Additional Information: *Best Practice Tariff proposals*

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**05585**
Document Purpose	Consultations
Document Name	Additional information on Best Practice Tariff proposals
Author	NHS England
Publication Date	29 July 2016
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , Medical Directors, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, Directors of Finance, NHS Trust CEs
Additional Circulation List	
Description	This document forms part of a package of materials published by NHS Improvement and NHS England which set out proposals for the National Tariff, and invite feedback.
Cross Reference	Tariff Engagement Document
Superseded Docs (if applicable)	N/A
Action Required	Provide feedback on the tariff proposals where appropriate.
Timing / Deadlines (if applicable)	**Details set out at https:www.england.nhs.uk/resources/pay-syst**
Contact Details for further information	Kate Oldfield Pricing Team / Finance Quarry House Quarry Hill Leeds LS2 7UE england.paymentsystem@nhs.net https:www.england.nhs.uk/resources/pay-syst

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled.

As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

1 Contents

2 Purpose

This document is published to provide additional information in relation to best practice tariff proposals in support of the engagement being undertaken by NHS England and NHS Improvement on National Tariff proposals for 2017 to 2019.

We propose to set a national tariff that would last from April 2017 to March 2019. This would include two price lists, one for 2017/18 and another one for 2018/19. We would also publish national variations and pricing rules that would apply for two years.

The engagement exercise seeks to share with the changes that we propose to make, and invite feedback that will help to shape the final proposals which will be subject to a statutory consultation later this year.

This document should be read in conjunction with the Tariff Engagement Document.

The Tariff Engagement Document can be found at the NHS Improvement national tariff webpage https://improvement.nhs.uk/resources/national-tariff-policy-proposals-1718-and-1819, here you can submit feedback on Best Practice Tariff and other proposals via an online survey.

To help us analyse the responses please use the online system wherever possible. If you are unable to use the online system you can download the word document version of the form and email it to nhsi.pricing@nhs.net

3 Introduction

A BPT is a national price that is designed to incentivise high quality and cost-effective care. The aim is to reduce unexplained variation in clinical quality and to encourage best practice. The price differential between best practice and usual care is calculated to ensure that the expected costs of undertaking best practice are reflected and to create an incentive for providers to shift from usual care to best practice.

Clinicians and national clinical leaders have suggested a number of areas where they felt the development of a BPT would be beneficial to patients. In reviewing these suggestions we have considered the following:

- quality improvement
- clinical area and target population
- activity levels
- evidence base (eg NICE accredited guidelines)
- variation in current practice
- data source to support measurement of the BPT (eg clinical audit)
- affordability and cost impact
- impact on health inequalities
- implementation timelines
- risk of unintended consequences.

As part of the engagement we are proposing a number of changes:

Proposed new BPTs	Proposal to amend existing BPTs	Proposal to remove existing BPTs
Straight-to-test for patients requiring lower gastrointestinal investigation	Day case procedures	Cataracts
Chronic obstructive pulmonary disorders (COPD)	Fragility hip fracture	Interventional radiology
Cardiac rehabilitation for myocardial infarction (MI)	Primary hip and knee replacements	
Non-ST segment elevation myocardial infarction (NSTEMI)	Same-day emergency care	

We do not propose to change the remaining BPTs included in the 2016/17 National

Tariff, with the exception of updates for HRG4+ and changes set out in the main engagement document on setting prices for best practice tariffs.

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

4.1 Context

The two most frequent tests for patients requiring lower GI investigation are flexible sigmoidoscopy and colonoscopy. In 2014-15, 564,665 colonoscopies and 307,714 flexible sigmoidoscopies were undertaken in England[1]. Alternatively, some patients may have a plain CT scan. There is currently significant variation in the design of diagnostic pathways for patients requiring lower GI investigation in the NHS in England.

Cancer survival in England, including bowel cancer, is poorer than many comparable countries[2,3] and improving early diagnosis is essential to address this. However, at present, England only undertakes circa 1/3 as much endoscopy per capita compared to Ireland and 1/6 of Australia[4]. Additionally, 20% of bowel cancers in England are diagnosed following an Emergency Department admission, when the disease is often too advanced for a positive outcome[5]. It is therefore imperative to expand access to lower GI diagnostic tests in order to improve outcomes.

In addition to the challenges above, endoscopy is already the most pressured diagnostic service in the NHS, responsible for over 50% of all diagnostic breaches of the 6 week wait target. Furthermore, it is forecasted that demand for endoscopy will increase by 44% by 2020, to a combined total of 750,000 extra tests per year[6].

The aim of this BPT would be to help tackle these challenges and reduce variation by incentivising consistent uptake of STT pathways, which are more efficient, reduce diagnostic and treatment waiting times and result in improved patient and GP experience.

[1] NHS England. Historical Time Series. Monthly Diagnostics Data 2015-16. Available from: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/04/Monthly-Diagnostics-Web-File-Timeseries-February-2016-yg25r.xls
[2] Walters S, Benitez-Majano S, Muller P, Coleman MP, Allemani C, Butler J, Peake M, Guren MG, Glimelius B, Bergström S, Påhlman L. Is England closing the international gap in cancer survival?. British journal of cancer. 2015 Sep 1;113(5):848-60.
[3] Maringe C, Walters S, Rachet B, Butler J, Fields T, Finan P, Maxwell R, Nedrebø B, Påhlman L, Sjövall A, Spigelman A. Stage at diagnosis and colorectal cancer survival in six high-income countries: a population-based study of patients diagnosed during 2000–2007. Acta Oncologica. 2013 Jun 1;52(5):919-32.
[4] National Cancer Screening Service. National Progress Report on Endoscopy Services. January 2011.
[5] Healthcare Quality Improvement Partnership. National Bowel Cancer Audit Report 2015. 2015.
[6] Cancer Research UK. Scoping the Future: An evaluation of endoscopy capacity across the NHS in England. September 2015.

