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Dear colleague

Payment by Results in 2013-14 – information only (no action required)

Introduction

I am writing to update you on the work that the Department has been doing to prepare the Payment by Results (PbR) package for 2013-14.

Our plans reflect a continuation of the priorities set out in *Equity and Excellence* and which have informed developments in recent years, such as expanding the scope of PbR tariffs and currencies, increasingly basing payment on the cost of best practice models of care and introducing tariffs which cover 'pathways' of care. We are also continuing to set tariffs which promote the shifting of care to less acute settings and reducing lengths of stay in hospital where clinically appropriate. As in previous years, clinical advice and expertise has been central to the development of our plans for PbR.

With preparations underway for the transfer of responsibility for currency design and price setting for the 2014-15 tariff and beyond, Monitor and the NHS Commissioning Board are working closely and the Department has involved both organisations in the development of PbR arrangements for 2013-14. In due course, Monitor and the NHS Commissioning Board will be issuing further information on their approach to their new roles and how this will affect the service.

The table at Annex A contains details of the proposed PbR arrangements for 2013-14, but I should like to take this opportunity to highlight some key messages for the service to note.

We are continuing with the managed **expansion of the scope of national tariffs and currencies**. For adult mental health services, we will continue to mandate the use of the cluster currency for contracting, and for 2013-14 we will also issue non-mandatory indicative prices. We also plan to mandate the use of a number of quality and outcome measures. Further information on our plans for mental health is provided at Annex B.

We plan to complete the transition to the mandatory year of care tariff for Cystic Fibrosis which began in April 2012. We will publish mandatory tariffs for chemotherapy delivery and external beam radiotherapy in 2013-14, though the expectation is that organisations will be able to move from local prices to the new tariffs in a staged way, which is similar to the approach that we took for the implementation of the tariff for renal dialysis.

Emerging findings from the evaluation of **best practice tariffs** indicates that the policy is delivering real improvements in the quality of care that patients receive. In 2013-14 we plan to further expand the number of best practice tariffs aimed at:

- Promoting better management of long term conditions to reduce the risk of avoidable hospital admissions
- Delivering care in appropriate settings, with further tariffs set to incentivise day case and outpatient treatments where clinically appropriate
- Improving the quality of particular interventions, by linking payment to service accreditation.

As is the case in 2012-13, where the pricing of best practice tariffs links to operational efficiency, we will recognise this when setting the overall efficiency requirement.

Earlier this year we published a package of materials to enable the service to prepare for the planned implementation in 2013-14 of the **maternity pathway payment system**[1].

We are planning on the basis that the pathway payment system will be mandated from April 2013, with mandatory prices for the delivery element of the pathway and non-mandatory prices for the ante and post natal elements. We will test this proposal as part of the sense check exercise.

The costs of **diagnostic imaging undertaken in an outpatient setting** are currently 'bundled' into the outpatient attendance tariff. Concerns have been raised that the current reimbursement arrangements may act as a disincentive for scans to be carried out which will benefit the patient and may not appropriately reflect the cost of imaging associated with specialised care.

To address this, in 2013-14 we propose to set tariffs for diagnostic imaging which are separate to the outpatient attendance tariff. We will test this proposal as part of the sense check exercise. We are aware of the potential financial risks associated with this change of approach, but believe the clinical benefits to be significant. We will look to mitigate the risk when drafting the PbR guidance for 2013-14. This may include an expectation that providers and commissioners work closely to manage the financial risk.

[1] Available at: http://www.dh.gov.uk/health/tag/maternity-pbr/

Information about PbR ‘business rules’, such as the marginal rate of payment for increases in the value of emergency admissions, will be set out in the draft PbR guidance for 2013-14, which will be published alongside the tariff for road testing in December.

As in previous years, we are sense checking the draft tariff with a small number of organisations and people. This is where we ask them to identify and help us correct any prices which might be anomalous or introduce perverse clinical incentives. We are also asking a number of providers and commissioners to model the impact of the draft prices using local activity data, and identify any unintended consequences. A list of the NHS organisations taking part this year is attached at Annex C.

