Payment by Results Guidance for 2009-10
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1. Introduction and main changes

**Introduction**

1. This document provides information to support the operation of Payment by Results (PbR) in 2009-10. This document should be used alongside the 2009-10 national tariff.

2. The guidance is split into seven sections, the contents of which are summarised below.

   **Section 1 – Introduction and main changes**  
   A brief overview of some key changes

   **Section 2 – Scope of the national mandatory tariff**  
   Sets out the services and organisations covered by the scope of PbR

   **Section 3 – Structure of the national mandatory tariff**  
   Information on how the tariff is structured, covering new elements such as the planned same day and short stay elective tariffs, and specialised service top-up arrangements in 2009-10

   **Section 4 – Non-mandatory prices**  
   Sets out why we won’t be issuing indicative tariffs in 2009-10, but instead are providing non-mandatory prices for a number of services, including outpatient procedures

   **Section 5 - Flexibilities**  
   This section sets out some principles for the use of local flexibilities, seeks to explain those currently available, and offers some examples as to how they might be used in future

   **Section 6 – Other operational issues**  
   Contains important information on the new market forces factor (MFF) payment processes and MFF payment indices

   **Section 7 – Useful links**  
   Provides links to other documents and information sources relevant to the operation of PbR, such as the 2009-10 NHS Operating Framework and standard NHS contract
3. 2009-10 sees an important step-change in PbR in England, with the roll-out of a new ‘designed-for-purpose’ tariff currency. This currency is Healthcare Resource Group 4 (HRG4) and supersedes HRG version 3.5, which has underpinned PbR tariff payment since 2005-06.

4. HRG4 is a new currency designed specifically to support a national tariff payment system for healthcare. HRGv3.5 has effectively supported the introduction of PbR, but was designed primarily for financial benchmarking. To adapt this to underpin a national tariff has required an increasing number of adjustments to ensure fair financial reward for services provided.

5. HRG4 has been designed so that pricing can support the delivery of services independent of their setting, and so that pricing is more sensitive to the complexity of the treatment being delivered. The full benefits of the new design will be realised gradually as the quality of underlying activity and cost data improves.

6. Due to data quality issues, HRG4 will not be used to underpin the tariff for Accident and Emergency (A&E) services this year. Therefore, the 2008-09 A&E tariff structure will continue for 2009-10.

7. How HRG4 affects the different elements of PbR will be covered in the relevant sections within this document. For more information on the design of HRG4, please visit the Information Centre website.¹

8. The objective of PbR remains to provide a transparent and rules-based financial regime supporting wider healthcare policies. PbR should also play a part in promoting agreed clinical pathways endorsed by local networks, partnerships or national standards.

9. Detailed information on applying PbR rules to data can be found in the document ‘PbR Business Rules’ which can be found on the Department’s website alongside this document.

¹ http://www.ic.nhs.uk/services/casemix/hrg4
Main changes in 2009-10

10. In addition to the introduction of HRG4 as the currency of tariff payment for most services within the scope of PbR, there are a number of important changes to be aware of, including:

- The introduction of the **planned same day (PSD) tariff**, which is designed to help incentivise the shift of activity, where clinically appropriate, to less acute settings. The PSD tariff will initially apply to day case activity only. For outpatient procedures, the PSD tariff will be non-mandatory in 2009-10. For further information, see Section 3.

- The introduction of the **short stay elective tariff**, which is designed to ensure that very short lengths of stay are appropriately rewarded and that incentives are aligned correctly between admissions and day cases. For further information, see Section 3.

- In 2009-10 there is a **new Market Forces Factor (MFF) payment index**. This follows the review undertaken by the Advisory Committee on Resource Allocation (ACRA). To help manage the introduction of the new MFF, PbR have introduced a capping policy. The objective of the cap is to limit the impact of introducing the new MFF on overall PbR income. With the underlying MFF index capped, a provider’s overall PbR income should not change by more than +/-2% as a result of using the new MFF rather than the old one, given all other changes to tariff in 2009-10. Further information is available in the MFF technical paper available on the Department’s website alongside this document.

- In 2009-10 the **MFF payment** associated with activity within the scope of PbR for mandatory tariff will be paid directly by the responsible commissioning PCT (for both contract and non-contract activity). This new payment mechanism replaces the four-stage central payment process in place for 2008-09. In 2009-10, the Department will no longer deduct MFF from PCT allocations, so PCTs will have the resources to meet the MFF costs directly. For further information, see Section 6.

- We will not be publishing indicative tariffs for 2009-10. Instead, we have issued a number of **non-mandatory prices**, further details of which can be found at Section 4.

- In 2009-10, under HRG4 the definition of a child is a patient aged under 19, with an adult being defined as 19 and over. This definition has changed from 2008-09 under the HRGv3.5 tariff.
11. For a full overview of PbR in 2009-10 it will be necessary to read this guidance document in its entirety, however a table summarising the main changes to be aware of in 2009-10 is provided at Annex A.

12. Figure 1 overleaf summarises the main PbR structural changes in 2009-10, compared with the 2008-09 arrangements.
Figure 1

PbR STRUCTURAL CHANGES FOR 2009-10

2008-09

Admitted Patient Care Spell (HRGv3.5)
- SSEM
- LSA
- ETA
- LSA

Non-elective inpatient

Elective inpatient

Day case

2009-10

Inpatient Spell (HRGv4)

Non-elective inpatient

Elective inpatient

Day case

PSD Planned Same Day (Elective) Procedure (HRGv4)

Outpatient: Procedure or Attendance x Treatment Function Code (TFC)
- OP Proc (8 only)
- OP Att
- OP Non F2F

A&E: attendance (3 categories – H,M,L Grouped HRGv3.2)
- A&E Att

Spec Top-up

Specialised services: (fixed %, eligible providers)
- Spec Top-up

Market Forces Factor: (fixed % - central payment)
- MFF

Specialised services (specialised children’s and orthopaedics, revised percentages, same eligible providers)
- MFF

Market Forces Factor (revised % uplifts - local payment)
- FA/FU

First Attendance/Follow Up

SP/MP Single Professional / Multi-Professional

UDI Unbundled Diagnostic Imaging (Excluding plain film)

Non Face to Face (telephone) contact

SSEM Short Stay Elective (adult only)

FA/FU

SP/MP

UDI

Short Stay Emergency (adult only)

Non Face to Face (telephone) contact

Long Stay Adjustment [Excess Bed Days]

Emergency Threshold Adjustment

Short Stay Adjustment [Excess Bed Days]

Adult/Child split

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Updates to tariff calculation

13. The tariff calculation model has been updated to reflect the introduction of HRG4, and any changes to the structure of the tariff. However, the key underlying principles have not changed. The most up-to-date national cost and activity data (2006-07) has been used to underpin the tariff in 2009-10. Although there have been issues with the data quality in some areas along with incomplete information, it is of similar quality to the 2005-06 data that was used to underpin the 2008-09 tariff.

14. Robust and good quality data is obviously important to underpin the tariff and make it as accurate as possible. Data quality is particularly important for the successful implementation of HRG4. Useful information on data quality can be found in the Audit Commission’s report on the 2007-08 Data Assurance Framework, which contains analysis from the PbR clinical coding audit programme undertaken at all acute NHS trusts in England in 2007-08.

15. Detailed information on how the tariff is calculated can be found in the document ‘A step-by-step guide to the calculation of the national tariff for PbR in 2009-10’ which is available on the Department’s website alongside this document.

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2 [www.audit-commission.gov.uk/pbr/assuranceframework.asp](http://www.audit-commission.gov.uk/pbr/assuranceframework.asp)
**Tariff uplift**

16. The tariff uplift reflects the balance of financial pressure in the NHS financial system, taking into account the range of issues affecting both the provider and commissioner sectors of the service. The key issues affecting the tariff uplift are pay deals, quality and reform requirements and efficiency requirements.

17. The tariff uplift for 2009-10 will be 1.7%. A breakdown of the assumptions underpinning this figure are provided as part of the 2009-10 tariff information available on the Department's website alongside this document.

18. This uplift figure should be used as the benchmark for contract arrangements for services that are currently out of scope of the national tariff. It will be for commissioners to determine with providers the extent to which there are legitimate additions or deductions from tariff uplift when considering contracting for the delivery of these services.

19. The tariff uplift in 2009-10 will reflect additional funding for the working time directive (WTD). This will support WTD compliance in trusts.

20. To support the Maternity Matters aim of reducing late bookings into antenatal care, we have increased the obstetrics outpatient tariff by 7%, which equates to £20 million.3 This takes into account that late bookers are disproportionately likely to be disadvantaged women with high levels of complexity, and that the subsequent increase in appointments with this group will increase the time and resources needed for an average outpatient attendance.

21. Other elements of the Maternity Matters funding are not included within tariff prices. The funding can therefore be used for increases in tariff activity (eg an expected increase in outpatient appointments from earlier booking), for non tariff activity (eg parenting education and post natal home visits) or to pay for quality improvements as part of the 0.5% uplift related to the Commissioning for Quality and Innovation payment framework.4

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3 Despite this increase, there has been little overall change to the obstetrics outpatient tariff because midwife-led activity (with cheaper reported costs) has been included in the mandatory tariff for the first time. See the outpatient attendances information in Section 3 for more details.

4 For further information on CQUIN see paragraphs 32-34.
22. There will be changes to the contributions to the Clinical Negligence Scheme for Trusts (CNST) for 2009-10. Contributions for 2009-10 will be £713 million which represents an increase of £316 million against the 2008-09 net figure. The impact will vary for individual members depending on the nature of their service provision, changes in recent periods, risk management discounting and the effect of claims experience rating.

23. The CNST contributions in 2009-10 are increasing for two reasons:

- a rebasing to account for the increased claims activity and cost base; and
- a recovery of the sums funded by DH in 2008-09 to fund a shortfall.

24. The NHS Litigation Authority notified individual NHS bodies of their scheme contributions for 2009-10 during the week beginning 22nd December 2008.

25. The contributions and associated increases for 2009-10 vary by specialty. Rather than include the cost pressure in the overall tariff uplift, specific, targeted adjustments have been made to certain tariff prices.

26. The basis for targeting the adjustment focused on two elements:

- Services where the size of the contribution and the proposed increase is significant
- Services which form well defined groups of activity within the tariff rather than activities which are spread across a wide range of service areas (eg anaesthetics)

27. For services where no specific adjustment has been carried out, the cost pressure is reflected in the tariff uplift. The split between specific tariff adjustments and overall tariff uplift is set out in table 1 below:

Table 1

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Amount</th>
</tr>
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<tr>
<td>Targeted tariff prices</td>
<td>£216m</td>
</tr>
<tr>
<td>Reflected in uplift</td>
<td>£100m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£316m</strong></td>
</tr>
</tbody>
</table>
28. The targeting of the costs on tariff prices has been done by identifying the relevant HRG chapters or sub-chapters and apportioning the costs across the HRGs in proportion to overall costs (Planned same day and inpatient activity only). Table 2 below shows the chapters that have been adjusted for each of the specialty areas reflected in the CNST scheme. Note that for A&E services the adjustment has been applied only to ‘standard’ and ‘high’ tariffs.