4.2 Proposal

Straight-to-test (STT) is the delivery of diagnostic tests to patients without an initial clinic appointment in secondary care. The proposed approach to incentivise through this BPT is 'triaged' STT, as follows:

i. Patients see their GP initially. If the GP decides that their symptoms are appropriate for further investigation they will refer the patient to a provider via the urgent 2 week referral pathway or via the 6 week diagnostic pathway. This proposal covers patients on both pathways (it is recommended, although not essential, that the referral is made via an electronic referral mechanism to facilitate timely processing).

ii. Following referral of the patient, the provider will make contact from their triage hub, usually operated by a nurse via telephone. The purpose of the triage hub is to confirm the indication and fitness for test and, aided by an algorithm, to decide on the most appropriate test (e.g. colonoscopy, flexible sigmoidoscopy, CT pneumocolon or plain CT) in partnership with the patient. The triage hub may also arrange for a further telephone call to ensure that patients are fully prepared for their procedure.

iii. If the patient is not suitable for investigation they may be offered a clinic appointment to discuss their symptoms. This would end the STT pathway and the appointment would be reimbursed via a normal outpatient attendance.

iv. Following the test, the diagnostic service is responsible for deciding on the appropriate next clinical steps, in partnership with the patient. There must be a local policy, agreed with the relevant clinicians, regarding how this is done.

We plan to assign the BPT price against colonoscopy and flexible sigmoidoscopy as these each have specific HRGs. The BPT price will also take into account the number of anticipated triage appointments which do not progress to a diagnostic test. It will not be appropriate to seek reimbursement for the triage separately.

For CT pneumocolon and plain CT, we will not be able to assign a BPT price as they do not have specific HRGs. We will continue to work with the National Casemix Office on this issue.

4.3 Rationale

There is evidence that STT pathways can reduce diagnostic[7,8 ,9 , 10]and treatment[11,12] waiting times for patients with colorectal cancer. Specifically, Homerton University Hospitals NHS Foundation Trust reduced their waiting time to treatment by 6 days and the Whittington Hospital NHS Trust reduced their time by 10 days. Barts Health NHS Trust reduced their mean time to diagnosis for patients on 18 week wait pathways to 5 days, a time saving of 96.5%.

There is evidence from Guy's and St Thomas' NHS Foundation Trust[13], Barts Health NHS Trust[14] and Dorset County Hospital[15] that straight to test pathways result in high patient and GP satisfaction. Specifically, at Barts Health NHS Trust:

- 94% of patients thought that the triage service was very convenient,
- 79% preferred telephone triage to outpatient clinic,
- 76% thought it was a very responsive service and
- 89% were very satisfied overall
- (based on 57% of users over the time period).

Finally, there is potential for significant cost savings from STT. An economic analysis from the Western Infirmary and Gartnavel General Hospital and the University of Glasgow concluded that STT pathways for patients with lower GI symptoms save an average of £105 per patient[16]. A similar economic evaluation from Barts Health NHS Trust reported potential savings of nearly £80,000 per annum due to reduced numbers of outpatient appointments[17]. In addition, removing the initial outpatient

[7] Mukherjee S, Fountain G, Stalker M, Williams J, Porrett TR, Lunniss PJ. The 'straight to test' initiative reduces both diagnostic and treatment waiting times for colorectal cancer: outcomes after 2 years. Colorectal Disease. 2010 Oct 1;12(10Online):e250-4.
[8] Thapar A, Rodney S, Haboubi D, Oshowo A, Bhan C, Wilson J, Walshe M, Haddow J, Mukhtar H. Straight to test lower GI endoscopy: the Whittington Experience. Whittington Hospital NHS Trust.
[9] Watson H. A Colorectal Telephone Assessment / Straight to Test Pathway (CTAP) for the Initial Assessment of Colorectal Referrals. Guy's and St Thomas' NHS Foundation Trust, November 2014.
[10] Andrews P, Steward L, Mistry M, Wong A, Machesney M. Straight to test for colorectal symptoms: A viable means of shortening time to a definitive diagnosis. Barts Health NHS Trust and London Cancer.
[11] Mukherjee S, Fountain G, Stalker M, Williams J, Porrett TR, Lunniss PJ. The 'straight to test' initiative reduces both diagnostic and treatment waiting times for colorectal cancer: outcomes after 2 years. Colorectal Disease. 2010 Oct 1;12(10Online):e250-4.
[12] Thapar A, Rodney S, Haboubi D, Oshowo A, Bhan C, Wilson J, Walshe M, Haddow J, Mukhtar H. Straight to test lower GI endoscopy: the Whittington Experience. Whittington Hospital NHS Trust.
[13] Watson H. A Colorectal Telephone Assessment / Straight to Test Pathway (CTAP) for the Initial Assessment of Colorectal Referrals. Guy's and St Thomas' NHS Foundation Trust, November 2014.
[14] Andrews P, Steward L, Mistry M, Wong A, Machesney M. Straight to test for colorectal symptoms: A viable means of shortening time to a definitive diagnosis. Barts Health NHS Trust and London Cancer.
[15] Watson H. A Colorectal Telephone Assessment / Straight to Test Pathway (CTAP) for the Initial Assessment of Colorectal Referrals. Guy's and St Thomas' NHS Foundation Trust, November 2014.
[16] MacKenzie S, Norrie J, Vella M, Drummond I, Walker A, Molloy R, Galloway DJ, O'Dwyer PJ. Randomized clinical trial comparing consultant- led or open access investigation for large bowel symptoms. British journal of surgery. 2003 Aug 1;90(8):941-7.
[17] Andrews P, Steward L, Mistry M, Wong A, Machesney M. Straight to test for colorectal symptoms: A viable means of shortening time to a definitive diagnosis. Barts Health NHS Trust and London Cancer.

appointment from the pathway will free clinicians to undertake other work and therefore make efficient use of their time.

4.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

When you complete the survey we are particularly interested to know if you anticipate any problems with delivering the pathway in a timely manner in order to allow meet NHS constitution standards.

5 New BPT for chronic obstructive pulmonary disease (COPD)

5.1 Context

COPD is a long-term respiratory condition characterised by airflow obstruction that is not fully reversible. The airflow obstruction does not change markedly over several months and is usually progressive. People with COPD often have exacerbations, when there is rapid and sustained worsening of symptoms beyond their usual day-to-day variation.

