Payment by Results for stroke and TIA services
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Prepared by the Vascular Programme Branch of the Department of Health

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### Payment by Results for Stroke and TIA Services

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**Contact details:** Stroke Team  
Vascular Programme  
133 -155 Waterloo Road  
London  
SE1 8UG  
MB-Stroke-Ideas@dh.gsi.gov.uk  
www.dh.gov.uk/stroke

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**Introduction**

The aim of this fact sheet is to help those affected by Payment by Results (PbR) understand how it works and ensure that the system operates in the best possible way for people in need of stroke care. This fact sheet begins by explaining the PbR tariff and looks at the key issues for stroke and TIA services.

PbR is a way of paying for services commissioned on behalf of NHS patients provided by NHS Trusts, NHS Foundation Trusts (FTs), Independent Sector Extended Choice Network providers and PCTs. There is a national price list for all activity within the scope of PbR – this is the “national tariff”. Providers are paid according to the amount of activity they do, multiplied by the relevant tariff price. **Activity x Price = Income**

PbR aims to reward efficiency and those providers that deliver good-value for money, increase activity to reduce waiting times and facilitate patient choice and diversity of providers by ensuring the money follows the patient. PbR enables money to move fairly and openly around the system.

The tariff is intended to base payments on an average price that balances out over the healthcare resource group (HRG). It does not reimburse a provider with the exact cost of treating individual patients.

The way that the tariff is set means that those providers whose costs are below average will benefit. This could be because they are very efficient or perhaps because there is scope for service improvement and so will be able to use the extra money to improve quality of care following discussion within the Trust. Trusts whose costs are above the tariff will have to look for savings and ways to become more efficient.

The Department of Health recognises that further work is needed to ensure that PbR adequately reflects the diverse range of stroke and TIA services. The tariff does not yet cover every aspect of stroke care. It is important to remember that the tariff is not the only way in which money can move around the system. Other important aspects of delivering and supporting care will need to be negotiated directly with PCTs.

These issues are covered more fully in this factsheet and in the Quick Reference Chart in Annex A.

PbR is just one of many levers and incentives of change within the NHS. Recognising that other means may also be needed to bring about improvements in stroke care the Department of Health is in the process of working with stakeholders to develop a new stroke strategy. On 9 July the Department published **A new ambition for stroke - a consultation on a national strategy**. The consultation period runs until 12 October 2007 and offers an opportunity for comment on the development of the future direction of stroke services.

In the interim the Department has already issued two interactive tools **ASSET** and **ASSET for commissioners** and has published **Improving Stroke Services: a guide for commissioners**.

More information about Payment by Results is available on the Department of Health website at: **www.dh.gov.uk/pbr**
The tariff

The tariff applies across the NHS for elective and non-elective admitted patient activity, daycases, outpatients and A&E (including Minor Injuries Units). Adult critical care continues to run in shadow form in 2007/08. The HRGs will be used but with locally negotiated prices.

The Healthcare Resource Groups

The tariff for in-patients is based on Healthcare Resource Groups (HRG). These are groupings of healthcare activities which are clinically similar, and which use similar levels of resources. e.g. A22 – Non-Transient Stroke or Cerebrovascular Accident (aged more than 69 years, or with complications or co-morbidities).

Over the years HRG classifications have been revised and improved. The current tariff is based on HRG version 3.5; however, work is ongoing to further refine and improve HRG classifications (version 4) and produce new intervention codes. HRG version 4 was released to the NHS to use for the 2006/07 Reference Cost collection. The aim is to use these new HRGs in commissioning from 2009/10. For further information on these new HRGs, and a report on the 2006 consultation, please consult the NHS Information Centre or the PbR development section of the DH website.

Setting the tariff

Tariffs are derived from ‘Reference Costs’ which are collected annually from all NHS providers. The Finance Director for each Trust has been asked to calculate the costs for each inpatient and outpatient activity in their hospital and submit it centrally. These reference costs are then averaged and adjusted to take account of data quality issues. In the past the system has operated with a two-year time lag between reference cost and tariff. For example, the 2006/07 tariff was based on the 2004/05 reference costs. In order to provide stability and planning certainty the tariff for 2007/08 is based on the 2006/07 tariff with a 2.5% uplift. Further details on how this was calculated can be found in Annex D of the PbR Guidance.