Table 2

<table>
<thead>
<tr>
<th>Chapter/Sub-chapter adjusted</th>
<th>Specialty</th>
<th>Approximate percentage increase on tariff prices</th>
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<tr>
<td>AA</td>
<td>Neurology, Neurosurgery</td>
<td>1.1%</td>
</tr>
<tr>
<td>B</td>
<td>Ophthalmology</td>
<td>1.4%</td>
</tr>
<tr>
<td>C</td>
<td>Otolaryngology and Plastic surgery</td>
<td>0.7%</td>
</tr>
<tr>
<td>E</td>
<td>Cardiology, Cardiothoracic Surgery</td>
<td>0.3%</td>
</tr>
<tr>
<td>F</td>
<td>General surgery</td>
<td>0.5%</td>
</tr>
<tr>
<td>G</td>
<td>General surgery</td>
<td>0.6%</td>
</tr>
<tr>
<td>H</td>
<td>Plastic surgery and Trauma &amp; Orthopaedics</td>
<td>0.8%</td>
</tr>
<tr>
<td>J</td>
<td>General surgery and Plastic surgery</td>
<td>0.6%</td>
</tr>
<tr>
<td>LB</td>
<td>Urology</td>
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</tr>
<tr>
<td>N</td>
<td>Obstetrics &amp; gynaecology</td>
<td>7.9%</td>
</tr>
<tr>
<td>Q</td>
<td>General surgery</td>
<td>0.4%</td>
</tr>
<tr>
<td>VA</td>
<td>Trauma &amp; Orthopaedics</td>
<td>0.8%</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>A&amp;E</td>
<td>2.2%</td>
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29. High Quality Care For All, Lord Darzi’s NHS Next Stage Review report, made three commitments specifically on PbR:\n
- Set out projections for tariff uplift and efficiency gains on a multi-year basis
- Facilitate the expansion of PbR to cover other services, for example by developing national currencies for mental health services available for use by 2010-11
- Develop a Best Practice Tariff programme

30. Meeting this first commitment, The Operating Framework set out that “providers should assume that the uplift for the year 2010-11 will not exceed 1.20 per cent on a comparable basis.”\n
31. Work will continue in 2009-10 on planning for the delivery of these commitments. If you are interested in getting involved in the work on extending the scope of PbR or on Best Practice Tariffs, please e-mail pbrcomms@dh.gsi.gov.uk

32. A separate commitment in High Quality Care for All but related to PbR is the introduction of the Commissioning for Quality and Innovation (CQUIN) payment framework in 2009-10. The CQUIN framework will make a proportion of provider income conditional on quality improvement and innovation. The intention is that the framework should apply to all services covered by national standard contracts and will therefore cover more than just tariff activity.

33. In the acute setting, the standard contract in 2009-10 includes the requirement for providers to agree a CQUIN scheme with their lead commissioner. Commissioners are expected to make 0.5% of the providers' contract values (covering both tariff, including the MFF, and non-tariff activity) available and to agree with their providers how these payments are linked to quality in 2009-10 contracts. The tariff uplift for 2009-10 does not include an explicit quality element, as had been included in 2008-09.

34. Further information is available in the CQUIN guidance available under the Operating Framework section of the Department’s website.\n
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5 These commitments are all in Chapter 4 of High Quality Care for All, in paragraphs 22, 23 and 40 respectively.
6 The Operating Framework for the NHS in England 2009/10, Chapter 4, para 25.
2. Scope of the national mandatory tariff

Introduction

35. HRG4 has become the currency underpinning the PbR tariff in 2009-10, with the exception of A&E services, for which the 2008-09 tariff structure will remain in place. The broad scope of services covered by the national tariff remains similar to 2008-09, meaning that not all of the service areas covered by the HRG4 design will have a national tariff in 2009-10. This is due to a number of reasons, such as the quality of costing and activity data available which could underpin a national tariff.

36. The costs of services that are currently outside the scope of reference costs are, by default, not included within the PbR mandatory or non-mandatory tariffs. The 2009-10 tariff is based on 2006-07 reference costs, further information on which can be found on the Department’s website.

Organisations within the scope of PbR

37. In 2009-10 the mandatory PbR tariff is payable for activity carried out by NHS trusts, NHS foundation trusts, PCTs as providers and independent sector providers.

38. The amounts payable to independent sector (IS) organisations providing activity within the scope of PbR will be the national tariff plus an adjustment for market forces factor (MFF) payable directly by the PCT. Further information on MFF payment arrangements can be found at Section 6.

Services within the scope of PbR

39. The mandatory tariff will be payable for admitted patient care, outpatient, and A&E services. The structure of the tariff is summarised in Table 3 below.

Table 3: PbR tariff structure in 2009-10

<table>
<thead>
<tr>
<th>Structure</th>
<th>Admission patients</th>
<th>Outpatients</th>
<th>A&amp;E</th>
</tr>
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<tr>
<td>Currency</td>
<td>HRG4 spell</td>
<td>Attendance by specialty</td>
<td>Attendance</td>
</tr>
<tr>
<td>Tariffs for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Electives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-Electives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Planned same day activity (day cases only in 2009-10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Short-stay elective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Short-stay emergencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tariffs for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• First attendance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Follow-up attendance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multi-professional as well as single professional appointments, for TFCs where data is available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Procedures carried out in outpatient setting subject to non-mandatory tariff, with the intention that this activity is covered by the mandatory PSD tariff in future years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-mandatory tariff for non face to face outpatient appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialised service adjustments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Top-up payment for specialised services for children and orthopaedic activity</td>
<td></td>
<td>Exclusions</td>
<td>Not applicable</td>
</tr>
<tr>
<td>• Exclusions</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Outliers</td>
<td>Long stay outlier payment triggered at pre-determined length of stay (dependent on HRG). Daily rate specific to HRG</td>
<td>No outlier policy</td>
<td>No outlier policy</td>
</tr>
<tr>
<td>Flexibilities</td>
<td>Unbundling of care pathway subject to local agreement</td>
<td>Unbundling of care pathway subject to local agreement</td>
<td>Local flexibilities could be applied to support service redesign</td>
</tr>
<tr>
<td></td>
<td>Local ‘pass through’ payments for new technology</td>
<td>Local ‘pass through’ payments for new technology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency readmissions - local arrangements for determining appropriate reimbursement and criteria</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Home births

40. In 2009-10, home births will continue to be reimbursed at the same rate as a normal delivery without complications. Local information flows will be required to support payment of home births in 2009-10 as they are not included in the PbR Secondary Uses Service (SUS).

What activity is excluded from PbR?

41. The national tariff is mandatory for activity within the scope of PbR. Some services and procedures remain outside the scope of PbR and the price of these remains subject to local negotiation. Services not covered by PbR in 2009-10 include primary care services, community services, mental health services and ambulance services. A full list of exclusions is available on the Department’s website alongside this document.

42. In 2009-10 for most activity where there is an HRG but not a mandatory tariff, there will be no non-mandatory price. This represents a change from previous years. New non-mandatory prices are provided for a number of services to help inform commissioning. Further information is provided at Section 4.

43. Details of exclusions are provided as part of the 2009-10 tariff information available on the Department’s website alongside this document, covering HRGs, outpatient Treatment Function Codes (TFCs) drugs, devices, procedures, products and services.

44. Throughout this guidance references will be made to TFCs and ‘main speciality codes’ (MSCs). More information on what these are can be found at the NHS Data Dictionary website9.

High cost drug, device and procedure exclusions (services and items to be priced locally)

45. In 2009-10 there will be a number of high cost drugs, devices, procedures and products that are excluded from the scope of PbR. Furthermore, drugs excluded from the scope of the tariff in 2009-10 will create unbundled HRGs where they are correctly coded. Details of these exclusions are provided as part of the 2009-10 tariff information available on the Department’s website alongside this document.

9http://www.datadictionary.nhs.uk/web_site_content/pages/codes/main_specialty_and_treatment_function_codes.asp
46. These items are excluded because existing classifications would not necessarily allow for fair reimbursement of these items if they were subject to a national tariff. This is because the numbers are low and unpredictable or the relevant HRG includes more routine treatment and the distribution of different activity within the HRG is not even across providers.

47. The list of exclusions was determined after wide-ranging consultation with various stakeholders. Only those items listed, or those items included within listed categories/sub-categories, are excluded.

48. In order to avoid obsolescence in our annual guidance, PbR high cost drug exclusions are linked to British National Formulary (BNF) categories where possible. Details are provided as part of the 2009-10 tariff information available on the Department’s website alongside this document. The BNF is updated regularly. If a new in-year drug is added to a BNF category/sub-category that is excluded from PbR, then the drug should be considered to be excluded from PbR.

49. The tariff information mentioned above also contains details of the individual high cost drugs excluded from PbR as at 1 January 2009. As such, it is not necessarily an exhaustive list of all drugs excluded from PbR. This list will not be updated in-year and as such any new drug that is added to an excluded category in the BNF will still be excluded, but may not be included on this list. The generic name of the medicine is used on this list. Corresponding brand names can be found in the BNF.\(^{10}\)

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

51. In most cases, the additional payment should cover only the cost of the excluded drug, product, device and associated consumables and services. However some procedures may entail additional direct costs over and above the cost of any drug, product, device and associated consumables and services, and these costs should also be taken into consideration in determining the appropriate additional payment. The level of this additional payment should be agreed between commissioners and providers, and local activity monitoring arrangements should be established. Further

\(^{10}\) www.bnf.org.uk
information on payment for services outside the scope of the mandatory tariff can be found in the standard NHS contract\(^\text{11}\).

52. In all cases, commissioners and providers will need to determine whether they wish to agree volumes and prices as part of contract agreements, or to operate on a case-by-case basis. For some excluded items, such as spinal cord stimulators or insulin pumps, it may be most appropriate to agree volumes and prices in advance within a contract, while for others such as Enzyme Replacement Therapy, a case-by-case approach may be preferred. Commissioners and providers will also need to ensure that usage of any drugs or devices is in keeping with relevant clinical guidance and guidelines (eg from NICE).

### Soft tissue sarcoma surgery procedure exclusion

53. Soft tissue sarcoma surgery will continue to be excluded in 2009-10. This surgery is only delivered in a very small number of units and has been defined as follows (conditions in both columns to be satisfied):

<table>
<thead>
<tr>
<th>ICD10 (in any position)</th>
<th>OPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>C40 Malignant neoplasm of bone and articular cartilage of limbs</td>
<td>Primary operation code is not missing (i.e. a surgical procedure has actually been carried out), and it is not a chapter X code (chemotherapy or amputation)</td>
</tr>
<tr>
<td>C41 Malignant neoplasm of bone and articular cartilage of other and unspecified</td>
<td></td>
</tr>
<tr>
<td>C48 Malignant neoplasm of retroperitoneum and peritoneum</td>
<td></td>
</tr>
<tr>
<td>C49 Malignant neoplasm of other connective and soft tissue</td>
<td></td>
</tr>
</tbody>
</table>

54. A local price will need to be agreed for this activity.

---
PET, PETCT and SPECTCT scans

55. PET scans, as in previous years, remain within the scope of PbR in 2009-10. The costs relating to PET scans are currently included within the tariff price of the HRG. However, PETCT scans and SPECTCT scans are outside of the scope of PbR for 2009-10 and as such are not included in the tariff. The unbundled non-mandatory diagnostic imaging tariffs for 2009-10 do not include PETCT scans or SPECTCT scans.

Cardiovascular Magnetic Resonance Imaging (MRI)

56. Clinical coding for cardiovascular MRI is currently under review, and until these issues are resolved cardiovascular/cardiac MRI will be outside the scope of PbR.

Wet age-related macular degeneration

57. In 2009-10, the drug Ranibizumab for the treatment of wet age-related macular degeneration will continue to be excluded, along with any associated costs and activity for administering the drug.

Orthopaedic prostheses

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

Cochlear implants

59. The tariffs for cochlear implants (CZ25N and CZ25Q) cover the costs associated with the admitted patient spell in which the device is implanted. They do not cover subsequent programming and maintenance of the device. Commissioners and providers should agree a local price for such maintenance.
60. For bi-lateral implant procedures, the additional cost of the procedure and implant should be subject to local negotiation.

**Outpatient treatment function exclusions**

61. In 2009-10, adult and paediatric burns care (TFC 161), clinical microbiology and medical ophthalmology outpatient attendances are excluded from the tariff.

62. Burns care has been excluded to maintain consistency across service locations as the burns-related HRGs continue to be excluded.

63. In 2009-10 an explicit volume threshold to have a mandatory tariff for outpatient attendances has been set; an outpatient TFC must have more than 1,000 first attendances and 10,000 total attendances reported in the 2006-07 national Reference Costs. Outpatient TFCs that fail to meet this threshold are excluded from the mandatory tariff.

64. Clinical microbiology (TFC 322) and medical ophthalmology (TFC 460) are excluded because they fail to meet this low volume threshold criteria for outpatient attendances.

65. For those treatment functions that are excluded, we are not publishing non-mandatory prices.

**Patient Transport Services**

66. In 2009-10 the costs associated with Patient Transport Services (PTS) for PbR activity have been removed from the national tariff.

67. This change was signalled in annex B of the *Options for the Future of Payment by Results 2008/09 to 2010/11 consultation exercise of March 2007*[^12], and was also covered in the document *Eligibility for patient transport services (PTS) of September 2007*[^13].

68. The 2006-07 reference cost collection (on which the 2009-10 tariff is based) separately identified PTS costs, which has facilitated the unbundling of PTS costs from inpatient and outpatient HRGs in 2009-10.