COPD causes 115,000 emergency admissions per year, 24,000 deaths per year and 16,000 deaths within 90 days of admission. Type 2 respiratory failure occurs in a quarter of COPD admissions (NHS England).

5.2 Proposal

We propose to introduce a BPT to improve the proportion of patients who receive specialist input in to their care within 24 hours of emergency admission for an exacerbation of COPD and that patients also receive a discharge bundle prior to leaving hospital.

Compliance against the BPT would be measured through the national COPD audit programme[18] which is currently in the process of being rolled out for full implementation in 2017/18.

Best practice would be considered achieved when:

i. a percentage of patients with a primary diagnosis of COPD, admitted for an exacerbation of COPD, receive specialist input in to their care within 24 hours of admission ***and***
ii. where they receive a discharge bundle prior to discharge as measured by the national COPD audit.

In order to ensure consistency between the BPT and COPD audit specialist input would be defined in the as a respiratory health professional deemed competent at reviewing and managing patients with acute exacerbation of COPD.

A discharge bundle could include the following activities[19]:

- Inhaler technique had been checked and medications reviewed.
- Written self-management plan and emergency drug pack, if appropriate, were in place.

[18] https://www.rcplondon.ac.uk/projects/national-copd-audit-programme
[19] Turner AM, Lim WS, Rodrigo C et al (2015) A care-bundles approach to improving standard of care in AECOPD admissions: results of a national project Chest Clinic

- Smoking status and assistance to quit where appropriate.
- Suitability for pulmonary rehabilitation had been assessed and PR offered, if appropriate.
- Follow-up (by phone or in person) within 72 hours of discharge.

Providers and commissioners would need to work together to agree the contents of a discharge bundle which best meets local need.

Table 1 below outlines the proposed achievement levels for specialist input i.e. the proportion of patients where specialist input will need to have taken place and reported to the national COPD audit. The table also presents the percentage of NHS trusts that are likely to meet the BPT criteria. Also presented is the estimated impact of combining discharge bundles in to the design of the BPT.

At the time of writing we are not able to calculate the proportion of patients at provider level who receive discharge bundles. We only have data on which hospitals report using discharge bundles. We have therefore estimated the impact on the BPT achievement levels of including discharge bundles. To do this we have assumed that all providers who report delivering discharge bundles have done so for all patients who receive specialist input. This is likely to overestimate the percentage of providers meeting the BPT criteria.

Table 1 – Current estimated achievement rates

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

5.3 Rationale

Specialist input has been shown to improve outcomes as well as the adherence to evidence based care processes[20] in the management of COPD exacerbations. However, only 57% of people admitted to secondary care receive specialist input in to their care within 24 hours of admission.

Patients who receive discharge bundles were more likely to receive better care than those who do not receive discharge bundles. However, only 68% of providers report using discharge bundles.

[20] https://www.nice.org.uk/guidance/CG101

We considered other quality improvement areas for the care of people with COPD admitted as an emergency, for example oxygen prescribed with target saturations. However, initial engagement with clinical stakeholders suggested that timely specialist input and the provision of discharge bundles are key priorities for the BPT.

There may be an impact locally on service configuration to ensure that timely specialist input is available in to the care of people admitted with an exacerbation of COPD, and that discharge bundles are provided.

We are currently working with the sector to help quantify this impact and will also use feedback from the tariff engagement.

5.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

When you complete the survey we are particularly interested to know whether you agree with the choice of specialist input and discharge bundles and whether there are any issues with using the proposed audit for recording and validating achievement of the BPT.

6 New BPT for cardiac rehabilitation for myocardial infarction (MI)

6.1 Context

Cardiac rehabilitation is a coordinated and structured programme designed to remove or reduce the underlying causes of cardiovascular disease. It provides the best possible physical, mental and social conditions so that people can, by their own efforts, continue to play a full part in their community. A healthier lifestyle and slowed or reversed progression of cardiovascular disease can also be achieved. *[MI – secondary prevention (NICE guideline CG172): full guideline]*

Cardiac rehabilitation is second only to aspirin and beta-blockers in terms of cost effectiveness[21].

6.2 Proposal

We propose to introduce a new BPT, based on the NICE quality standard (QS99)[22] on secondary prevention after a myocardial infarction (MI), which incentivises the referral to cardiac rehabilitation of appropriate post-MI patients within 3 days of an initiating event[23] and prior to discharge. The number of patients who are referred to cardiac rehabilitation would be calculated through the National Audit of Cardiac Rehabilitation (NACR)[24].

It is not possible to calculate the number of eligible patients who should be referred to cardiac rehabilitation i.e. the target population, using nationally collected data sources. Therefore we propose that the target population should be extracted locally through SUS based on admissions, discharged to their usual place of residence, whose admission was an emergency admission with a primary diagnosis of one of the following ICD10 codes.

Table 2 – Target population ICD10 codes (primary diagnosis)

ICD10 code	Description
I210	Acute transmural myocardial infarction of anterior wall
I211	Acute transmural myocardial infarction of inferior wall
I212	Acute transmural myocardial infarction of other sites
I213	Acute transmural myocardial infarction of unspecified site

[21] 2014;21:664–81.Fidan D, Unal B, Critchley J, et al. Economic analysis of treatments reducing coronary heart disease mortality in England and Wales,2000–2010. QJM 2007;100:277–89
[22] www.nice.org.uk/guidance/qs99
[23] This a data field in the NACR. 'the primary reason why the patient was referred to Cardiac Rehabilitation, this may be a diagnosis such as MI or treatment such as CABG
[24] www.cardiacrehabilitation.org.uk

ICD10 code	Description
I214	Acute subendocardial myocardial infarction*
I219	Acute myocardial infarction, unspecified
I220	Subsequent myocardial infarction of anterior wall
I221	Subsequent myocardial infarction of inferior wall
I228	Subsequent myocardial infarction of other sites
I229	Subsequent myocardial infarction of unspecified site

We have proposed a target achievement rate of 45%[25], which takes into account that the method outlined above, of calculating the target population, is likely to overestimate the number of people requiring cardiac rehabilitation: not all people admitted with an MI will be eligible for cardiac rehabilitation, for example, due to poor health.