Our provisional timetable for the rest of the process is as follows:

Date	**Action**
20 September to 19 October 2012	Sense check – draft prices shared with PbR Clinical Advisory Panel, External Advisory Group, other partners and a number of NHS organisations
December 2012 to January 2013	Road test – tariff and draft guidance issued for comment
February 2013	Publication of final tariff package

I will write to you again should there be any amendments to this timetable.

Yours sincerely

David Flory CBE
Deputy NHS Chief Executive

ANNEX A: Proposals for Payment by Results in 2013-14

Tariff structure and adjustments

Issue	Detail
Tariff structure	We propose to 'unbundle' diagnostic imaging costs from the outpatient attendance tariff and make this activity subject to a separate tariff. We are aware of the potential financial risks associated with this change of approach, but believe the clinical benefits to be significant. We will look to mitigate the risk when drafting the PbR guidance for 2013-14. This may include an expectation that providers and commissioners work closely to manage the financial risk. We plan to set prices which are the same across all settings for an increased number of Healthcare Resource Groups (HRGs). This is intended to incentivise the provision of care in less acute settings where clinically appropriate.
Underpinning cost data	The 2013-14 tariff is largely based on 2010-11 reference cost data, though we have also made use of patient-level cost data to help inform the setting of some prices.
Healthcare Resource Groups	There will be a small increase in the number of HRGs that will have a mandatory tariff, primarily as a consequence of HRG design changes.
Accident & Emergency	We plan to introduce a more 'granular' A&E tariff in 2013-14, with separate prices for all 11 HRGs rather than grouping HRGs into five price bands as is the case in 2012-13. We also plan to align PbR A&E tariff definitions with those used in the NHS data dictionary by making all type 2 A&E departments eligible for the full range of A&E tariffs. This addresses a long-standing issue whereby type 2 A&E departments attract the lowest price in SUS PbR even though these may include some consultant-led single specialty 24 hour departments.
Outpatient procedures	There will be a further managed expansion in the number of HRGs that will have a mandatory outpatient procedure price.

Issue	Detail
Maternity	Organisations should be operating the maternity pathway payment system in shadow form in 2012-13, using the materials published by the Department earlier this year[2]. We are planning on the basis that the pathway payment system will be mandated from April 2013, with mandatory prices for the delivery element of the pathway and non-mandatory prices for the ante and post natal elements. This means that some non-delivery maternity admissions and outpatient attendances will be covered by non-mandatory rather than mandatory tariffs in 2013-14. We will test this proposal as part of the sense check exercise.
Funding for specialised services	Following work with the UK Children's Healthcare Alliance, we plan to move from a single to a two-tiered specialist top-up payment for children's services in 2013-14, to recognise different levels of specialisation. The new top-up levels will be 64% and 44%, though we are maintaining the overall value of the current children's top-up. We will also create separate chapter-level long stay payments for children-specific HRGs. Other specialist service top-ups will remain unchanged for 2013-14: • Spinal surgery – 32% • Neurosciences - 28% • Orthopaedic - 24%
Long stay payments	There will be two long stay payment rates per chapter – one for children-specific HRGs and one for all other HRGs. We will retain the five-day trim point 'floor,' so that relatively short stays do not attract a long stay payment.
Short stay emergency tariff	Threshold percentages will remain unchanged.
'Cherry picking'	The Government's response to the *NHS Future Forum report* included a commitment to tackle the 'cherry picking' of patients. Having consulted with our PbR

[2] Available at: http://www.dh.gov.uk/health/tag/maternity-pbr/

Issue	Detail
	advisory groups, we do not plan to tackle this issue through changes to tariff structure. We will instead look to strengthen guidance, with the possibility of including a list of procedures that appear to be most prone to 'cherry picking.'
Exclusions	We are reviewing and updating the list of excluded services, procedures, drugs and devices.