69. PTS will need to be commissioned by PCTs, who will also want to consider adjustments to non-tariff prices if necessary.

Healthcare Travel Costs Scheme

70. Healthcare Travel Costs Scheme (HTCS)\textsuperscript{14} costs were separately identified in the 2006-07 reference cost collection, and have been excluded from PbR in 2009-10.

71. Provider units (NHS trusts and NHS foundation trusts, or PCTs in cases where the provider is not an NHS trust) are legally obliged to pay the NHS travel expenses of eligible patients through the Healthcare Travel Costs Scheme. PCTs will reimburse provider units for the payments made under the scheme for all patients resident within their area.

Chemotherapy

72. As in 2008-09, chemotherapy remains out of scope of tariff for 2009-10, therefore funding for this service should be agreed locally. For clarity, some further information is set out below on the differences between HRGv3.5 and HRG4 in relation to chemotherapy and on other issues.

73. In 2008-09, under HRGv3.5, those HRGs that ended with “98” were excluded from PbR. This meant that those episodes/spells which involved chemotherapy were outside of scope for PbR.

74. The “98” codes included care for both a primary diagnosis as well as chemotherapy. An example of a 98 code is “A98” for “Chemotherapy with a Nervous System Primary Diagnosis”. As the entire “98” code was excluded, both care related to the primary diagnosis as well as chemotherapy were excluded from tariff.

75. Under HRG4 chemotherapy can no longer be identified by the “98” ending and the two elements of care within the same episode/spell are separated. There is now a core HRG (the care related to the primary diagnosis or surgical procedure) and unbundled HRGs (for the chemotherapy). For further details on the structure of HRG4 and on unbundling, please see the Information Centre’s Casemix website\textsuperscript{15}.

\textsuperscript{14} Details on the arrangements for HTCS are available in Healthcare Travel Costs Scheme: Instructions and Guidance for the NHS (March 2008) at \url{http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083704}

\textsuperscript{15} \url{http://www.ic.nhs.uk/services/casemix}
76. In 2009-10, core HRGs will be in scope of tariff, however the unbundled elements related to the chemotherapy service will remain out of scope of tariff and prices will need to be agreed locally.

**Figure 2**

<table>
<thead>
<tr>
<th>Primary Diagnosis/ Surgical Procedure</th>
<th>Chemotherapy Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core HRG under HRG4</td>
<td>Unbundled HRGs (split by Procurement/Delivery) under HRG4</td>
</tr>
<tr>
<td>Within Scope</td>
<td>Out of Scope/ Agree Locally</td>
</tr>
</tbody>
</table>

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

78. Under HRG4, the unbundled chemotherapy HRGs are split between chemotherapy drug procurement (regimen) HRGs and delivery HRGs. Each patient is allocated one HRG for the regimen procured and one HRG for delivery. The chemotherapy procurement HRGs are for the procurement of drugs for regimens according to band. There are 10 such regimen bands.

79. There will be costs associated with procurement for inpatients, outpatient and day cases. The costs of each of the procurement HRGs contain all costs associated with “procuring” each drug cycle- including pharmacy costs (including indirect cost and overheads).

80. The chemotherapy delivery HRGs are assigned for each attendance for treatment to reflect the complexity of treatment and hence resource usage. An example of a delivery HRG is SB12Z for delivery of simple parenteral chemotherapy at first attendance.
81. The delivery HRGs are generated for outpatients or day cases only. For inpatients, delivery HRGs should not be generated as OPCS delivery codes are not recorded for inpatients. Instead, for inpatients, costs of chemotherapy delivery are included within the costs of the core HRG.

82. Due to the structure of HRG4, a core HRG will be generated even when a day case patient or outpatient attends solely for the purpose of delivery of chemotherapy and no additional outpatient consultation has taken place. This will need to be taken into account when agreeing the local price for the chemotherapy service to avoid over-paying for an outpatient or day case chemotherapy episode/spell.

Table 5

<table>
<thead>
<tr>
<th></th>
<th>Core</th>
<th>Unbundled Chemotherapy Procurement HRG</th>
<th>Unbundled Chemotherapy Delivery HRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Within scope of tariff- includes costs for chemo delivery</td>
<td>HRG generated, agree payment locally</td>
<td>No HRG generated</td>
</tr>
<tr>
<td>Outpatient</td>
<td>HRG generated, within scope of tariff</td>
<td>HRG generated, agree payment locally but check if core payment justified</td>
<td>HRG generated, agree payment locally but check if core payment justified</td>
</tr>
<tr>
<td>Day Case</td>
<td>HRG generated, within scope of tariff</td>
<td>HRG generated, agree payment locally but check if core payment justified</td>
<td>HRG generated, agree payment locally but check if core payment justified</td>
</tr>
</tbody>
</table>

83. Drugs which are excluded from the tariff when used for chemotherapy may also have other purposes. When used for non-chemotherapy purposes they may or may not continue to be excluded, eg Rituximab will always be excluded as it is excluded on the grounds of high cost and not just when used as a chemotherapy drug.
Figure 3

Consider drug

Drug used only for chemotherapy?

Yes
Agree locally

No

Consider specific drug usage

Is drug being used for purpose of chemotherapy?

Yes
Agree locally

No

Is the drug itself, or its current usage, subject to other tariff exclusions?

Yes
Agree locally

No

Within scope of tariff
The replacement of N12

84. The introduction of HRG4 for reimbursement has meant that HRG N12 (ante natal admission not related to a delivery event) has been replaced by HRGs NZ04 to NZ09. However, the expected differentiation in reported costs for these HRGs has not occurred, with comparatively high costs reported for the simpler HRGs given their likely duration. We have not altered the quantum relating to these HRGs, but we have changed the relativities to emphasize the increase in complexity from NZ04 (Clinical Contact for Observation, ante-natal and post-natal) through to NZ09 (Admission with full investigation). Even with this adjustment, there is a large differential between NZ04 and the obstetrics outpatient price.

85. It therefore appears that the introduction of these new HRGs will not immediately solve the issues around N12. Commissioners and providers should consider the application of appropriate performance standards (including the use of benchmarking) to ensure that there is not over-reimbursement for short lengths of stay. Providers are also encouraged to ensure that reference costs submitted for these HRGs accurately reflect their duration, so that this issue is resolved over time.
3. Structure of the national mandatory tariff

Inpatient activity

86. As in previous years, the tariff for admitted patients is based on spells - that is the period from admission to discharge or death rather than finished consultant episodes of care (FCEs) within a spell.

87. An outlier payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a trim point specific to the HRG. The daily rate is specific to the HRG.

88. In 2009-10 there are separate tariffs for elective and non-elective activity. Day case activity is not covered by the elective tariff in 2009-10; this is now covered by the new planned same day (PSD) tariff.

Planned same day tariff

89. A major change to the PbR tariff in 2009-10 is the introduction of the planned same day (PSD) tariff. The PSD tariff will initially apply to day case activity only, but not to regular day or night admissions. In time we expect to expand the scope of the PSD tariff to include procedures undertaken in outpatient departments and so have opted to name the tariff PSD, rather than day case, from the beginning.

90. The principle of HRGs is that they should reflect the care of the patient and not the setting in which care is delivered. In previous years, this principle has been supported by the tariff having a single price which covered the same service whether it was delivered as inpatient care or day case care. There was thus a financial incentive to treat patients as daycases where it was clinically appropriate to do so. In 2009-10 the prices attached to inpatient and day case activity have been separated and day case work will therefore attract a lower price which more closely represents the actual cost of delivering day case activity.

91. As clinical services evolve and as the direction of policy travel is now clearly set towards patients receiving their care in less acute settings, the tariff is also changing so that it can support those providers at the forefront of delivering care as close to home as possible. However, at present only services that have data which can be submitted through SUS and allocated to an HRG for payment can be funded through PbR.
92. One of the new design features of HRG4 is that it provides much better coverage of non-admitted patient activity. Under HRG4, procedure-driven outpatient activity will create core HRGs in a similar way to HRGs for admitted patients. Providing the procedure is correctly coded, it will generate an HRG. This is because all outpatient activity, irrespective of whether there is a procedure or not, will generate an HRG.

93. In 2009-10 the extent to which organisations are capable of coding and monitoring activity taking place in outpatient departments varies greatly and, as a result, we have taken the decision not to include outpatient procedures within the mandatory PSD tariff. We have, instead, made the PSD tariff non-mandatory for outpatient procedures, which can be used as part of the negotiations to price activity which generates outpatient procedure tariffs (see Section 4).

94. PSD prices have been calculated using a weighted average of reported costs for day case and outpatient procedure activity. As there is an imbalance between the large amount of activity recorded as day case and the smaller amount recorded as outpatient procedure this means that the PSD price is heavily skewed, and in some cases directly equivalent to, the day case price.

95. The HRGs where the day case price (PSD tariff) is deflated by more than 5% due to the reported outpatient procedure data are flagged in the published tariff tables. HRGs where the PSD tariff has been normatively adjusted have not been flagged.

96. The longer term intention is that the PSD tariff, when it includes both day case and outpatient procedures, will help incentivise the shift of activity, where it is clinically appropriate, to less acute settings including outpatient clinics.

97. To qualify for a PSD tariff the contact should be planned, but not necessarily the procedure. The patient will normally have spent time on a waiting list and will be formally admitted to the hospital for treatment. Non-elective (which includes emergency) activity which also takes place on a same day basis, with no overnight stay, will not be included in the PSD tariff. Commissioners will want to monitor levels of this activity to ensure that there is no change in the way such patients are managed which is detrimental to good patient care.
98. PSD tariffs have been supplied for all activity meeting certain criteria. Unusually, there may be activity taking place on a planned same day basis which does not have a tariff. Sometimes this will be a matter of incorrect coding or attribution but may also be due to changes in the way treatment is delivered. As far as possible we have sought clinical advice to ensure that where it is not clinically appropriate for activity to take place on a same-day basis, there is not a PSD tariff. Where commissioners and trusts are satisfied that that activity is suitable for inclusion as a planned same day case, the activity should be subject to locally agreed pricing. Local reference costs will be available to support this process but we suggest that both commissioner and provider need to be satisfied that the activity is being correctly coded and categorised before a local PSD price is agreed.

99. From 2009-10, when calculating the PSD tariff, SUS will apply new logic. This logic will affect any planned day case episodes that are for the same patient, at the same provider and with the same date of admission that would previously have been ‘spelled’ into the same spell. Under the new logic, the fact that the episodes have the same date of admission will not trigger their amalgamation. Instead, these different planned day case episodes will now be ‘spelled’ separately, and as such each individual planned day case episode will attract a PSD tariff (although there can be more than one procedure carried out in a single patient admission).

**Short stay elective tariff**

100. With the introduction of the new PSD tariff, in order to ensure that very short lengths of stay in hospital are appropriately rewarded, and that the incentives are aligned correctly between elective inpatients and day cases, a short stay elective tariff has been introduced.

101. An adjustment for short stay elective admissions applies where there is a clear disparity between the elective and PSD tariffs, and to disincentivise providers from using elective inpatients over day cases, unless clinically appropriate.

102. The short stay elective tariff applies to certain HRGs when all three of the following criteria are met:

- there is a PSD tariff
- there is considerable short stay activity (defined as zero or one day) - at least 25% of elective activity nationally must be short stay (as determined by 2006-7 HES data)
- there is a significant difference between the PSD and elective tariff, ie the elective tariff is twice the price of the PSD tariff.
103. These criteria are national and not local, and are currently built into the SUS PbR Grouper. If these criteria are met, then any elective admission with a length of stay of less than two days (ie zero or one day) receives the PSD tariff. Any adjustments to the tariff, such as specialised service top-ups, will be applied to the reduced tariff.

104. As with the short stay emergency tariff, the short stay elective tariff does not apply to children (defined as less than 19 years of age).

105. Details of the HRGs to which the short stay elective tariff applies are provided on the Department’s website as part of the 2009-10 tariff information.

**Short stay emergency tariff**

106. The short stay emergency tariff is a mechanism for ensuring appropriate reimbursement for lengths of stay of less than two days where the average HRG length of stay is longer.

107. The tariff adjustments for short stay emergencies have been revised for 2009-10 using more up-to-date costings, and reflect higher resource usage. The new short stay percentages are calculated by comparing non-elective costs with observation / pre-assessment unit costs.