The calculation of appropriate tariffs depends on the accuracy of the reference costs submitted by Trusts. The introduction of the new HRGs will be accompanied by an Education, Awareness and Training project designed to help people understand the changes being made.

It is crucial that all Trusts submit accurate reference costs for their stroke services, in order to ensure that the tariff reflects the real cost of stroke care across the country.

Local differences in cost

Tariffs are adjusted by the Market Forces Factor (MFF) to take into account unavoidable differences in costs at different geographical locations. The tariffs quoted exclude the MFF, which is paid separately.

For example: The non-elective tariff for A23 – Non-Transient Stroke or Cerebrovascular Accident (aged under 70 years without complications) is £2884, for Wirral Hospital NHS Trust this tariff is multiplied by a MFF of 1.065406, creating an adjusted tariff of £3073.
Using the tariff to drive change

In 2007/08 indicative tariffs have been issued which support the unbundling of services. The key purpose of unbundling is to put in place the correct incentives to encourage appropriate alternatives to traditional hospital “bundles of care”.

These developments are of relevance to stroke services and unbundling stroke rehabilitation has been used as a model in the technical guidance.

The initial work around unbundling has had a clear clinical focus; however, there is recognition that the approach described in the technical guidance is not perfect. Commissioners and providers have scope to agree different local solutions for their areas.

Unbundling rehabilitation

The indicative tariffs support the unbundling of non-discrete rehabilitation from the tariff. In the past, the tariff has included a component of post-acute care but the new unbundled tariff has a reduced price which only covers acute care. As a result resources can be shifted to support rehabilitation in a non-acute setting (Funding for discrete rehabilitation remains outside the scope of the tariff and is for local negotiation). The implementation of unbundled tariffs is guided by a set of principles to be followed by commissioners:

- High quality rehabilitation in an acute setting should not be disrupted.
- All rehabilitation should meet high quality standards consistent with wider national guidance.
- Indicative tariffs for the acute phase of care should apply only to patients who are moved to an alternative care setting.
- During the acute phase, patients should be adequately assessed in order to plan for management in the post-acute phase.
- Local models of post-acute care should involve specialised stroke multidisciplinary teams.
- Some stroke patients with non-complex needs may only need uni-disciplinary rehabilitation.

Early supported discharge

When examining the issue of unbundling rehabilitation the clinicians who were consulted divided care into a series of phases.

<table>
<thead>
<tr>
<th>Care Type</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>0-7 days</td>
</tr>
<tr>
<td>Early Post-Acute Care</td>
<td>7-12 days</td>
</tr>
<tr>
<td>Later Post-Acute Care</td>
<td>12+ days</td>
</tr>
</tbody>
</table>

The indicative tariff only covers the first 7 days of acute care and in practice it has been suggested that the early post-acute phase is often most appropriately provided in a specialist admitted patient setting and, if so, should not be unbundled.
It may be more typical for commissioners to unbundle the later post-acute phase through Early Supported Discharge schemes. In this case the indicative acute phase tariff will have to be adjusted to cover the early post-acute phase.

Local commissioners and providers will have to agree how they make these adjustments but the technical guidance offers some suggestions.

For example, the non-elective indicative acute tariff for A22 Non-Transient Stroke or Cerebrovascular Accident (aged over 69 with complication) is £2,697. The average excess bed day tariff (uplifted from 2006/7 figures) is £136. If it is assumed that the early post-acute phase covers days 7-12 (5 days total) then the indicative tariff for A22 covering acute and early post-acute would be £3,377 [£2,697 + (5 x £136)].

Many Early Supported Discharge schemes are often provided with substantial input from the acute sector. The indicative acute phase tariffs do not include this support and this may also have to be considered for local adjustment.