Best practice tariffs

Issue	Detail
Best practice tariffs	We are rolling forward the following existing best practice tariffs: • Adult renal dialysis • Cholecystectomy • Transient ischaemic attack (mini-stroke) • Hip and knee replacement • Fragility hip fracture and stroke • Paediatric diabetes • Interventional radiology • Home haemodialysis and assisted automated peritoneal dialysis • Major trauma In recognition of the administrative difficulties associated with its implementation, in 2013-14 we plan to make the cataracts best practice tariff non-mandatory. It will however still be available for commissioners and providers to use. We plan to make amendments to the following existing best practice tariffs: • Consider expanding the list of clinical scenarios covered by the Same Day Emergency Care best practice tariff to include: - Transient ischaemic attack (TIA) - Community acquired pneumonia - COPD - Supraventricular tachycardias - Minor head injury

Issue	Detail
	- Low risk pubic rami - Bladder outflow obstruction - Anaemia - Abdominal pain • Setting further best practice tariffs to incentivise the delivery of care in appropriate settings: - Hysteroscopy - Tympanoplasty procedures to be carried out as a day case in line with BADS guidelines - Treatment for pleural effusion to be delivered as a day case Proposed new areas for the best practice tariff programme in 2013-14 are: • Promoting better management of long term conditions to reduce the risk of avoidable hospital admissions, as per NICE clinical guidelines, for: - Paediatric epilepsy - Early inflammatory arthritis - Parkinson's disease - Diabetic ketoacidosis and hypoglycaemia for adults • Improving the quality of particular interventions: - Making an element of the tariff for endoscopy dependent on providers having attained, or being in the process of attaining, the relevant accreditation

Scope of PbR

Issue	Detail
Cystic Fibrosis	We plan to complete the transition to a mandatory year of care tariff for Cystic Fibrosis.
Chemotherapy and radiotherapy	We will publish mandatory tariffs for chemotherapy delivery and external beam radiotherapy in 2013-14, though organisations will be able to move from local prices to the new tariffs in a staged way. This will be similar to the approach that we took for the implementation of the tariff for renal dialysis.

Issue	Detail
	This approach will ensure that whilst progress in the development of tariffs for chemotherapy and radiotherapy is maintained, the logistical pressures and the risks for providers and commissioners are managed. As part of the introduction of mandatory tariffs for chemotherapy delivery and external beam radiotherapy, we will bring regular day and night attenders within the scope of PbR for these services and for renal dialysis.
Post discharge tariffs	The post discharge tariffs for pulmonary and cardiac rehabilitation and rehabilitation following hip and knee replacement will continue to be mandatory in 2013-14 for those trusts providing relevant integrated acute and community services. As part of the continued drive to shift the provision of care to more appropriate settings, further development of the post discharge tariff will form part of the ongoing 'recovery, rehabilitation and reablement' (RRR) work programme. The aim here is to provide the flexibility to 'unbundle' elements of the acute tariff to support best practice models of care.
Outpatient attendances	We are reviewing non-mandatory tariffs for neurology and neurosurgery outpatient attendances. We are also looking to introduce a mandatory outpatient attendance tariff for the new spinal surgery Treatment Function Code.
Mental health	We plan to issue non-mandatory indicative prices for the mandatory cluster currency for adult mental health services and mandate the use of a number of quality and outcome measures. See Annex B for further details.
Currencies	Ambulance services and adult and neonatal critical care will continue to have mandatory national currencies for contracting. We plan to introduce mandatory currencies with local prices for specialist rehabilitation and HIV outpatient care. Work is underway on the development of currencies and tariffs for the health assessments carried out on looked after children in out-of-area placements, and for 2013-14 we propose to introduce a mandatory currency

Issue	Detail
	and non-mandatory tariffs for these assessments. We are working with NHS colleagues on the development of a currency and tariffs for renal transplants, and we plan to introduce the currency on a mandatory basis in 2013-14.
Year of Care Funding Model	We anticipate that work to develop a Long Term Conditions Year of Care Funding Model will continue in 2013-14, with the aim being to deliver more patient-centred care and more effective use of resources. Seven 'early implementer' sites are currently testing the proof of concept and process of implementation, with a view to understanding how a robust national pricing structure might be developed.