108. The short stay emergency tariff applies when ALL of the following criteria are met:
- the emergency admission has admission code 21-24 or 28
- the assignment of the HRG can be based on a diagnosis code, rather than on a procedure code alone
- the spell is not for a child, defined as aged under 19 years on date of admission. (Note: this is a change from the 2008-09 guidance, in which a child was defined as under 17).
- the patient’s length of stay is either zero or one bed-days
- the HRG’s average length of emergency stay is two days or more
- the HRG does not have an inbuilt length of stay
- the HRG is not a mental health HRG nor invalid for grouping.

109. If all of these criteria are met, then the short stay emergency tariff applies, regardless of whether the patient is admitted under a medical or a surgical specialty. Any adjustments to the tariff, such as specialised service top-ups, will be applied to the reduced tariff.

110. The level of reduction depends on the national average length of stay of the HRG. The short stay non-elective prices are published as part of the tariff and do not need to be locally calculated, see Table 6 below:
Table 6: Percentage of full tariff payable when short stay emergency adjustment applies

<table>
<thead>
<tr>
<th>HRG with national average length of stay</th>
<th>Short stay tariff (% of full tariff applied)</th>
<th>2008-09 figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 days</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>3-4 days</td>
<td>55%</td>
<td>35%</td>
</tr>
<tr>
<td>5 or more days</td>
<td>35%</td>
<td>20%</td>
</tr>
</tbody>
</table>

111. The above table works in the following manner:

- if an HRG has an average length of stay of 2 days, and the patient’s length of stay is 0 or 1 days, the organisation receives 75% of that HRG’s tariff
- if an HRG has an average length of stay of 3 or 4 days, and the patient’s length of stay is 0 or 1 days, the organisation receives 55% of that HRG’s tariff
- if an HRG has an average length of stay of 5 days or more, and the patient’s length of stay is 0 or 1 days, the organisation receives 35% of that HRG’s tariff.

Removal of the differential tariff

112. We introduced this variation to the tariff in 2006-07 in order to share equally between providers and commissioners the financial risk of increasing numbers of certain emergency admissions.

113. Under the variation, a reduced rate of 50% of the relevant tariff has applied to emergency spells above and below an activity threshold, which for 2008-09 was set using the 2007 calendar year. This reflected stakeholder views that demand management initiatives were making a difference on the ground and so the most up-to-date threshold should be used to reflect this.

114. Stakeholders suggested that the need for the differential tariff would diminish as arrangements to manage admissions to secondary emergency care improved. Generally this has proved to be the case, and so we are removing this adjustment from 2009-10.
115. **It is therefore confirmed that there will no longer be a differential tariff for emergency admissions in 2009-10.**

116. This change means that all emergency activity within the scope of PbR will be subject to payment in line with national contract terms.

### Outpatient attendances

117. In 2009-10, consultant-led clinics start to attract the mandatory outpatient attendance tariff. There is no national tariff for non-consultant-led clinics, but we encourage health economies to consider setting local prices for this activity. We are interested in hearing both about such local approaches and suggestions for a national approach to reimbursing non-consultant-led care; please e-mail pbrcomms@dh.gsi.gov.uk

118. The exception to this approach is for maternity services. We have set the same mandatory price for consultant and non-consultant led activity, reflecting that the majority of pregnant women receive the same care through a midwife, whether or not a consultant is responsible. This tariff applies to both treatment function codes 501 (obstetrics) and 560 (midwife episode). Providers should code consultant-led activity to 501 and non-consultant led care to 560.

119. Aside from maternity, there are two other significant changes in 2009-10. First, the costs associated with diagnostic imaging HRGs are unbundled from outpatient attendances. Payment for this activity will not be included within outpatient attendance tariffs, and needs to be agreed as a separate funding flow. Non-mandatory tariffs are being issued for these activities, and these are covered in Section 4. Diagnostics not covered by these unbundled HRGs, such as plain film x-rays, continue to be included within the cost of outpatient attendances. Diagnostic Imaging HRG costs have been rebundled for all inpatient activity (PSD, elective and non-elective).

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16 The NHS Data Dictionary definition of a consultant led service is a “service where a consultant retains overall clinical responsibility for the service, care professional team or treatment. The consultant will not necessarily be physically present for each Consultant Led Activity but the consultant takes clinical responsibility for each patient’s care.” According to data definitions, a consultant led service does not apply to nurse consultants or physiotherapist consultants.

17 The NHS Data Dictionary states that “All non-consultant led activity is identified in the Admitted Patient Care CDS and HES by a pseudo Main Speciality Code of 560 for midwives, 950 for nurses and 960 for allied health professionals.”
120. Second, there are now tariffs for multi-professional as well as single-professional outpatient attendances. All mandatory Treatment Function Codes (TFCs) have these tariffs, but in some cases the costing data was poor, suggesting that multi-professional attendances were cheaper than single-professional attendances. In the absence of a costing evidence-base, for these TFCs we have set the same tariff price for single-professional as for multi-professional attendances, and expect local flexibilities to continue to be applied (as they could be in 2008-09) to ensure fair reimbursement. Where cost data showed the multi-professional attendances to be much more expensive, we have set the price at 200% of the single-professional figure.

121. The multi-professional tariff applies where multiple care professionals (including consultants) see a patient together, in the same attendance. It does not apply where a patient sees single professionals sequentially as part of the same clinic – such sequential appointments count as two separate attendances and should be recorded as such. We expect the multi-professional tariff to be used when a patient benefits in terms of care and convenience from accessing the expertise of two healthcare professionals at the same time. It would not apply if one professional is simply supporting another, e.g. in the taking of notes. As this is the first year for this new type of tariff we expect commissioners and providers to monitor its use closely.

122. For joint clinics where two consultants from different specialties see a patient together, the Treatment Function Code that the activity is recorded against should be determined locally. Multi-disciplinary meetings where the patient is not present continue to be treated as an overhead in 2009-10, although we are reviewing how this activity should be reimbursed. Please send your views to pbrcomms@dh.gsi.gov.uk

123. Third, there are no longer separate tariff prices for adult and child (defined for PbR in 2008-09 as under 17) attendances for each Treatment Function Code. For 2009-10, we have published tariffs for the new Paediatric Treatment Function Codes. These should be applied for services with dedicated staff and facilities for paediatric patients (defined as under 19, which is a change from the ‘under 17’ definition used in 2008-09) only.

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18 This is in line with Connecting for Health guidance on joint consultant clinics: http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/help/faqs-07/shared-care
124. Apart from these changes, the outpatient attendance tariff operates in the same way as in previous years. The outpatient attendance does not have to take place in trust premises, so clinics held in a GP practice or a children’s centre would be eligible to receive the tariff. For these clinics, it will be important to make sure the data can be fed into the Secondary Uses Service. Home visits are not eligible and should be subject to local pricing. We will be considering how to bring home visits into the scope of PbR in future years and encourage the local payment for these on an activity basis.

125. A first attendance is the first or only attendance in respect of one referral. Follow-up attendances are those that follow first attendances as part of a series in respect of the one referral. The episode (or series) ends when the patient is not given a further appointment by the consultant or the patient has not attended for six months with no forthcoming appointment. If, after discharge, the condition deteriorates and the patient returns to the clinic run by the same consultant, this is a new episode, that is the attendance is classified as a first attendance.

126. The end of a financial year does not necessarily signify the end of a particular outpatient episode. If two outpatient attendances for the same course of treatment are in two different financial years but are less than six months apart, or where the patient attends having been given a further appointment at their last attendance, the follow-up tariff applies.

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

128. For information on non-mandatory prices for non face to face outpatient activity, please see Section 4.

Pre-operative assessments

129. Pre-operative assessment can take place either on the day of intended admission or a number of days or weeks prior to the admission. Where the assessment takes place following admission the costs will be reflected in the inpatient HRG. Where the assessment takes place on a day prior to the admission, and meets the definition of a pre-booked consultant-responsible clinic, it will be recorded as an outpatient appointment and should attract the relevant tariff. Where the outpatient tariff does not apply, it will be for commissioners and providers to reach local agreement on pricing.
130. Where agreed, providers should make patient data available to commissioners in order to facilitate unbundling.

131. Any in-year changes to previously existing counting and costing procedures need to take place in accordance with the guidance in the standard NHS contract for Acute Services and the PbR Code of Conduct around in-year changes to counting, coding and costing.

**Accident & Emergency (A&E) and Minor Injury Units (MIUs)**

132. The 2008-09 tariff structure will continue for 2009-10. There are three tariffs (high, medium and low) for services delivered in A&E and MIUs, spread over twelve reference cost classifications, based on investigation and disposal. Table 7 provides a mapping of the twelve reference cost codes to the three tariff categories.

**Table 7: A&E and MIU categories and tariffs**

<table>
<thead>
<tr>
<th>Reference cost classifications</th>
<th>Code Label</th>
<th>Tariff</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>U06</td>
<td>Attendance disposal Invalid for grouping</td>
<td>No payment</td>
<td></td>
</tr>
<tr>
<td>DOA</td>
<td>Dead on Arrival</td>
<td>Standard</td>
<td>80</td>
</tr>
<tr>
<td>V01</td>
<td>High cost imaging (Died / Admitted)</td>
<td>Standard</td>
<td>80</td>
</tr>
<tr>
<td>V02</td>
<td>High cost imaging (Died / Discharged)</td>
<td>High</td>
<td>109</td>
</tr>
<tr>
<td>V03</td>
<td>Other high cost investigation (Died / Admitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V04</td>
<td>Other high cost investigation (Referred / Discharged)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V05</td>
<td>Low cost investigation (Died / Admitted)</td>
<td>Standard</td>
<td>80</td>
</tr>
<tr>
<td>V06</td>
<td>Low cost investigation (Referred / Discharged)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V07</td>
<td>No investigation (Died / Admitted)</td>
<td>Minor A&amp;E and MIU</td>
<td>59</td>
</tr>
<tr>
<td>V08</td>
<td>No investigation (Referred / Discharged)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V100MC *</td>
<td>Non 24 hour A&amp;E Department / Casualty Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V100MI *</td>
<td>Discrete Minor Injuries Unit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Removal of the 80/20 rule for A&E services**

133. The 80/20 funding mechanism was originally introduced to safeguard capacity in A&E, by paying 80% of the forecast costs as a block payment upfront, with the remaining 20% paid on the basis of actual activity.

134. This mechanism is no longer needed, and so it will not apply in 2009-10.
Specialised service top-up payments

135. The specialised services that will attract a top-up in 2009-10 for admitted patient care are specialised services for children and orthopaedic services. With the greater granularity and specificity of HRG4, the other specialised services no longer require a top-up to HRG prices.

136. As in 2008-09, all organisations will remain eligible for the orthopaedic top-up. The specialised services for children top-up will continue to be available only to those organisations deemed eligible in 2008-09. The list of eligible organisations is published as part of the 2009-10 tariff information. For clarity, ‘children’ are defined as under 19 years of age.

137. Top-ups are a percentage of the relevant HRG tariff. Details of these top-ups are shown in Table 8 below.

Table 8: Admitted patient tariff top-ups

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% Top-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised services for children</td>
<td>63%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>14%</td>
</tr>
</tbody>
</table>

138. The procedure and diagnosis codes that attract the top-up are provided as part of the 2009-10 supporting information available on the Department’s website alongside this document.

139. These codes are based on the Specialised Services National Definition Set, 2nd edition (December 2002). Further details regarding the codes to be used in 2009-10 can be found in a technical paper issued as part of the 2009-10 tariff package on the Department’s website.

140. Some HRGs already discretely identify specialised activity. Reference costs should already reflect the nature of the activity and these HRGs do not qualify for specialised top-ups. Non-applicable HRGs are listed with the 2009-10 tariff.

141. As in 2008-09, top-ups will be triggered by primary diagnosis and/or procedure(s) recorded in any valid position.
4. Non-mandatory prices

Introduction

142. Indicative tariffs for services not covered by the mandatory tariff have previously been issued as part of the PbR package to support and encourage the local agreement of prices for these activities.

143. This has been within a system, HRGv3.5, in which the services were never likely to become subject to a mandatory tariff in the near future because of issues relating to HRG design and data flows supporting the activity. However, as we now move to an HRG4-based tariff, the main issue preventing some activities having a mandatory tariff is the quality of the underpinning cost data, particularly for new services not previously covered by the HRG currency (eg chemotherapy).