We currently working with NACR to further assess the suitability of the data to be used in measuring compliance of the BPT and assess variation in achievement of the BPT criteria. For the purpose of payment we propose a 10% price differential between the non-BPT and BPT price and that SUS will automate payment of the base BPT price.

Table 3 shows HRGs that fall within the scope of the BPT where there is also a primary diagnosis included from the Table 2 above, *excluding ICD10 code I214 'Acute subendocardial myocardial infarction'. This code is not included for the purpose of payment because, alongside the below HRGs, it is basis for a different BPT[26]and therefore payment.

Table 3 - HRGs that are within the scope of the BPT (where there is also a primary diagnosis included from the Table 2)

HRG code	HRG name
EB10A	Actual or Suspected Myocardial Infarction, with CC Score 13+
EB10B	Actual or Suspected Myocardial Infarction, with CC Score 10-12
EB10C	Actual or Suspected Myocardial Infarction, with CC Score 7-9
EB10D	Actual or Suspected Myocardial Infarction, with CC Score 4-6
EB10E	Actual or Suspected Myocardial Infarction, with CC Score 0-3
EY40A	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 12+
EY40B	Complex Percutaneous Transluminal Coronary Angioplasty with CC Score 8-11
EY40C	Complex Percutaneous Transluminal Coronary Angioplasty with

[25] www.cardiacrehabilitation.org.uk/docs/BHF_NACR_Report_2015.pdf
[26] Timely access to coronary angiography

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

6.3 Rationale

Cardiac rehabilitation aims to address the underlying causes of cardiovascular disease and improve physical and mental health after a myocardial infarction. Cardiac rehabilitation encourages a healthy lifestyle which slows the progression of heart disease. It also reduces the risk of dying prematurely, especially as a result of a myocardial infarction. People who are referred to rehabilitation programmes early[27] have better rates of uptake and adherence as well as improved clinical outcomes. (NICE quality standard on secondary prevention after a myocardial infarction).

We considered a number of options in developing the proposal but these were primarily in relation to defining a timely referral (3 or 5 days or just prior to discharge). We also considered whether other groups of people should be included in the scope of the BPT, for example, people with angina or heart failure. However, stakeholder feedback to date suggests that people post-MI may be the most appropriate group in the first iteration of the BPT.

[27] Fell J, Dale V, Doherty P. Does the timing of cardiac rehabilitation impact fitness outcomes? An observational analysis. Open Heart. 2016 Feb 8;3(1):e000369. doi: 10.1136/openhrt-2015-000369. eCollection 2016

There may be an impact on services managing increased referrals for cardiac rehabilitation for patients post MI. We aim to work with the sector to quantify this impact.

6.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

When you complete the survey we are particularly interested to know whether there are any issues with using the proposed audit for recording and validating achievement of the BPT and whether you think that the methodology for calculating the BPT and setting achievement rates is fair.

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

7.1 Context

Myocardial infarction (MI) is usually caused by blockage of a coronary artery producing tissue death and consequently the typical features of a heart attack: severe constricting chest pain, changes on the electrocardiogram (ECG), and raised concentrations of proteins released from the dying heart tissue into the blood. There are two types of MIs:

- *ST segment elevation myocardial infarction (STEMI)*, which is generally caused by complete and persisting blockage of the coronary artery
- *non-ST segment elevation myocardial infarction (NSTEMI)*, reflecting partial or intermittent blockage of the coronary artery.

According to the Myocardial Ischaemia National Audit Project (MINAP) database, there were 80,724 admissions for MI in 2013/14. Of these, 39% were STEMIs and 61% were NSTEMIs.

7.2 Proposal

We propose to introduce a BPT to improve the time from admission to receipt of coronary angiography for those people with NSTEMI. The current achievement rate nationally for this is 55% for those people with NSTEMI.

We also propose to include patients who are transferred between hospitals to receive care within the scope of the BPT i.e. where a patient is transferred from one hospital to another to undergo the procedure, the time will be calculated from the admission time to the first hospital.

Compliance against the proposed BPT would be measured through the MINAP database[28] which collects data on time from admission to coronary angioplasty for patients experiencing both NSTEMI and STEMI events. Best practice will be considered achieved where 60% of NSTEMI patients, undergoing coronary angiography, do so within 72 hours of first admission.

We propose to apply the BPT price and base price to a group of HRGs where the primary diagnosis on admission is ICD10 code I214 ‘acute subendocardial myocardial infarction’. This is because the HRGs will cover a larger group of patients than that intended by the BPT.

[28] We are intending to publish separate guidance around the process for BPT validation

Table 4 - HRGs that are within the scope of the BPT (where there is also a primary diagnosis ICD10 of I214)

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

The ICD10 codes are based on the national standard for the coding of NSTEMI (2015).

Under the proposal, the BPT price would be increased compared to the conventional HRG prices to reflect any increases in cost providers may incur in achieving the best practice criteria. Providers that do not meet the BPT criteria will receive a price below the current conventional HRG prices in order to incentivise delivery of the BPT.

7.3 Rationale

The economic analysis conducted to support NICE clinical guideline 94 on unstable angina and NSTEMI states that timely access to angioplasty, followed by PCI where required, is clinically effective and cost effective. Patients who receive earlier angiography are likely to be discharged sooner, therefore avoiding prolonged hospitalisation.

The NICE costing statement for NSTEMI states that a reduced time from admission to angiography will have a national cost impact of under £1 million.

During 2015/16 we asked the sector to consider the appropriate BPT threshold for the proportion of NSTEMI patients undergoing coronary angiography within 72 hours of admission. The options proposed were 60%, 70% or 80%. Based on a series of engagement sessions on this BPT and the feedback we received from the sector and an expert working group it was suggested that an achievement rate of 60% (including transfers) was a reasonable rate to set as the data suggested that the current achievement (excluding transfers) was already at 55%.

By setting the rate at 60% in the first year, we would create a solid base from which to propose increases in subsequent years as the sector reaches the achievement rates. This would allow us to embed best practice as normal practice. Once these standards have been normalised we would then consider removing the best practice tariff.