Unbundling diagnostic imaging

Alongside rehabilitation, the unbundling of diagnostic imaging has been the other area of focus. The technical guidance envisages two broad scenarios for unbundling diagnostic imaging:

- Diagnostics commissioned as a direct access service from the same provider carrying out the outpatient appointment.
- Diagnostics carried out by an alternative provider to the one in which the outpatient appointment takes place.

However, where a diagnostic test is requested at an outpatient attendance, and is carried out by the same provider, the tariff should not be split. It is unlikely that there would be any circumstances where the models of care for stroke or TIA services would be eligible for unbundling.
Issues for stroke services

New technologies and services

There are range of adjustments and flexibilities covered in the technical guidance to take account of new technologies and services for stroke and TIA.

For example, for stroke devices, technology and drugs that have not yet been subject to any NICE appraisal, a pass-through payment can be agreed locally which allows PCTs to pay for the additional costs in a supplemental fashion for a period of up to two years.

For further details on adjustments, exclusions and flexibilities in the tariff please see the 2007/08 technical guidance.

Thrombolysis

The issue of thrombolysis was raised during the unbundling discussion. It was felt that the service is still in development and for 2007/08 thrombolysis can be subject to a pass-through payment if it meets the following conditions:

1. It is coded to a relatively high volume HRG where the activity within the HRG is heterogenous in nature and:
2. Delivered in a limited number of centres and;
3. Of disproportionate cost relative to the HRG tariff.

Reduced short stay emergency tariff

The short stay emergency tariff applies in cases where actual length of stay is less than two days and only applies where the assignment of the HRG is based on diagnosis rather than procedure code.

The level of reduction will depend on the national average length of stay of the HRG as follows:

<table>
<thead>
<tr>
<th>HRGs with average length of stay</th>
<th>Short stay tariff (% of tariff applied)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 -1</td>
<td>100% of tariff</td>
</tr>
<tr>
<td>2 days</td>
<td>50%</td>
</tr>
<tr>
<td>3 - 4 days</td>
<td>35%</td>
</tr>
<tr>
<td>5 or more days</td>
<td>20%</td>
</tr>
</tbody>
</table>

Long stay outliers

Those patients who require an extended stay will be eligible for daily rate payments if the length of stay exceeds a “trim point” defined for each HRG.
Issues for TIA services

If a patient is admitted to hospital with a TIA they will be covered under A20 or A21. If a patient attends a clinic there are a number of possibilities for how the tariff will be applied.

Geriatric medicine outpatient

The tariff for first attendance is £288 and £129 for follow-up. This type of clinic may not be applicable for many TIA patients.

Multi-disciplinary clinics

In 2007/08 there is flexibility to negotiate additional funding for multi-professional outpatient attendances. This includes multi-disciplinary or joint clinics where there are representatives from more than one speciality.

High cost clinics

Where treatment is delivered appropriately in an outpatient setting and the local cost of delivering this is more than twice the relevant speciality level tariff, the service can be funded at a locally negotiated rate.

Carotid endarterectomy

If surgery is required the procedure is covered under Q05 Extracranial or Upper Limb Arterial Surgery. The elective tariff is £2,812 and the non-elective tariff is £3,966.
Other ways to receive payment

Trusts will need to negotiate separate payments from PCTs for all the other services they provide that are not yet covered by the tariff.

This will be important for discrete rehabilitation services and specialist stroke teams who increasingly provide services like outreach occupational therapy and physiotherapy services; support to family and carers; and educating, training and mentoring for primary care providers. Stroke teams need to ensure that their Trust Chief Executives and Medical Directors understand the scope and importance of this work and ensure that the Trust is being paid for it.

Final advice for Trusts

a) Make sure that there is a clear model of care based on the RCP National Clinical Guidelines, the Older People’s NSF and the forthcoming stroke strategy.
b) Make sure that the roles of the various teams and individuals involved in delivering stroke services are clearly defined and agreed by all parties.
c) Check that accurate reference costs are collected.
d) Check that all activity is correctly coded so appropriate HRG tariffs and specialist supplements apply.
e) Try to document work not covered by the tariff and have discussions with your Trust to ensure it is recognised.
f) Let DH know of any pass-through arrangements via PbRComms@dh.gsi.gov.uk

Future developments

PbR will continue to be built upon and refined over the coming years. The Department of Health recently conducted consultation: Options for the Future of Payment by Results: 2008/09 to 2010/11.