ANNEX B

Mental health PbR in 2013-14

We will continue to roll-out mental health PbR in 2013-14 and embed the use of the currencies as the basis on which contracts are agreed. We also want to ensure that actions are undertaken during the year that could allow national tariffs to be introduced at a future date, subject to agreement by the NHS Commissioning Board and Monitor.

For 2013-14 we will be producing stand-alone PbR mental health guidance. This will be published alongside the main PbR road test package. There are three particular aspects of the forthcoming guidance that we would like to highlight.

Firstly, we will be publishing an indicative (non-mandatory) price for each cluster period, based on the review periods set out in the mental health clustering booklet. These will be informed by the reference costs submitted for 2011-12. Providers will be able to adjust the indicative cluster price by the relevant market forces factor to understand what they might receive per service user per cluster period if mandatory PbR tariffs were in place. These indicative prices can be used by providers for benchmarking purposes.

Secondly, we have already signalled the need to move to a single cluster price per provider. Some providers have already been able to agree to do this with all of their commissioners. Where this has not been possible local cluster prices based on the current contract value will need to be agreed. The mental health guidance will set out more detail about this, and how we envisage moving forward.

Thirdly, we will also be mandating the use of some quality and outcome measures for 2013-14. Agreement about exactly which measures should be used will not take place until towards the end of 2012, but it is planned to mandate a Patient Recorded Outcomes Measure (PROM) and a Clinical Led Outcome Measure (CLOM). Details of these will also be included in the road test package.

Both costing and cluster data need to be improved over the next year. Commissioners should consider whether there is a need to put in place a Commissioning for Quality and Innovation (CQUIN) goal to help improve data quality.

Whilst contracts should be agreed on the basis of the clusters, providers and commissioners should continue to have Memoranda of Understanding (MOUs) and risk sharing agreements in place for 2013-14.

ANNEX C: NHS organisations participating in the sense check exercise

Provider organisations
Alder Hey Children's NHS FT
Birmingham Children's Hospital NHS FT
Birmingham Women's NHS FT
Brighton & Sussex University Hospitals NHS Trust
Central Manchester University Hospitals NHS FT
Countess of Chester Hospital NHS FT
County Durham & Darlington NHS FT
Derby Hospitals NHS FT
Dorset County Hospital NHS FT
Great Ormond Street Hospital for Children NHS FT
Liverpool Heart & Chest Hospital NHS FT
Liverpool Women's NHS FT
North Bristol NHS Trust
North West London Hospitals NHS Trust
Oxford University Hospitals NHS Trust
Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS FT
Royal National Orthopaedic Hospital NHS Trust
Royal Orthopaedic Hospital NHS FT
Salford Royal NHS FT
Sheffield Children's NHS FT
Sheffield Teaching Hospitals NHS FT
South Warwickshire NHS FT
Stockport NHS FT
The Christie NHS FT
The Walton Centre NHS FT
University Hospital Birmingham NHS FT
University Hospitals Bristol NHS FT
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital Southampton NHS FT
Warrington and Halton Hospitals NHS FT
Wirral University Teaching Hospitals NHS FT
Wrightington, Wigan & Leigh NHS FT

Commissioners
Brighton & Hove City PCT
Bristol PCT
County Durham PCT
Coventry PCT
Darlington PCT
Derby PCT
Dorset CCG
Hampshire PCT
North West London PCT
Salford PCT
Sheffield PCT
South Birmingham PCT
Stockport PCT / Stockport CCG
Warrington PCT
Warwickshire PCT
Western Cheshire PCT / West Cheshire CCG
Wirral PCT