We have considered other options such as including other care processes, for example, the delivery of appropriate medication in the BPT. However, our stakeholder engagement to date suggests that time to coronary angiography was the main priority for quality improvement. We also considered different achievement thresholds for the BPT, however, stakeholder engagement during 2015/16 suggested that 60% would be the most appropriate achievement level.

We recognise that the introduction of this BPT could lead to unintended consequences. For example, providers may face additional implementation costs in achieving BPT targets. We would particularly welcome feedback that highlights any advantages, concerns and risks associated with introducing this BPT.

We believe that this will have a small financial impact from the increased costs in meeting this target. We also suggest there will be a small administrative burden on monitoring and validating compliance.

However, these impacts are outweighed by the benefits to patients from improved outcomes, reduced rates of hospitalisation and therefore improved utilisation of resources.

7.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

When you complete the survey we are particularly interested to know whether you think that the target rate is set at an appropriate level (60%).

8 Amendment to the day case BPT

8.1 Context

The day case procedure BPT aims to increase the proportion of elective activity performed as a day case, where clinically appropriate. Day case procedures offer advantages to both patients and providers. For many patients it is safer and more convenient to be treated in a day case setting, while the local health economy benefits from reduced pressure on admitted patient beds. This also correlates to improved patient satisfaction.

The British Association of Day Surgery[29] (BADS) publishes a directory of procedures that are suitable for day case admissions along with proportions that it believes are achievable in most instances. We have used this information to develop our proposals.

The BPT is made up of two prices for each procedure: one applied to day case admissions and one applied to ordinary elective admissions. By paying a relatively higher price for day case admissions, the BPT creates an incentive for providers to treat patients in a day case setting.

8.2 Proposal

The BPT programme currently includes 15 procedures selected from the British Association of Day Surgery's Directory. Through discussions with BADS and internal data analysis, we have identified a further 19 procedures where the same approach could be taken. These areas have been selected based on minimum activity levels, suitable scope for improvement and evidence of high achievement for some providers.

The 19 areas are as proposed during the engagement in the summer of 2015 and are identified below:

Table 5 – Proposed additional clinical procedures

Clinical Area	BADS rate	Current observed rate	Proposed calculation rate
Day Surgical Procedures			
Anterior or posterior colporrhaphy	40%	13%	25%
Autograft anterior cruciate ligament reconstruction	40%	28%	40%
Biopsy / sampling of cervical lymph	80%	74%	80%

[29] www.daysurgeryuk.net

Clinical Area	BADS rate	Current observed rate	Proposed calculation rate
nodes			
Creation of arteriovenous fistula for dialysis	80%	63%	80%
Dacryocysto-rhinostomy including insertion of tube	90%	70%	80%
Endoscopic insertion of prosthesis into ureter	90%	48%	60%
Endoscopic resection / destruction of lesion of bladder	50%	7%	25%
Excision biopsy of lymph node for diagnosis (cervical, inguinal, axillary)	80%	65%	80%
Excision of lesion of parathyroids	30%	11%	25%
Implantation of cardiac pacemaker	90%	59%	70%
Laparascopic Oophorectomy and salpingectomy (including bilateral)	70%	17%	30%
Optical Urethrotomy	90%	42%	55%
Polypectomy of internal nose	90%	55%	65%
Repair of other abdominal hernia	85%	68%	85%
Transluminal operations procedures on femoral artery	70%	50%	60%
Ureteroscopic extraction of calculus of ureter	50%	29%	40%
Medical Procedures			
Bone marrow biopsy	95%	68%	80%
Liver Biopsy	90%	68%	80%
Renal Biopsy	95%	67%	80%

Source: BADS directory Fourth Edition and HES 2013/14

In addition to expanding the day case BPT to cover new clinical areas, we propose to increase the target rates for two clinical areas as outlined below:

Table 6 – Proposed clinical procedures with increased target rates

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

Source: BADS directory fourth edition and HES 2013/14

8.3 Rationale

An evaluation of the BPT programme by the University of Manchester and the University of Nottingham found this BPT had been successful in increasing the proportion of activity seen on a day case basis[30]. Adding to the scope of this BPT will create an added incentive for providers to move more activity into day cases.

For some of the new procedures, the target proportion used to calculate price relativities is set below the recommended BADS proportion as the latter are likely to be too ambitious for providers to achieve immediately. Transitional targets for these new proposed BPT day case areas have been calculated by adding a 10 percentage point increase from current baseline (rounded up to the nearest 5). It is believed that this reflects the degree of change we may reasonably expect in one year following introduction of the BPT.

Where this calculation has placed the day case rate within 5 percentage points of the BADS threshold, the BADS threshold has been adopted as the day case target.

We propose to raise the target rates on two existing procedures, female incontinence and tympanoplasty. Providers have improved their performance for these procedures and we would like to continue to move toward the BADS rate. For procedures to manage female incontinence we feel the improvements have been sufficient to propose a move to the BADS rate, while for tympanoplasty we are proposing to reduce the gap between the target rate and that contained in the BADS directory.

The BPT would be automated by the grouper meaning there is no additional administrative burden associated with measuring compliance.

Our proposals to increase the target rates for these procedures were included in the 2016/17 statutory consultation notice. We received feedback that showed support for increasing the target rates for two procedures to clinically acceptable levels as a routine feature of BPTs to promote continuous improvement.

We also received feedback during the 2015 summer engagement exercise that we should consider including the impact of those procedures where activity also occurs as an outpatient procedure.

Some providers may carry out a significant amount of the activity for the clinical areas under consideration in an outpatient setting. This may impact the achievability of the BADS rates. However, the proposed targets are based on the estimate of current achievement plus a change that may be reasonably expected within a year based on the performance of previous day case BPT area.

[30] www.population-health.manchester.ac.uk/healtheconomics/research/reports/bpt-dh-report-21nov2012.pdf

We are planning to review the BPT, for consideration in future years, in line with an updated fifth edition of the BADS directory of procedures and to consider the impact of outpatient procedures.

8.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

9 Amendment to the fragility hip fracture BPT

9.1 Context

For patients with a fragility hip fracture, care needs to be quickly and carefully organised. By quickly stabilising patients and ensuring that expert clinical teams respond to their complex frail conditions, the most positive outcomes can be achieved. Equally, the care that these patients receive following surgery is just as important, as it is in the initial days following surgery that the greatest gains can be made in patient outcomes.