144. The expectation is that, as the NHS becomes more familiar with HRG4, the quality of cost data will improve so that it can support a mandatory tariff. There are, therefore, risks associated with the continued use of indicative tariffs that could change materially in the next few years as the quality of reference cost data improves.

145. Other service areas (eg cystic fibrosis) have had indicative tariffs published in the past for currency units (eg outpatient contacts) that are being superseded by ongoing development work on alternative currencies.

146. For these reasons, we have therefore decided not to publish indicative tariffs for services not covered by the national tariff in 2009-10.

147. We are, however, issuing a number of non-mandatory prices for 2009-10 to support the achievement of specific policy aims. These areas are as follows:

- Unbundled diagnostic imaging activity associated with outpatient attendances
- Outpatient procedures
- Non face-to-face outpatient appointments
- Acute phase of rehabilitation
- Transthoracic Echocardiograms
- Adult Hearing Services
- Dermatology outpatient appointments

148. The rationale for publishing non-mandatory prices for these areas is explained in the detailed sections which follow.
149. These prices are non-mandatory in 2009-10 and so can be varied/negotiated to reflect local circumstances. They can be used as part of the negotiations. Separate data flows between providers and commissioners will need to be established for the purposes of local monitoring. As with the mandatory tariff, they are published net of MFF.

150. We are also publishing initial benchmark data relating to the new adult critical care HRGs. The information does not signal a non-mandatory price for each HRG, but gives an indication that the direction of travel is that we expect to introduce prices for these HRGs in the future.

**Diagnostic imaging**

151. One of the key features that the HRG4 currency offers the national tariff is the option for unbundling certain services which were previously bundled into inpatient spells and outpatient attendances under HRGv3.5.

152. In 2009-10, the mandatory outpatient attendance tariffs do not include the costs of diagnostic imaging carried out as part of this activity. As in 2008-09, diagnostic imaging carried out as part of inpatient and planned same day (PSD) activity, however, continues to be covered by the inpatient and PSD tariffs.

153. Non-mandatory prices for unbundled diagnostic imaging activity in outpatients are being issued for use in 2009-10 and the following guidance explains how these need to be applied. It is likely that as the NHS makes greater use of these unbundled prices, we will move in future to having a mandatory tariff.

**Applicability**

154. The unbundled tariffs have been issued for 2009-10 for the following diagnostic imaging activities:

- Diagnostic Imaging MRI
- Diagnostic Imaging CT
- Diagnostic Imaging Dexa
- Diagnostic Imaging Contrast Fluoroscopy
- Diagnostic Imaging Ultrasound (not obstetric)
- Diagnostic Imaging Nuclear Medicine

155. It should be noted that plain film x-rays (and their equivalents) and obstetric ultrasounds do not have unbundled tariffs. Plain film x-rays continue to be included in the core outpatient attendance cost and obstetric ultrasounds “map” directly to obstetric/maternity core (PSD) HRGs.
156. The unbundled tariffs should also be used where the services specified in paragraph 152 are operating as direct access services. Direct access for plain film x-ray and its equivalents will need to be priced locally.

157. In terms of operating these prices in 2009-10, the decision process shown at Figure 4 below should be followed, involving both providers and commissioners:

**Figure 4**

Within your local health economy, are you going to operate unbundled tariffs for diagnostic imaging activity?

- **YES**
  - A process needs to be put in place to determine what price will apply locally for this activity
  - **THEN**
    - Where unbundled tariffs are to be operated, putting in place appropriate reporting and monitoring arrangements that support the operation of tariffs for this activity.

- **NO**
  - A process needs to be put in place to determine an adjustment to the outpatient tariff locally to reflect the rebundling of the diagnostic imaging activity
  - **THEN**
    - A plan of action needs to be agreed to support the introduction of these tariffs into operation in the future.

158. The assumption here is that commissioning networks will apply a consistent approach with individual providers, ie one provider would not have different approaches with different commissioners for the same activity as this would be undesirable. However, it is recognised that there are many different and effective approaches adopted for the delivery of these activities, and organisations should consider adopting accepted best practice in managing this activity.
159. Organisations also need to look at what operational level the above process is followed at, ie is the decision to adopt the unbundling approach, or not, at scan level, scan-type level or for all scans commissioned together.

**Contrast imaging activity**

160. The cost and activity data underpinning the non-mandatory tariffs for diagnostic imaging indicates that there are similar amounts of activity occurring for ‘Magnetic Resonance Imaging Scan, one area, post contrast only’ as for ‘Magnetic Resonance Imaging Scan, one area, pre and post contrast’. Clinical input into the development of these non-mandatory tariffs advises that ‘post-contrast only’ activity should only occur in exceptional circumstances and suggests this activity and costing information is not representative of the activity that is happening, more how this activity is being counted and costed. As part of the process for these tariffs becoming mandatory within the system, it is important that this activity is more accurately reported to enable a more accurate and reliable tariff to be calculated.

**Reporting only**

161. We have also issued non-mandatory prices for ‘reporting only’ for unbundled diagnostic imaging as in previous years. If an organisation does not carry out the scan, but does provide the report, the reporting only tariff should be used.

162. The non-mandatory tariff price for unbundled diagnostic imaging includes the reporting element, and as such if a provider carries out the unbundled diagnostic imaging and reports upon it then only the unbundled diagnostic imaging tariff applies.

**Core HRG for unbundled tariffs**

163. All unbundled HRGs will have an associated core. For outpatient activity the core HRG may be a procedure-driven core, or an outpatient specific (attendance) core. Therefore, if an unbundled scan carried out in an outpatient setting does not have an associated attendance (eg if it is a service accessed directly) then the attendance needs to be recorded against an appropriate treatment function code (TFC) which will have a zero price.

164. For 2009-10 this activity needs to be recorded against TFC 812 “Diagnostic Imaging”. The price for such “scan only” attendances will be the unbundled HRG non-mandatory tariff only.
165. If an unbundled scan is carried out in an outpatient setting and does have an associated attendance then the combination of both the attendance tariff, which is mandatory and the unbundled scan tariff, which is non-mandatory, will form the overall price. PCTs will need to pay for both elements.

**Outpatient procedures**

166. Provided that they are correctly coded, procedures carried out in an outpatient setting will, under HRG4, generate an HRG and an associated price. In future years, it is intended that these prices will be the same as the relevant mandatory planned same day (PSD) tariff, which in 2009-10 will apply only to day case activity.

167. PSD prices have been calculated using a weighted average of reported costs for day case and outpatient procedure activity. As there is an imbalance between the large amount of activity recorded as day case and the smaller amount recorded as outpatient procedure this means that the PSD price is heavily skewed, and in some cases directly equivalent to, the day case price.

168. In 2009-10 the tariff generated by coding a procedure in an outpatient setting will be non-mandatory. As such a local price will need to be negotiated between commissioners and providers. SHAs may choose to offer guidance across or within economies to assist in price negotiation and reduce the risk of disputes arising.

169. When negotiating local price, commissioners and providers should pay due attention to the conditions of the standard NHS contract. That is the agreed price should be based on properly-incurred costs plus a reasonable margin. Other key factors which may need to be considered include the local reference costs and, given that coding in outpatient clinics is now being encouraged, the potential increase in recorded activity.

170. The ability to negotiate local price is being offered in recognition of the variability amongst providers with respect to their ability to code procedures taking place in outpatient departments and their ability to make that data flow within activity and payment systems

171. Providers and commissioners should have regard to the PbR Code of Conduct when agreeing contracts for this activity.

172. The nine outpatient procedures which attracted a mandatory tariff in 2008-09 are no longer treated any differently to other procedures and are now subsumed within the non-mandatory tariff for 2009-10.
173. All trusts and commissioners need to be aware that our intention is to move to a mandatory PSD tariff for outpatient procedure activity. Processes should be agreed and put into place to monitor, code and flow data from outpatient departments whenever relevant activity takes place. Commissioners and providers will want to ensure that the move to counting and coding this activity is properly managed both in terms of accuracy and potential impact.

Non face to face outpatient appointments

174. In 2009-10 there is a non-mandatory price of £23 for non face to face outpatient appointments. This applies to all Treatment Function Codes (TFCs) that have a mandatory tariff for face to face activity and is applicable to both consultant-led and non consultant-led activity. The funding for this activity is no longer in the outpatient attendance tariff as an overhead.

175. The definition of a non face to face appointment is an appointment which must directly entail contact with a patient or with a proxy for the patient such as a parent of a young child. A non face to face contact should replace a face to face appointment. The introduction of this non-mandatory price is designed to support the use of convenient communications.

176. The tariff is designed to apply where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the implications of test results to a patient would warrant the use of this tariff, but a telephone call, text or e-mail to report a result would not.

177. To improve this non-mandatory price in future years we are interested in your feedback. Please send comments to pbrcomms@dh.gsi.gov.uk

Acute phase of rehabilitation

178. HRG4 introduces unbundled HRGs for rehabilitation. We are not setting a mandatory tariff for these in 2009-10, as better costing information is needed. However, we do want to support the provision of rehabilitation in alternative settings. We are therefore continuing to publish non-mandatory prices for the acute phase of care for stroke, pneumonia, hip replacement and fractured neck of femur, as we did in 2008-09. The HRGs for these diagnoses/procedures have changed under the move to HRG4. Non-mandatory prices that are published do not relate to discrete rehabilitation.
179. Table 9 below shows new non-mandatory prices under HRG4 for 2009-10.

Table 9: Non-mandatory prices under HRG4 for 2009-10

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Elective Acute Phase Tariff (£)</th>
<th>Non-Elective Acute Phase Tariff (£)</th>
<th>% of Full tariff</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA22Z</td>
<td>Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy</td>
<td></td>
<td>2,224</td>
<td>55%</td>
</tr>
<tr>
<td>DZ11A</td>
<td>Lobar, Atypical or Viral Pneumonia with Major CC</td>
<td>1,961</td>
<td></td>
<td>49%</td>
</tr>
<tr>
<td>DZ11B</td>
<td>Lobar, Atypical or Viral Pneumonia without CC</td>
<td>1,437</td>
<td></td>
<td>61%</td>
</tr>
<tr>
<td>DZ11C</td>
<td>Lobar, Atypical or Viral Pneumonia without CC</td>
<td>1,050</td>
<td></td>
<td>69%</td>
</tr>
<tr>
<td>HB12A</td>
<td>Major Hip Procedures for non Trauma Category 1 with Major CC</td>
<td>3,407</td>
<td></td>
<td>59%</td>
</tr>
<tr>
<td>HB12B</td>
<td>Major Hip Procedures for Non-Trauma category 1 with CC</td>
<td>4,449</td>
<td></td>
<td>78%</td>
</tr>
<tr>
<td>HB12C</td>
<td>Major Hip Procedures for Non-Trauma category 1 without CC</td>
<td>4,509</td>
<td></td>
<td>83%</td>
</tr>
<tr>
<td>HA12B</td>
<td>Major Hip Procedures Category 1 for Trauma with CC</td>
<td>7,072</td>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>HA12C</td>
<td>Major Hip Procedures Category 1 for Trauma without CC</td>
<td>7,535</td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>HA13A</td>
<td>Intermediate Hip Procedures for Trauma with Major CC</td>
<td>5,071</td>
<td></td>
<td>66%</td>
</tr>
<tr>
<td>HA13B</td>
<td>Intermediate Hip Procedures for Trauma with Intermediate CC</td>
<td>5,635</td>
<td></td>
<td>86%</td>
</tr>
<tr>
<td>HA13C</td>
<td>Intermediate Hip Procedures for Trauma without CC</td>
<td>5,515</td>
<td></td>
<td>89%</td>
</tr>
<tr>
<td>HA91Z</td>
<td>Hip Trauma Diagnosis without Procedure</td>
<td>1,280</td>
<td></td>
<td>49%</td>
</tr>
</tbody>
</table>

180. These prices are based on the typical length of the acute phase for these HRGs. Further detail on how they are calculated can be found in ‘A step-by-step guide to the calculation of the national tariff for PbR in 2009-10’ which is available on the Department’s website alongside this document.

181. Further work is being done on developing payment for rehabilitation. This involves work with interested stakeholders as well as best practice work on pricing for stroke, as set out in Lord Darzi’s report High Quality Care For All. We would welcome expressions of interest in this work via pbrcomms@dh.gsi.gov.uk

Echocardiograms

182. In 2008-09, we published an indicative tariff for a direct access transthoracic echocardiogram in order to aid meeting the 18 weeks target. In 2009-10, the non-mandatory price for a direct access simple transthoracic echocardiogram is £87 plus MFF.

