinopathy - Sickle Cell	Other	8%

PSS Flag	Flag description	Top-up Area	Rate
NCBPS01L	Soft cell sarcoma	Cancer	37%
NCBPS01M	Head and Neck cancer	Cancer	6%
NCBPS01O	Bone sarcoma	Cancer	22%
NCBPS01T	Teenage and Young Adults Cancer	Cancer	6%
NCBPS01U	Upper GI Surgery - oesophageal and gastric cancer	Cancer	8%
NCBPS01X	Specialised Urology - Penile cancer	Cancer	24%
NCBPS01Y	Rare Cancers	Cancer	4%
NCBPS01Z	Specialised Urology - Testicular cancer	Cancer	21%
NCBPS03Z	Haemophilia	Other	27%
NCBPS06Z	Spinal - Spinal Surgery	Spinal	41%
NCBPS08O	Neurosciences - Neurology	Neuroscience	6%
NCBPS08S	Neurosciences - Neurosurgery	Neuroscience	29%
NCBPS13C	Cardiac - Inherited heart disorders	Cardiac	10%
NCBPS13E	Cardiac - Cardiac surgery	Cardiac	13%
NCBPS13F	Cardiac - PPCI and Structural Heart Disease (Complex Invasive Cardiology)	Cardiac	8%
NCBPS19V	Hepatobiliary - pancreatic cancer	Cancer	4%
NCBPS19Z	Hepatology & Pancreatic	Other	8%
NCBPS23A	Childrens services - Cancer	Paediatrics	27%
NCBPS23B	Childrens services - Cardiac	Paediatrics	101%
NCBPS23F	Childrens services - Gastroenterology	Paediatrics	15%
NCBPS23H	Childrens services - Haematology	Paediatrics	23%
NCBPS23M	Childrens services - Neurosciences	Paediatrics	65%
NCBPS23N	Childrens services - Ophthalmology	Paediatrics	94%
NCBPS23Q	Paediatric Surgery - Trauma and Orthopaedics	Paediatrics	31%
NCBPS23T	Childrens services - Respiratory	Paediatrics	94%
NCBPS23X	Childrens services - Surgery	Paediatrics	44%
NCBPS29B	Respiratory - Complex thoracic surgery	Respiratory	24%
NCBPS29E	Respiratory - Management of central airway obstruction	Respiratory	25%
NCBPS30Z	Vascular Services	Other	6%
NCBPS33C	Colorectal - Transanal Endoscopic Microsurgery	Other	38%

NCBPS34A	Orthopaedic Surgery	Orthopaedics	51%
NCBPS38S	Haemoglobinopathy - Sickle Cell	Other	8%

To return to the proposal to change top-up payments for specialised services please click here.

10.15. New non-mandatory currencies

Table 20: Non-mandatory wheelchair currencies

Categorisation and activity bundling	
Nominal code	**Activity**
LO 00A	Low Need – Assessment
ME 00A	Medium Need – Assessment
HI 01A	High Need – Manual Assessment
HI 02A	High Need – Powered Assessment
LO 00E	Low Need – Equipment
ME 00E	Medium Need – Equipment
HI 01E	High Need – Manual Equipment
HI 02E	High Need – Powered Equipment
AA 01M	All Needs – Manual Repair and Maintenance
AA 02M	All Needs – Powered Repair and Maintenance
AA 00R	All Needs – Review
AA 00C	All Needs – Review substantial (a review followed by a modification/new accessory or resulting in a completely new follow-up assessment if a new wheelchair is required)

Figure 3: Non-mandatory currencies for palliative care

ADULTS

Currency unit	Phase	Other
Adult Acute Inpatient		
AW_1	Stable	1 diag
AW_2	Stable	1+ diag <75yrs
AW_3	Stable	1+ diag 75+yrs
AW_4	Unstable	1 diag
AW_5	Unstable	1+ diag
AW_6	Deteriorating	1 diag
AW_7	Deteriorating	1+ diag, <75 yrs
AW_8	Deteriorating	1+ diag, 75+ yrs
AW_9	Dying	1 diag
AW_10	Dying	1+ diag
Adult Hospice Inpatient		
AH_1	Stable	Low function
AH_2	Stable	Med/high function
AH_3	Unstable	Low function
AH_4	Unstable	Med/high function
AH_5	Deteriorating	Low function
AH_6	Deteriorating	Med/high function
AH_7	Dying	Low function
AH_8	Dying	Med/high function
Adult Community		
AC_1	Stable	Low function
AC_2	Stable	Med function
AC_3	Stable	High function
AC_4	Unstable	Low function
AC_5	Unstable	Med function
AC_6	Unstable	High function
AC_7	Deteriorating	Low function
AC_8	Deteriorating	Med function
AC_9	Deteriorating	High function
AC_10	Dying	

CHILDREN

Currency unit	Phase	Age group /other
Children Acute Inpatient		
CW_1		<1
CW_2		1-4
CW_3	Stable	5-9
CW_4	Unstable	5-9
CW_5	Det/dying	5-9
CW_6	Stable	10+
CW_7	Unstable	10+
CW_8	Det/dying	10+
Children Hospice Inpatient		
CH_1		<1
CH_2		1-4
CH_3	Stable	5-9
CH_4	Unstable	5-9
CH_5	Det/dying	5-9
CH_6	Stable	10+
CH_7	Unstable	10+
CH_8	Det/dying	10+
Children Community		
CC_1	Stable	Low phy severity
CC_2	Stable	Med/high phy severity
CC_3	Unstable	<1
CC_4	Unstable	1-4
CC_5	Unstable	5-9
CC_6	Unstable	10+
CC_7	Deteriorating	<1
CC_8	Deteriorating	1-4
CC_9	Deteriorating	5-9
CC_10	Deteriorating	10+
CC_11	Dying	0-9
CC_12	Dying	10+

To return to the proposal to introduce non-mandatory currencies please click here.

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