The aim of the BPT is to promote best practice in the care pathway from admission to discharge and try to prevent the next fragility fracture in line with the clinical guideline and quality standard from NICE (CG124[31] and QS16[32]).

9.2 Proposal

We propose to remove three measures relating to the *joint admissions protocol*, *Multidisciplinary Team working* and *Post-op Abbreviated Mental Test* and replace them with four new measures:

- **A nutritional assessment during the admission.** This has proven to significantly improve outcomes and nutritional supplementation, where indicated, can help to reduce mortality.

- **Persistence with bone treatment after discharge.** All patients who have a hip fracture require some form of medication to reduce the risk of further fractures. The current BPT ensures that patients are assessed and treatment started in hospital but it is well recognised that long-term compliance is poor. Telephone follow-up is effective and significantly increases the rate of long-term compliance with treatment. The proposal is that this telephone appointment will take place 120 (+/- 60) days later from the date of discharge. The National Hip Fracture Database allows for this measure to be recorded[33]. (To note: Patients who are deceased will be excluded from this measure but still eligible for BPT if all other criteria have been met as identified in the NHFD).

- **A delirium assessment during the admission.** This would replace the post-op AMT measurement and allow care to focus on the causes of delirium.

[31] www.nice.org.uk/guidance/cg124
[32] www.nice.org.uk/guidance/qs16
[33] Patients who are deceased will be excluded from this measure but still eligible for BPT as all other criteria have been met

- **Assessed by Physiotherapist the day following surgery.** This would help ensure that all patients who are fit enough are mobilised from bed the day following surgery. This should reduce complications, enhance recovery and improve outcome.

9.3 Rationale

The new measures would target nutritional assessment, persistence with bone treatment, delirium assessment and ensure that patients are assessed by a physiotherapist the day following surgery. Collectively this would help improve patient experience and the follow-up care by the provider will increase the use of bone protection by patients to strengthen bones and help prevent further fractures.

We have reviewed the suitability of these new measures in consultation with clinical leads, the National Hip Fracture Database (NHFD) team and Healthcare Quality Improvement Partnership (HQIP) team. The NHFD collects data on all the newly proposed measures and will assist providers and commissioners in validating achievement.

9.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

When you complete the survey we are particularly interested to know whether you think that the four new measures proposed are appropriate for encouraging improved patient outcomes. We are also interested to know whether there might be any impact on payment reconciliation arising from the proposal to pay the BPT top-up once a follow-up appointment has taken place 120 (+/-60) days after discharge.

10 Amendment to the primary hip and knee replacement BPT

10.1 Context

Patient Reported Outcome Measures (PROMs) assess the quality of care NHS funded care delivered to patients from the patient perspective.

Information is collected about a patient's health status (or health-related quality of life) before surgery and again six months after the procedure, with any change in health state attributed to the intervention. For the purpose of this BPT, changes in health state are assessed using the casemix adjusted condition specific Oxford Hip Score and Oxford Knee Score for primary joint replacements only. PROMs have been collected by all providers of NHS-funded care since April 2009.

The purpose of the BPT for primary hip and knee replacements is to link payment to the outcomes that are important from the patient's perspective. The aim of this BPT is to reduce the unexplained variation between providers in the outcomes reported by patients.

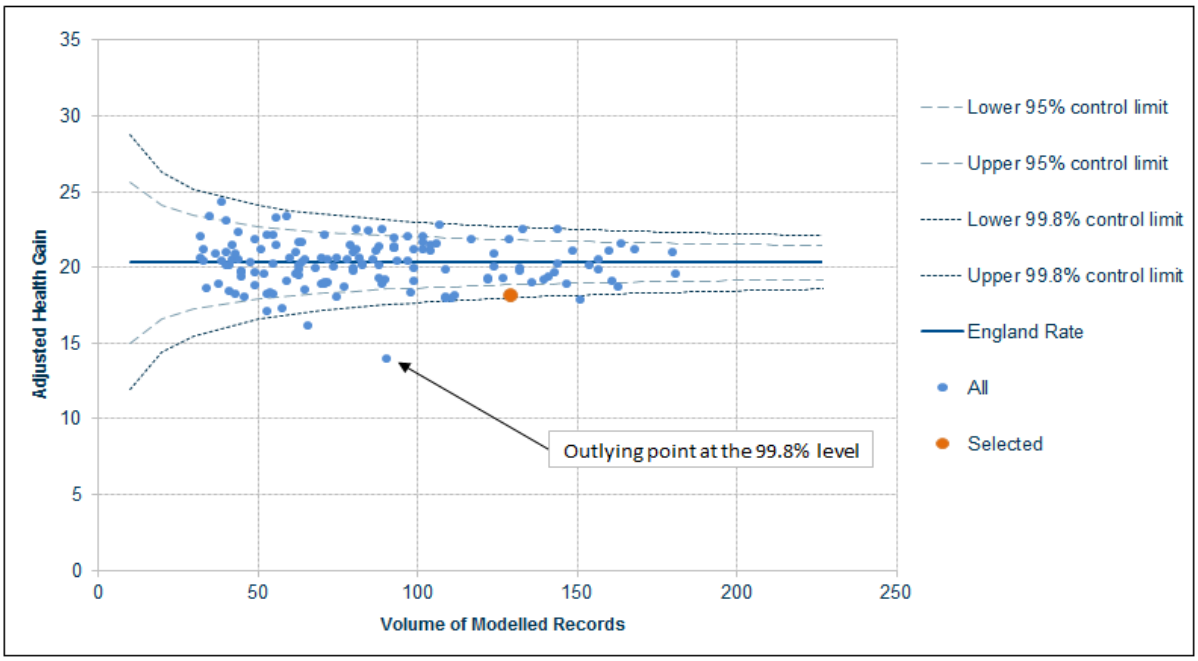
In 2016/17 the criteria for payment of the BPT are:

a) the provider not having an average health gain significantly below the national average
b) the provider adhering to the following data submission standards:
    i. a minimum Patient Reported Outcome Measures (PROMs) participation rate of 50%
    ii. a minimum NJR compliance rate of 85%
    iii. an NJR unknown consent rate below 15%.