183. There are also two mandatory HRGs for echocardiograms: complex at £413 plus MFF (EA45Z) and simple at £87 plus MFF (EA46Z).
Adult hearing services

184. In 2008-09 there were four indicative tariffs for direct access adult hearing services:

i) Audiology hearing aid assessment
ii) Audiology hearing aid fitting
iii) Audiology aid device
iv) Audiology hearing aid follow-up

185. For 2009-10, the Department’s Audiology Board have developed pathways for direct access adult hearing services (see Figure 5).

186. A set of non-mandatory prices based on these pathways have been developed, using reference cost data (see Table 10 below). Any deviation from the pathways and prices can be agreed locally.

Table 10: Non-mandatory pathway prices for direct access adult hearing services (2009-10 prices).

<table>
<thead>
<tr>
<th>Tariff 1</th>
<th>Audiology hearing aid assessment only</th>
<th>£57</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tariff 2</td>
<td>Pathway for hearing aid assessment, fitting of one hearing aid device, cost of one device &amp; first follow up</td>
<td>£285</td>
</tr>
<tr>
<td></td>
<td>Breakdown as follows</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid assessment</td>
<td>£55</td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid fitting</td>
<td>£69</td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid device (x1)</td>
<td>£112</td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid follow up</td>
<td>£49</td>
</tr>
<tr>
<td>Tariff 3</td>
<td>Pathway for hearing aid assessment, fitting of two hearing aid device, cost of two device &amp; first follow up</td>
<td>£397</td>
</tr>
<tr>
<td></td>
<td>Breakdown as follows</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid assessment</td>
<td>£55</td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid fitting</td>
<td>£69</td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid device (x2)</td>
<td>£112 + £112</td>
</tr>
<tr>
<td></td>
<td>Audiology hearing aid follow up</td>
<td>£49</td>
</tr>
<tr>
<td>Tariff 4</td>
<td>Hearing aid aftercare</td>
<td>£26</td>
</tr>
</tbody>
</table>
Adult critical care

187. One of the key requirements for including critical care services within the scope of PbR is suitable casemix measures backed up by appropriate information systems and collection. A programme of development has been underway to introduce HRGs for adult critical care services for a number of years.

188. The adult Critical Care Minimum Dataset (CCMDS) has been in use since 1 April 2006. This data collection supports the proposed HRGs that have been developed for adult critical care services.

189. CCMDS data is grouped at patient level to determine the relevant HRG for the total number of organs supported within a critical care stay. The payment structure is the HRG price multiplied by the number of bed days of the stay.
190. During 2007-08 and 2008-09, the Department has analysed CCMDS data for 47,000 patients across 31 NHS provider organisations. The results have been encouraging in terms of quality of data and results of the analysis.

191. Consequently, we are publishing comparative information from the project that can be used by providers and commissioners alike to help inform the contracting process, and to provide an impetus to improving the quality of financial data reported by critical care units.

192. The benchmark data in Table 11 below allow providers and commissioners to discuss critical care delivery and funding, alongside comparative information. The data are based on 2006-07 patient-level activity from the organisations that participated in a national project, and 2006-07 reference cost information from all NHS trusts.

193. These data do not include the costs of high cost drugs and blood products published as exclusions to PbR.

194. The average profile of bed days per HRG (the ‘casemix’) from providers that took part in the project is given, with other comparative information that may be useful for the contracting process. This information needs to be looked at in total terms, not at an individual patient basis, as there are some patients who have long-stays in each HRG.

195. Further information on the adult critical care HRGs, their derivation, scope and use can be found at the Department’s website and also at the Information Centre’s website.

Table 11: Adult Critical Care benchmark data and other comparative information

<table>
<thead>
<tr>
<th>HRG</th>
<th>Organs supported</th>
<th>Average Casemix</th>
<th>Days that &gt;80% of patients stay in critical care</th>
<th>Proportion of patients that stay for one night only</th>
<th>Benchmark data (2009-10 prices)</th>
</tr>
</thead>
<tbody>
<tr>
<td>XC01Z</td>
<td>6</td>
<td>1.0%</td>
<td>NA</td>
<td>NA</td>
<td>£1,422</td>
</tr>
<tr>
<td>XC02Z</td>
<td>5</td>
<td>5.3%</td>
<td>NA</td>
<td>NA</td>
<td>£1,422</td>
</tr>
<tr>
<td>XC03Z</td>
<td>4</td>
<td>11.3%</td>
<td>13</td>
<td>19%</td>
<td>£1,351</td>
</tr>
<tr>
<td>XC04Z</td>
<td>3</td>
<td>20.7%</td>
<td>9</td>
<td>29%</td>
<td>£1,273</td>
</tr>
<tr>
<td>XC05Z</td>
<td>2</td>
<td>27.1%</td>
<td>5</td>
<td>33%</td>
<td>£1,116</td>
</tr>
<tr>
<td>XC06Z</td>
<td>1</td>
<td>32.9%</td>
<td>3</td>
<td>50%</td>
<td>£826</td>
</tr>
<tr>
<td>XC07Z</td>
<td>0</td>
<td>1.6%</td>
<td>2</td>
<td>67%</td>
<td>£510</td>
</tr>
</tbody>
</table>

20 http://www.ic.nhs.uk/services/casemix/hrg4/prepare-for-hrg4
• In a typical trust, 80% of critical care patients would require organ support for 3 organs or less, with a third of patients only requiring support for only 1 organ.

• For patients with a total of two organs supported during their critical care stay, 80% will have been discharged from critical care within 5 days (4 nights) with a third of patients only in for one night (two days).

• The total cost of outreach services, as submitted in reference costs, are included within this data.

• The data excludes support of the liver and critical care activity in specialist burn units, spinal units and specialist hepatic critical care units.

196. The DSCNs relating to critical care are 01/2005 (HRGs) and 13/2005 (CCMDS). These set out the data requirements and describe the HRGs. Further detailed information and background is available via the Department’s website.21

197. Commissioners and providers should agree the structure of their funding model as part of the contract negotiations: a capacity funding (80/20) model, a 100% patient-based model, or a different model, and introduce agreed local arrangements for the payment structure for long-stay patients.

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

Dermatology outpatient appointments

199. In 2009-10 (as for 2008-09) we are not publishing a mandatory tariff for dermatology outpatient appointments. Instead, we have published non-mandatory prices. These prices should be used to inform local negotiations. The local price for the service should take into account any local service reconfigurations and the resulting changes to the casemix being seen by both primary and secondary providers.

200. Where there has been little change to service delivery, the non-mandatory prices may still be appropriate. Where less complex work has moved from a secondary into a primary care setting, the secondary care outpatient tariff should be set at a level higher than the non-mandatory tariff to take account of this casemix change.
5. Flexibilities

Introduction

201. PbR is meant to be a tool, not a strait jacket. Having a national price for defined units of care is useful for both commissioners and providers because it:

- **Improves transparency** – A published list of tariff prices increases transparency as everyone can see the price of treatment for a defined spell of care across England
- **Increases certainty** – Providers and commissioners know the cost of care in advance
- **Facilitates competition** – A set price ensures that providers are competing on the basis of quality and not simply seeking to reduce costs at the expense of all other factors
- **Simplifies negotiations** – It avoids the need for every PCT or Practiced Based Commissioning Consortium to negotiate with their providers on price as part of the contracting process.

202. These benefits, the result of national tariffs as part of PbR, are considerable. However, we recognise a national pricing structure can never reflect the reality of the most innovative care occurring locally. Therefore, in line with the principle of subsidiarity, there needs to be the opportunity for local discretion, so that PbR is not seen as a barrier to providing the best care for patients.

203. Within PbR, the application of such local discretion to national currencies and/or prices is referred to as a flexibility. This section of the guidance establishes some principles for the use of flexibilities, seeks to explain existing flexibilities in PbR and offers some worked examples of how flexibilities can be used in future. It aims to steer a course that protects the benefits of national price and currencies, whilst allowing for local innovation and material redesign of services.

**Principles for the application of local flexibilities**

204. To ensure that local flexibilities are applied reasonably and achieve their desired outcome, we thought it would be useful to set out a few clear principles for their application.
Figure 6 – Flexibility principles

The flexibility supports the provision of care that is better for the patient and the NHS – Obviously, any local flexibility should be supporting better care for patients, whether it is closer to home, more convenient or of higher quality. A flexibility may also benefit the NHS as a whole, by reducing the costs to the whole health system.

The flexibility supports material service redesign and is not simply a change to national price – Local flexibilities are NOT a means of reducing or increasing national prices without any change to how services are provided. This would negate the benefits of national pricing.

The flexibility is the product of local agreement – With due regard to the PbR Code of Conduct, flexibilities should be agreed in advance by providers and commissioners and, where appropriate, local discussions can be supported by SHA PbR leads.

The flexibility is clearly established and documented – An audit trail for the agreed flexibility is necessary and it should be documented as part of contract negotiations.

The flexibility should be time limited and reviewed as appropriate – Flexibilities are not set indefinitely. For instance, pass through payments for new technology apply for three years. It may be that a local innovation becomes the national norm and the tariff changes to recognise this.

205. As the recent Audit Commission Report *The right result? Payment by Results 2003-07* noted “PbR must be operated transparently and according to the rules to ensure its future credibility and success as a policy.” Following these national principles should ensure that PbR’s transparency and credibility are safeguarded.

Unbundling

206. Unbundling is the term given to separating out elements of care contained within bigger packages of care such as rehabilitation (from an inpatient stay) or diagnostic imaging (from an outpatient appointment). Unbundling allows for the provision of services in more convenient ways – for instance a patient can be supported to recover from a stroke in their own home.

207. We support unbundling where it benefits patients, and we have sought to provide tools to facilitate unbundling, such as the provision of non-mandatory prices for diagnostic imaging. HRG4 also unbundles some other elements of care.

'Pass through' payments

208. Pass through payments exist to allow additional payments for new devices, drugs, treatments and technologies or a new application of existing technologies. They give the commissioner the flexibility to make an additional payment for care that is better than the standard care covered by the national tariff. This additional payment may have longer-term efficiency benefits, eg reducing the likelihood of the need to repeat a procedure.

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

- The pass through arrangement should be fixed for a maximum period of three years only from the date at which the pass-through funding arrangement first applies (this could be mid-way through a financial year). In exceptional circumstances these arrangements may be extended, with the agreement of both commissioner and provider.

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

- The price to be attached to the pass-through funding should be agreed in advance and the price should only relate to the additional costs associated directly with the device or technology and its use relative to the cost of the alternative treatment.

- If appropriate, the device, technology or procedure should be included on the NICE list of Interventional Procedures.

- PCTs should have due regard to the procurement arrangements for these drugs, devices, technologies or treatments identified as being suitable for pass through funding.

210. It is important to let the Department know when a pass through payment has been agreed as this helps us improve and develop PbR to take into account innovation. Please e-mail details on pass through payments to pbrcomms@dh.gsi.gov.uk.
Emergency readmissions

211. It is generally undesirable for a patient if they are re-admitted shortly after a hospital stay. The PbR guidance is clear that emergency readmissions should not attract full reimbursement if the provider did not provide sufficient quality of service or prepare patients adequately for discharge.

212. To ensure fair reimbursement, we recommend that contracts have provisions in place allowing PCTs to not pay for higher than expected levels of readmissions. We encourage commissioners to look at this issue locally – the recent Audit Commission report found that provisions around emergency readmissions were not always included in contracts.\(^{23}\)

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

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

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

\(^{23}\) The Audit Commission, *The right result? Payment by Results 2003-07*, March 2008
215. PCTs and providers should agree as part of contract discussions what level of emergency readmissions are to be expected in the coming year. This estimate will take account of the specific services noted above and any other local services where open access arrangements are a feature. Historical levels of readmissions should be reviewed along with the reasons for the existing levels. Any emergency readmissions above this locally agreed rate can be considered for adjustments to the level of reimbursement by PCTs at year-end.

Fixing local prices for activity outside the scope of PbR

216. As the Options for the Future of PbR 2008-09 to 2010-11 consultation\(^{24}\) emphasised, the absence of a national tariff does not mean local health economies have to resort to block contract funding arrangements.

217. The establishment of local prices for services that do not have a mandated tariff is not strictly a flexibility, as the only constraint is the desire of providers and commissioners to reach a local agreement.