This document addressed the four key challenges for PbR to develop a system which:
• rewards appropriate, high quality care and not simply activity;
• supports partnership working;
• supports the commissioning of integrated care based on evidence-based protocols;
• supports a sustainable funding system for urgent and emergency care.

The document identified the building blocks of PbR, (patient-level data, clinically meaningful currencies and accurate costing) and examined how they can be strengthened.

The consultation also considered a number of issues related to the development of the tariff, the future of tariff setting and extending the scope of PbR.

The consultation period closed on June 22 and the DH will publish a response in the autumn 2007.
### Annex A: Quick reference chart

#### Quick reference chart

<table>
<thead>
<tr>
<th>Issue</th>
<th>Relevant HRGs</th>
<th>Action</th>
<th>Example (if applicable)</th>
<th>PbR guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIA Clinics</td>
<td>If patient attends Geriatric Medicine then outpatient code 430 is used. If there is an attendance at a multi-disciplinary clinic then additional funding can be made available at a locally negotiated rate</td>
<td>Look up long stay trimpoint on tariff and additional daily rate payment</td>
<td>For non-elective stroke (A23) the trim point is 25 days. Stays over that length will receive £171 per day</td>
<td>Pg 26, para 109</td>
</tr>
<tr>
<td>Outlier long stay</td>
<td>A19, A20, A21, A22, A23</td>
<td>Look up long stay trimpoint on tariff and additional daily rate payment</td>
<td>For non-elective stroke (A23) the trim point is 25 days. Stays over that length will receive £171 per day</td>
<td>Pg 16, paras 67-69</td>
</tr>
<tr>
<td>Reduced short stay emergency tariff</td>
<td>A19, A20, A21, A22, A23</td>
<td>Look up reduced short stay emergency tariff</td>
<td>For non-elective A23 the reduced short stay emergency tariff is £577, 20% of the non-elective spell tariff</td>
<td>Pg 15, paras 54-58</td>
</tr>
<tr>
<td>Rehabilitation in a discrete ward or unit</td>
<td>N/A – out with the scope of the tariff and therefore there is no need to unbundle; fund at locally negotiated rate</td>
<td>Record with treatment function code 314</td>
<td>For non-elective A23 the reduced short stay emergency tariff is £577, 20% of the non-elective spell tariff</td>
<td>Pg 11, para 31</td>
</tr>
<tr>
<td>Early supported discharge</td>
<td>A22, A23</td>
<td>Based on the indicative tariffs local commissioners and providers should agree how to calculate the tariff for inpatient care prior to early supported discharge.</td>
<td>For non-elective A22 the indicative tariff for the acute phase of care is £2,697. The average excess bed day tariff is £136. If it is assumed that the early post-acute phase covers days 7-12 (5 days total) then the indicative tariff for A22 covering acute and early post-acute would be £3,377 (£2,697 + (5 x £136)).</td>
<td>Pg 20, para 80</td>
</tr>
<tr>
<td>Thrombolysis</td>
<td>A pass-through payment over and above the relevant HRG tariff can be negotiated</td>
<td>The price attached to the pass-through payment should be agreed in advance and fixed for a maximum period of 2 years. DH to be informed of these arrangements via <a href="mailto:PbRComms@dh.gsi.gov.uk">PbRComms@dh.gsi.gov.uk</a></td>
<td></td>
<td>Pg 24, paras 100-101</td>
</tr>
</tbody>
</table>
Payment by Results for Stroke and TIA Services

Steps to calculating your tariff

1. Look up the tariff for the HRG.

2. Multiply the tariff by the MFF for your provider.

3. Check to see eligibility for any specialised services uplift. If the activity is eligible for an uplift, add this to tariff.

4. Check to see if the service is subject to any exclusions or flexibilities.

5. Check on LOS trimpoint for this HRG. Add daily rate for outlier length of stay, if appropriate. Reduce tariff for short stay, if appropriate.