Providers' average health gain is presented in Figure 1 below as a funnel plot and compared with the national average of all providers in England. The funnel plot indicates whether a provider's health gain is statistically significantly different to the national average. According to the PROMs publication, providers are outliers if they have:

a) below the lower 95% significance level labelled 'alerts'
b) below the 99.8% significance level labelled 'alarms'.

Figure 1: PROMs provider score comparison



Providers below the lower 99.8% control limit do not receive the BPT. Whether identified as an outlier or not, all providers should work to achieve the best possible outcomes as outliers are identified relative to the national average, which may change as the data is updated throughout the year.

10.2 Proposal

We have received feedback during the 2016/17 consultation programme that the current rules to identify outliers are too low and more challenging rules should to be applied to incentivise continuous improvement. As such, we propose to change the outlier criteria so that providers below the lower 95% control limit do not receive the BPT.

We also present an option for comment to increase the NJR compliance rate to 90% or 95%.

10.3 Rationale

The suggested changes are appropriate because they imply stricter rules to identify outliers and intent to improve quality of care for patients by reducing unwarranted variation. Although this proposal means that less providers would be eligible for BPT reimbursement it would not affect the overall funds available for primary hip and knee replacement within the pricing calculation model.

An alternative option considered was a potential change of the NJR compliance rate. Although the rate has changed recently from 75% to 85%, we have explored the expected impact of changing the NJR rate to 90% or 95%in the analysis below.

We have considered the impact of changing the outlier criteria from 99.8% to 95% control limit and NJR compliance rate from 85% to 90% or 95% and the estimated effect to providers' eligibility is set out in Table 7 below.

Table 7: Expected impact in number of providers eligible to meet the BPT criteria from a change in outlier criteria and NJR compliance

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

** This is the current estimated eligibility*

Following engagement with the National Joint Registry we will consider options in future years to bring revision surgery in to the scope of the BPT.

10.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

When you complete the survey we are particularly interested to know which of the suggested changes we should consider:

- change of control limit to 95% for the outlier criteria
- change of NJR compliance target to 90% or 95%
- change both change of control limit to 95% for the outlier criteria and the NJR compliance target.

11 Amendment to same-day emergency care BPT

11.1 Context

There are 19 existing scenarios from the NHS Institute's 'Directory of Ambulatory Emergency Care in Adults'[34] already as part of the National Tariff. The directory is a list of potential clinical scenarios, 49 in total, that can be managed using ambulatory emergency care. The existing 19 scenarios either are in the top 25, or are related to them.

11.2 Proposal

We propose to amend the number of clinical scenarios to now include:

- Abnormal liver function
- Acutely hot painful joint
- Chronic indwelling catheter related problems
- Gastroenteritis
- Transient ischaemic attack
- Upper gastro-intestinal haemorrhage
- Urinary tract infections

We propose to include the HRGs set out in the table below.

Table 8 – Proposed HRGs to bring in to the scope of the BPT

HRG	HRG Description	Level	Proposed clinical scenario
GC17K	Non-Malignant, Hepatobiliary or Pancreatic Disorders, without Interventions, with CC Score 0-1	SUB HRG	Abnormal Liver Function
HD26G	Musculoskeletal Signs or Symptoms, with CC Score 0-3	SUB HRG	Acutely hot painful joint
LB15E	Minor Bladder Procedures, 19 years and over	SUB HRG	Chronic indwelling catheter related problems
LB20F	Infection or Mechanical Problems Related to Genito-Urinary Prostheses, Implants or Grafts, without Interventions, with CC Score 2-6	HRG	Chronic indwelling catheter related problems

[34] http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,181.htm

HRG	HRG Description	Level	Proposed clinical scenario
LB20G	Infection or Mechanical Problems Related to Genito-Urinary Prostheses, Implants or Grafts, without Interventions, with CC Score 0-1	HRG	Chronic indwelling catheter related problems
FZ36P	Gastrointestinal Infections without Interventions, with CC Score 2-4	HRG	Gastroenteritis
FZ36Q	Gastrointestinal Infections without Interventions, with CC Score 0-1	HRG	Gastroenteritis
AA29F	Transient Ischaemic Attack with CC Score 0-4	HRG	Transient Ischaemic Attack
LA04Q	Kidney or Urinary Tract Infections, without Interventions, with CC Score 4-7	HRG	Urinary tract infections
LA04R	Kidney or Urinary Tract Infections, without Interventions, with CC Score 2-3	HRG	Urinary tract infections
LA04S	Kidney or Urinary Tract Infections, without Interventions, with CC Score 0-1	HRG	Urinary tract infections
FZ38P	Gastrointestinal Bleed without Interventions, with CC Score 0-4	SUB HRG	Upper gastro-intestinal haemorrhage
FZ91M	Non-Malignant Gastrointestinal Tract Disorders without Interventions, with CC Score 0-2	SUB HRG	Upper gastro-intestinal haemorrhage

Early engagement suggested that we should be considering surgical scenarios, which may be appropriate to bring in to the scope of the same-day emergency care BPT, and so we will consider this for future years.

11.3 Rationale

We have undertaken an analysis of activity based on the clinical codes outlined in the Directory of Ambulatory Emergency Care in Adults.

Potential clinical scenarios for BPT development were identified where there was a significant proportion of activity, with a length of stay of one to three days. This identified 26 clinical areas that are not currently part of the existing BPT. We reviewed these areas, with clinical input, and excluded a number of the scenarios based upon:

- there been small numbers of identified activity (n<10,000)
- activity related to maternity services
- activity already in scope of an existing BPT
- clinical advice of appropriateness for inclusion

To ensure consistency with the current BPT, and on clinical advice, we limited the HRGs applicable to those with a low complications and comorbidities (CC) score.

The table below shows the current average 'same day' rate for each of the proposed clinical scenarios. The table also shows the 75th percentile same-day rate. It is proposed to set the 75th percentile as the target achievement rate.

It is believed that these rates represent a sufficiently challenging, but achievable, rate for most providers. It also means that there is a margin to accommodate local circumstances where providers have started to implement alternative AEC pathways.