218. Local prices can be established in advance of national prices – for instance one health economy had a set price for home births before a national price was established in 2008-09.

219. In order to establish a local price there needs to be clarity as to what currency is being used, ie the unit for which a payment is being made. There are a range of options here (see Figure 7 overleaf).

\(^{24}\) http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_073103
Figure 7

Currency Options

There are pros and cons to any point along this spectrum.

Block budget/grant: Lump sum over period of time (e.g. 1 yr). Sum independent of no. of patients.

Per head - capitation: Periodical (e.g. annual) lump sum per patient. Usually on list or enrolment system.

Fee for individual service: Payment for providing a defined pathway of care with multiple episodes/interventions. Used where patients have stay in hospital. Can be set to reduce over time.

ENTIRELY AGGREGATED

ENTIRELY ATOMISED

What does it look like?

For what is it used?

GP contract increased weighted capitation & added quality adjustments

PbR has enabled choice, increased day cases, reduced LoS & helped tackle waiting.

Fee for individual service

Block budget/grant

Per head - capitation

Per period - eg year of care

Per patient pathway

Per case - diagnostic/procedure

Per day - individual service

Currency Options

220. Once the currency is decided, the agreement of local prices may be facilitated by utilising national or local cost data, including reference costs. We also encourage the use of patient level information and costing, to establish a price from the bottom-up.\(^{25}\)

221. For the establishment of local prices involving equipment and technology it may be beneficial to consider buyer’s guides and evaluations carried out by the Centre for Evidence Based Purchasing.\(^ {26}\)

222. The document Currency and Pricing Options for Community Services explores these issues in more detail with particular reference to the community setting.\(^ {27}\)

\(^{25}\) http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHScostingmanual/DH_080056

\(^{26}\) http://www.pasa.nhs.uk/PASAWeb/NHSprocurement/CEP

\(^{27}\) The Currency and Pricing Options for Community Services document can be found at the following link: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093008
Creative use of flexibilities in the future

Bundling or pathways

223. The bundling of different aspects of care together to create an integrated pathway, could be beneficial in promoting seamless care for people with ongoing care needs. We are keen for local health economies to explore this approach and have also nationally introduced a non-mandatory price for a pathway of care for adult hearing services in 2009-10 (see Section 4).

224. Such an approach could allow one provider to co-ordinate care and potentially allow for the shifting of risk on to that provider. For instance, the costs of emergency admissions for a patient with long term conditions could become the responsibility of the provider of integrated care.

Issues to consider when bundling

- Do the patient benefits from bundling outweigh the potential loss of choice?
- Is it possible to produce an accurate cost for the bundled elements (this may require a detailed understanding of the costs of the constituent elements)?
- Is it possible to arrive at a clear specification for what is included within the bundle?

225. Some local health economies are already pursuing a pathway approach, as shown by Figure 8.

Figure 8 – case study

Somerset PCT has set up an integrated community service for people with Chronic Obstructive Pulmonary Disease (COPD). A single service provider covers all aspects of COPD community care (including assessment, pulmonary rehabilitation, oxygen service, support for self management, and care planning), and interfaces with GPs, hospitals and other providers as necessary.

The service is funded through a fixed value contract (based on need and activity estimates) which incorporates an incentive and rewards framework, including patient outcomes and reduced hospital admissions. GP and acute hospital care continue to be separately funded.
Joint incentives and gain sharing

226. The application of tariff payments is generally a simple transaction. If a provider does more activity they will be paid more by their commissioner, and are able to retain any surplus.

227. However, with service redesign there is an opportunity to do some gain sharing and apply joint incentives.

228. We encourage commissioners and providers to think through the balance of incentives and see if there are examples where both can gain.

Infectious Disease Isolation Units

229. Additional funding can be provided by PCTs for infectious disease isolation wards. The same arrangements apply as for the pass through payments.

SHA flexibilities

230. There are specific instances in which an SHA, involving its PCTs where appropriate, may exercise its discretion to provide support in addition to tariff income, or to recover support that was previously given:

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

Major new capital investment and PFI

231. The national tariff is currently based on average costs reported by NHS organisations. These average costs will show the full cost of providing the service, including the cost of buying, owning and maintaining buildings, equipment and other fixed assets. The annual tariff uplift takes account of anticipated increases in capital charges, and the revenue impact of new Private Finance Initiative (PFI) projects becoming operational.
Proud of a local approach? Let us know
We are very interested in hearing about any innovative ways in which local agreement has been reached on payment to allow better care for patients. If you would like to share what you have achieved locally please e-mail your example to pbrcomms@dh.gsi.gov.uk
6. Other operational issues

Market Forces Factor (MFF) payment process for mandatory tariff activity

232. In 2009-10 the MFF payment associated with activity within the scope of PbR for mandatory tariff will be paid directly by the responsible commissioning PCT (for both contract and non-contract activity). This new payment mechanism replaces the four-stage central payment process in place for 2008-09. The Department will no longer deduct MFF from PCT allocations so PCTs will have the resources to meet the MFF costs directly.

New payment process

233. From 1 April 2009, the new ‘local’ approach to paying the MFF for mandatory tariff activity for 2009-10 aims to achieve:

   i)  greater consistency in approach across all providers (eg community, Independent Sector (IS))
   ii) consistency in approach with non mandatory tariff activity (ie local prices have always included MFF element)
   iii) improved cash flow for NHS organisations (monthly reconciliations allow faster update to figures – not dependent upon the central process)
   iv)  a reduction in burden for all organisations involved in the central four-stage payment process
   v)  a more transparent process, controlled and managed by providers and commissioners.

234. Where prices for activity have been negotiated locally, as a result of local flexibilities including unbundling, the MFF element of the agreed local price should continue to be paid locally by the PCT.

235. It is expected that the MFF element in respect of mandatory tariff activity will be included as part of the agreement of activity levels for 2009-10 between commissioners and providers, included in contract values. MFF will no longer be deducted from PCT allocations by the Department so PCTs will have the resources to meet the MFF costs directly.

236. For example, if an NHS provider (ABC) undertakes £500,000 worth of mandatory tariff activity (based on national tariff prices) with commissioner XYZ, the value of the contract will now include the relevant MFF payment (ie £500,000 x MFF index). See Table 12 below for an example:
Table 12

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
<th>Column D</th>
<th>Column E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual contract value @ national tariff</td>
<td>MFF Index</td>
<td>MFF payment</td>
<td>Total contract value</td>
<td>Monthly Invoice amount for PCT XYZ*</td>
</tr>
<tr>
<td>500</td>
<td>1.20</td>
<td>100</td>
<td>600</td>
<td>50</td>
</tr>
</tbody>
</table>

* in 2009-10, reflecting the move away from a central payment mechanism, initial monthly instalments will be subject to change based on reconciliation process.

237. The MFF payable in respect of the tariff value is non-negotiable and will be calculated based on the value of tariff activity, including any adjustments required by the operation of PbR (eg specialist top-ups).

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

239. In order to facilitate this process, it is expected that the MFF element of the amounts payable should be itemised separately on the contract value and the monthly reconciliation accounts. It may be necessary for NHS organisations to update their contracting software to accommodate this change in approach. SUS PbR will include the final tariff value to facilitate this process.

**MFF indices used to determine MFF payments**

240. Organisations should use the relevant PbR MFF payment index, which is provided as part of the supporting information available on the Department’s website alongside this document.

241. Table 13 below provides a summary of the arrangements for MFF payments associated with provision of PbR activity.
Table 13: Arrangements for MFF payments associated with provision of PbR activity

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Payment arrangements</th>
<th>MFF value</th>
<th>MFF payment mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS acute trusts / foundation trusts</td>
<td>National tariff</td>
<td>NHS Trust</td>
<td>MFF paid directly to provider by PCT</td>
</tr>
<tr>
<td>PCT as provider</td>
<td>National tariff *</td>
<td>PCT Provider</td>
<td>MFF paid directly to provider by PCT</td>
</tr>
<tr>
<td>IS (including previous Extended Choice Network and Free Choice Network providers)</td>
<td>National tariff</td>
<td>MFF of the NHS acute trust nearest to the location where the care was delivered</td>
<td>MFF paid directly to provider by PCT</td>
</tr>
<tr>
<td>ISTCs</td>
<td>As per contract</td>
<td>As per contract</td>
<td>As per contract</td>
</tr>
</tbody>
</table>

* national tariff where defined as ‘hospital based services’ or equivalent – otherwise payment based on local PBC arrangement.

242. SHAs should notify the Department in the event of a potential merger, to allow for the Department to recalculate the relevant indices. The Department will communicate any change in the MFF index for any NHS organisations in-year (for example, as a result of a merger), through the normal channels (SHA PbR Leads). In the case of a merger, the revised MFF index (where applicable) for the organisation will be applicable from the official date of the merger.

243. Payment of the MFF element for non-contract activity should also be managed locally using the relevant provider’s MFF index. Therefore, invoices for Non Contract Activity (NCA) should include MFF at the appropriate rate for the provider organisation.

244. The process for payment of the MFF element for non-mandatory tariff activity remains unchanged, as locally agreed prices for this activity will already include the MFF element.
245. The new MFF payment mechanism for mandatory tariff activity (from 1 April 2009) does not affect the 4-stage central process that is in place in respect of (contract and non-contract) activity carried out in 2008-09.

**Activity commissioned by devolved administrations and non-contract activity**

246. Separate guidance will be published in support of payment for this activity. Until this is available, English providers should continue to negotiate local prices for these patients.

**NICE adjustments**

247. NICE produces a range of guidance including appraisal guidance (guidance on specific health interventions, including pharmaceuticals).

248. To date, adjustments to the tariff (or other approaches) have focused on technology appraisals because these are generally treated as ‘must dos’ and are normally supported by a three month funding direction.

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

- Through an adjustment within the national tariff uplift (dealing with pay and prices, pay reform and technical issues)
- Through specific adjustments to the national tariff prices directly
- Through an exclusion to PbR, eg high cost drug exclusion.

250. Table 14 shows the adjustments for 2009-10 which take account of NICE guidance. This includes three current adjustments and an amendment to an existing adjustment. Drug exclusions are provided alongside the 2009-10 tariff.

251. The use of the drug alteplase for stroke will continue to receive a targeted adjustment of an increase in payment. This will deliver an increase of £828 when HRG AA22Z (Non-Transient Stroke or Cerebrovascular Accident, Nervous systems infection or Encephalopathy) is coded with unbundled HRG XD07Z (Fibrinolytic Drugs Band 1)\(^{28}\).

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\(^{28}\) XD07Z is the unbundled HRG that contains the OPCS Code X83.3 (Fibrinolytic Drugs), which was used as the trigger code for the alteplase top-up in 2008-09.
252. The adjustment made for coronary artery stents has been amended following the publication by NICE of revised guidance in July 2008. The accompanying NICE Costing Template estimates an annual cost saving of the revised guidance of £5.2m. Therefore the HRGs have been adjusted downwards. To prevent too much variation in prices, the 2008-09 adjustment of £25.5m has been continued, meaning for 2009-10 a net adjustment of £20.3m has been made.

Table 14: NICE technology appraisals meeting criteria for adjustment

<table>
<thead>
<tr>
<th>Technology Appraisal</th>
<th>Publication Date</th>
<th>Adjustment for 2009-10 tariff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENT ADJUSTMENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA73: Angina and myocardial infarction - myocardial perfusion scintigraphy</td>
<td>November 2003</td>
<td>Adjust HRGs (EB01B, EB01Z, EB10Z) by £1.2m in proportion to activity (as in 2008-09)</td>
</tr>
<tr>
<td>TA105: Colorectal cancer- laparoscopic surgery (review)</td>
<td>August 2006</td>
<td>Adjust HRGs (FZ08A, FZ08B, FZ09A, FZ09B, FZ10A, FZ10B) by £2m in proportion to activity (as in 2008-09)</td>
</tr>
<tr>
<td>TA122: Ischaemic stroke - alteplase</td>
<td>June 2007</td>
<td>Targeted adjustment with top-up on AA22Z combined with unbundled HRG XD07Z 'Fibrinolytic Drugs Band 1'</td>
</tr>
<tr>
<td><strong>AMENDMENT TO EXISTING ADJUSTMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA152: Coronary artery disease – drug-eluting stents (review)</td>
<td>July 2008</td>
<td>Adjust HRGs (EA31Z, EA32Z, EA33Z, EA34Z) by £20.3m in proportion to activity</td>
</tr>
</tbody>
</table>

De-hosting

253. The de-hosting of services which were previously provided on an ‘all-comers’ basis is primarily to incentivise the redesign of services to improve access, in particular providing services closer to people’s homes. Under hosted services, money does not follow patients in the way the national tariff does, meaning host commissioners bear all the financial responsibility for the provision of these services, irrespective of which PCT is responsible for the patient.

254. De-hosting also aims to ensure that the element of PCT allocations designated for provision of previously hosted services is fair, and that non-host PCTs do not receive for free services which they have been allocated monies for. This aim, however, needs to be balanced against the risk of disproportionate bureaucracy, and so this is being managed locally by SHAs.
255. The relevant services, mainly A&E and GUM services, continue to be de-hosted in 2009-10. These arrangements continue to be managed by SHAs, including how cross-SHA border activities are managed.

**Figure 9 – De-hosting worked example**

As part of developing secondary care demand management strategies, PCT X are scoping whether to provide a new minor injuries unit (MIU) close to the major rail station of the area. This station is used by commuters from a wide range of PCT areas.

Under the principle of hosted services, they would be responsible for funding the care of all the patients using the service, irrespective of who was the patients responsible PCT. This makes this plan unviable as it is forecast that given the planned location of the facility, there would be a significant number of patients from other PCTs but no mechanism to recover funds for this activity.

However under de-hosting the host PCT has a mechanism for the re-charging for services provided for other patients PCTs. This therefore supports PCT X’s plans and makes it a more viable option.

**Timeliness of payments**

256. Increased timeliness of payments for PbR was introduced via the standard NHS contract for acute services, to provide more timely information for commissioning as well as supporting steps being taken nationally to achieve faster closing of accounts.

257. Payment reconciliations for PbR activity in 2009-10 will now be as per the standard NHS contract.

**Long stay outliers**

258. The HRG costs reported in the published 2006-07 reference costs do not include the cost of stays beyond a defined ‘trimpoint’ (these are listed separately as excess bed days). The outlier payment will operate after a patient’s length of stay exceeds the trimpoint. The trimpoint is defined in the same way as for reference costs, but is spell-based and there are separate elective and non-elective trimpoints. An HRG specific daily rate will be applied beyond this trimpoint. These are listed as part of the tariff information.
259. For spells that start before and finish in 2009-10, the 2009-10 tariff and trimpoints should apply on discharge.

260. The specialised service percentage top-up is not applicable to the long stay outlier payment.

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

**Zero price / no tariff price**

262. Where no data exists for a HRG / outpatient TFC, or a tariff is deemed inappropriate for a certain HRG / outpatient TFC and admission type (eg a PSD tariff for LA03A Kidney Transplant from Live donor 19 years and over), then no tariff price (£-) is supplied and local pricing will have to be agreed.

263. The only HRGs / outpatient TFCs that have a mandatory tariff zero pounds (£0), ie no payment should be agreed or made for this activity, are those which would not be appropriate under any circumstances. Four such HRGs / outpatient TFCs that fall into this category and are listed below.

**Table 15**

<table>
<thead>
<tr>
<th>HRG Code</th>
<th>HRG Description</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>PB03Z</td>
<td>Healthy Baby</td>
<td>Costs are included with the mothers care</td>
</tr>
<tr>
<td>UZ01Z</td>
<td>Data invalid for grouping</td>
<td>Organisations should not be funded for invalid data</td>
</tr>
<tr>
<td>U06</td>
<td>Data invalid for grouping</td>
<td>Organisations should not be funded for invalid data</td>
</tr>
</tbody>
</table>

**TFCs**

<table>
<thead>
<tr>
<th>TFC</th>
<th>TFC Description</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>812</td>
<td>Diagnostic Imaging</td>
<td>To ensure that ‘direct access’ diagnostic imaging unbundling can have a core HRG/OP TFC without a tariff.</td>
</tr>
</tbody>
</table>
7. Useful links

This section provides links to associated documents and websites that should be used when operating PbR in 2009-10:

- **PbR pages on the Department of Health website**

- **2009-10 NHS Operating Framework (which includes a link to the standard NHS contract)**

- **Who pays? Establishing responsible commissioner (published 18 September 2007)**

- **NHS Connecting for Health website**
  [www.connectingforhealth.nhs.uk](http://www.connectingforhealth.nhs.uk)

- **NHS Information Centre for health and social care website**
  [www.ic.nhs.uk](http://www.ic.nhs.uk)

- **British National Formulary**
  [www.bnf.org](http://www.bnf.org)

- **Audit Commission website pages on PbR**
  [www.auditcommission.gov.uk/pbr](http://www.auditcommission.gov.uk/pbr)
# Annex A – Summary of changes to PbR in 2009-10

<table>
<thead>
<tr>
<th>Tariff component</th>
<th>Status</th>
<th>Details</th>
<th>Para ref</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scopes &amp; Structures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisations within the scope of tariff</td>
<td>Little or no change from 2008-09</td>
<td>In 2009-10 the mandatory PbR tariff is payable for activity carried out by NHS trusts, NHS foundation trusts, PCTs as providers and independent sector providers</td>
<td>37-38</td>
</tr>
<tr>
<td>Services within the scope of the tariff</td>
<td>Little or no change from 2008-09</td>
<td>The mandatory tariff will be payable for elective and non-elective admitted patient care, outpatient attendances and A&amp;E services.</td>
<td>39</td>
</tr>
<tr>
<td>Currency underlying the tariff</td>
<td>Changed from 2008-09</td>
<td>Elective and non-elective admitted patient care and outpatient attendances - HRG4 A&amp;E services - HRGv3.5.</td>
<td>4</td>
</tr>
<tr>
<td>New MFF</td>
<td>Changed from 2008-09</td>
<td>New MFF payment indices following review of MFF by ACRA</td>
<td>232-245</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient activity</td>
<td>Changed from 2008-09</td>
<td>The inpatient tariff will no longer apply to day case activity. There will be four tariffs for inpatient activity:</td>
<td>86-88</td>
</tr>
<tr>
<td>- elective inpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- short stay elective inpatient (adults only and applies only to HRGs meeting specific criteria)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- non-elective inpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- short stay non-elective inpatient (adults only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist top-ups</td>
<td>Changed from 2008-09</td>
<td>There will be a reduced number and amount of top-ups for specialised services. The remaining top ups will continue to be available only to those organisations deemed eligible in 2008-09.</td>
<td>135-141</td>
</tr>
<tr>
<td>Short Stay Elective tariff</td>
<td>New</td>
<td>With the introduction of the new PSD tariff, in order to ensure that short stay electives are appropriately rewarded and that the incentives are aligned correctly between admissions and day cases, a short stay elective tariff has been introduced.</td>
<td>100-105</td>
</tr>
<tr>
<td>Short Stay Emergency Tariff</td>
<td>Changed from 2008-09</td>
<td>New percentages calculated by comparing non-elective costs with observation/pre-assessment costs.</td>
<td>106-111</td>
</tr>
<tr>
<td>Removal of the differential tariff</td>
<td>New</td>
<td>There will no longer be a differential tariff for emergency admissions. All emergency activity within the scope of PbR will be subject to payment at 100% tariff.</td>
<td>112-116</td>
</tr>
</tbody>
</table>
### Planned Same Day

| Planned Same Day tariff | New | Day case activity will attract the new planned same day (PSD) tariff. | 89-99 |

### Outpatients

| Outpatient attendances | Changed from 2008-09 | First and follow-up split retained. New features:  
- mandatory tariffs no longer include costs associated with diagnostic imaging  
- introduction of a multi-professional outpatient attendance tariff  
- introduction of a combined tariff for non consultant-led and consultant-led obstetric outpatient activity  
- non mandatory tariff for non face-to-face contacts where they replace a face-to-face contact  
- introduction of paediatric TFCs (removes need for child & adult split tariffs) | 117-131 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Procedures</td>
<td>Changed from 2008-09</td>
<td>Non-mandatory tariffs will be provided for a wider range of procedures. There will be no mandatory tariffs in 2009-10.</td>
<td>166-173</td>
</tr>
</tbody>
</table>

### Accident & Emergency

| A&E | Little or no change from 2008-09 | The 2008-09 HRGv3.5 tariff structure for A&E services will remain in place for 2009-10. The 80/20 funding rule will no longer apply | 132-134 |

### Operating rules

| Market Forces Factor (MFF) | Changed from 2008-09 | PCTs will retain funding for, and the responsibility for, payment of the MFF to providers in 2009-10. The MFF index for each organisation will be set centrally. | 232-245 |

### Exclusions

| High Cost Drug, Device and Procedure Exclusions | Changed from 2008-09 | As in 2008-09, a number of high cost drugs, devices, procedures and products will be excluded from the scope of tariff. These have been updated in line with advice from relevant stakeholders. | 45-52 |
| PTS out of scope | New | In 2009-10 the costs associated with patient transport services (PTS) for PbR activity will not be included within the national tariff. PTS will need to be commissioned directly by PCTs from providers of these services. | 66-69 |
### HTCS out of scope

| New | In 2009-10 the costs associated with Healthcare Travel Costs Scheme (HTCS) for PbR activity will not be included within the national tariff. HTCS will need to be commissioned directly by PCTs from providers of these services. |

### Flexibilities

| Little or no change from 2008-09 | As in 2008-09, a range of flexibilities, such as ‘pass-through payments’, will continue to be available. SHAs will also continue to have flexibilities available to them, which can be used to:
- specifically manage the financial impact of the introduction of HRG4
- manage risk associated with PbR Development Sites
- agree - exceptionally - to allow specialist top-ups to be paid to a provider who is not on the published list, provided the commissioner can make a compelling case for inclusion. |

### Non-mandatory prices

| New | In 2009-10 we will not publish indicative tariffs, but instead will publish a number of non-mandatory prices where these are necessary, for example to support the delivery of another policy such as Care Closer to Home, or where we want to signal the future development of a mandatory tariff.

In 2009-10 we will publish non-mandatory prices for the following:
- non face to face outpatient attendances
- adult hearing services
- echocardiography
- diagnostic imaging for outpatient attendances
- acute phase of rehabilitation
- outpatient procedures
- Dermatology outpatient appointments |
### Annex B – List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
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<tr>
<td>CCMDS</td>
<td>Critical Care Minimum Data Set</td>
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<tr>
<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<td>CT</td>
<td>Computerised Tomography</td>
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<td>DES</td>
<td>Device Evaluation Service</td>
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<td>DEXA</td>
<td>Dual Energy X-ray Absorptiometry</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DSCNs</td>
<td>Data Set Change Notices</td>
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<tr>
<td>FCEs</td>
<td>Finished Consultant Episodes of Care</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GUM</td>
<td>Genito-urinary Medicine</td>
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<td>HES</td>
<td>Hospital Episode Statistics</td>
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<tr>
<td>HRG4</td>
<td>Healthcare Resource Group 4</td>
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<tr>
<td>HRGv3.5</td>
<td>Healthcare Resource Group version 3.5</td>
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<td>HTAs</td>
<td>Health Technology Assessments</td>
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<td>HTCS</td>
<td>Healthcare Travel Cost Scheme</td>
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<td>IS</td>
<td>Independent Sector</td>
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<td>MFF</td>
<td>Market Forces Factor</td>
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<td>MIU</td>
<td>Minor Injury Unit</td>
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<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>NCA</td>
<td>Non Contract Activity</td>
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<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>MSC</td>
<td>Main Speciality Codes</td>
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<td>OPCS</td>
<td>Office for Population Censuses and Surveys</td>
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<td>PbR</td>
<td>Payment by Results</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PDT</td>
<td>Photodynamic Therapy</td>
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<td>PET</td>
<td>Positron Emission Tomography</td>
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<tr>
<td>PETCT</td>
<td>Positron Emission Tomography - Computed Tomography</td>
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<td>PFI</td>
<td>Private Finance Initiative</td>
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<td>PSD</td>
<td>Planned Same Day</td>
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<td>PTS</td>
<td>Patient Transport Services</td>
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<td>Strategic Health Authority</td>
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<td>SLAs</td>
<td>Service Level Agreements</td>
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<td>Single Photon Emission Computed Tomography with Computed Tomography</td>
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<td>SUS</td>
<td>Secondary Uses Service</td>
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<td>TFC</td>
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