Table 9 – Proposed clinical scenarios showing current rate and 75th percentile (target rate)

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

11.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Are there any barriers to implementation we need to be aware of?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

When you complete the survey we are particularly interested to know whether you think that all of the clinical scenarios are appropriate to bring into the scope of the BPT, and whether we should consider removing any of the existing clinical scenarios.

For consistency we have removed HRGs with a high complications and comorbidities (CC) score, and we would welcome feedback on whether you think this is appropriate.

12 Removal of the cataract BPT

12.1 Context

The cataract BPT was introduced to encourage the provision of a streamlined pathway to improve patients experience and encourage efficient care. The pathway is in line with the Royal College of Ophthalmologists' guidelines[35].

The cataracts BPT applies to adults only. The price applies to the entire elective cataract pathway by covering the sum of the costs of the individual outpatient attendances as well as the surgical procedure.

12.2 Proposal

We propose to remove the non-mandated cataracts BPT from the national tariff document and remove the non-mandated price. As this is already a non-mandated BPT, we propose that for local health economies that may have successfully implemented this BPT, or wish to do so in future, continue to agree and submit a local variation[36].

12.3 Rationale

There is anecdotal evidence that this BPT is not working as originally intended and therefore we feel this BPT requires removal from the national tariff.

We are not aware there has been significant uptake of this BPT. As SUS applies the non-BPT national price for the relevant HRGs, any use of the BPT price is for local agreement and financial adjustment. As such, we propose there is no need to continue to make the BPT available and existing local variation mechanisms are more appropriate.

If there is future evidence[37] of unwarranted variation in the quality or outcomes relating to cataract surgery then we will consider proposing a new BPT in relation to cataract surgery.

12.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey[38]. The questions included in the survey are set out below.

- Do you support this proposal?

[35] https://www.rcophth.ac.uk/standards-publications-research/clinical-guidelines/
[36] https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor
[37] http://www.hqip.org.uk/resources/national-opthalmology-database-audit-annual-report-2016/
[38] https://www.surveymonkey.co.uk/r/2017-18TariffProposalsSurvey

- Are you aware of any unintended consequences of this proposal?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

13 Removal of the interventional radiology BPT

13.1 Context

The interventional radiology (IR) BPT was introduced in 2011/12 to raise the visibility of the procedures within the payment system and ensure more appropriate reimbursement. The current BPT for IR covers seven procedures.

Our proposal, if implemented, is to set relative prices using HRG4+. This would mean that the current BPT IR procedures will be identified mainly within a new HRG chapter for vascular procedures and disorders and imaging interventions (chapter Y). These new HRGs should ensure visibility and more appropriate reimbursement for a wider range of IR procedures.

13.2 Proposal

We propose to remove the seven IR BPTs (below) from the scope of the BPT programme. Instead, we propose that prices for these procedures are set on the basis of the modelling approach for the relevant HRGs.

Table 10 – Suggested mapping of current BPT structure to proposed HRG4+ currency design

Procedure	Condition	Proposed HRGs[39]
Angioplasty and stenting of the superficial femoral artery (SFA) or iliac artery	Peripheral artery disease (PAD)	• YR10 - Percutaneous Transluminal Angioplasty of Multiple Blood Vessels • YR11 - Percutaneous Transluminal Angioplasty of Single Blood Vessel
Angioplasty and stenting	Diabetic foot disease	• YR10 - Percutaneous Transluminal Angioplasty of Multiple Blood Vessels • YR11 - Percutaneous Transluminal

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

Procedure	Condition	Proposed HRGs[39]
		Angioplasty of Single Blood Vessel • YR12 - Percutaneous Transluminal Angioplasty with Insertion of Stent Graft into Peripheral Blood Vessel
Thoracic endovascular aortic repair (EVAR)	Thoracic aneurysm	• YR01 - Complex Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm • YR02 - Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm
Transjugular intrahepatic portosystemic shunt (TIPS)	Portal hypertension	• YR16 - Transjugular Intrahepatic Creation of Portosystemic Shunt
Vacuum assisted percutaneous excision of benign breast lesions	Benign breast lesions	• JA43 - Unilateral Intermediate Breast Procedures
Abdominal endovascular aortic repair (EVAR)	Abdominal aortic aneurysms	• YR01 - Complex Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm • YR02 - Endovascular Repair of, Thoracic or Thoracoabdominal Aortic Aneurysm • YR03 - Complex Endovascular Repair of Abdominal Aortic

Procedure	Condition	Proposed HRGs[39]
		Aneurysm • YR04 - Endovascular Repair of Abdominal Aortic Aneurysm
Uterine Fibroid Embolisation (UFE)	Uterine fibroids (benign tumours of the uterus)	• YR55 - Uterine Artery Embolisation

13.3 Rationale

This BPT was originally introduced to ensure visibility and appropriate reimbursement for a set of IR procedures. Therefore, with the proposed introduction of HRG4+ these procedures are better described, and at a lower level of granularity than with HRG4, so we propose that this BPT is no longer required. It is felt that the continuation of the BPT would lead to a further level of complexity and less clarity of re-imbursement.

Our engagement on this proposal in 2015 suggested that continuing with this BPT would add an unnecessary complexity and lack of clarity to the payment system, and offers little or no benefit gained by the proposed move to the HRG4+ currency design.

If the proposal to move to HRG4+ is not accepted then we propose to retain the IR BPT.

We received several comments about the price relativities of Uterine Fibroid Embolisation (UFE) verses open hysterectomy and there is a need to ensure that the price relativities developed for HRG4+ continue to incentivise best practice.

13.4 Engagement questions

We would like your feedback on this proposal. Please let us know your views by completing the online survey. The questions included in the survey are set out below.

- Do you support this proposal?
- Are you aware of any unintended consequences of this proposal?
- Do you have any other comments on this proposal?
- Is there any other information you need on this proposal?

14 Equality and Health Inequalities Analysis

NHS Improvement and NHS England's final proposals for the 2017-2019 National Tariff will be accompanied by NHS Improvement's Impact Assessment.

The engagement exercise that this document is a part of will help us to gather information on the potential impact of our proposals, which will inform our final proposals for statutory consultation later in the year.