Dear colleague,

The Payment by Results team at the Department of Health has recently issued the 2013-14 road test package for comment. The purpose of this exercise was to provide an opportunity for the NHS to test out the proposed new tariff(s).

The package released on the DH website (http://www.dh.gov.uk/health/2012/12/pbr-acute-mental) includes a proposed best practice tariff for rheumatology services in England. The proposal was developed over several months of joint working between British Society for Rheumatology, Arthritis Research UK and the Department of Health (DH), and including discussions with the National Rheumatoid Arthritis Society (NRAS) and other stakeholders. Subject to feedback, the tariff will be implemented in April 2013.

Arthritis Research UK and the British Society for Rheumatology think that the successful implementation of this best practice tariff is an important element of our work to improve treatment for inflammatory arthritis by strengthening rheumatology services nationally. This will be the first time there is a best practice tariff in rheumatology and it will therefore act as a way of raising the profile of rheumatology conditions to improve the quality of patient care.

We have put together some “Frequently Asked Questions” regarding the proposed tariff below. Please do contact us if you have any other questions.

Yours sincerely,

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Frequently Asked Questions

1. **What is a best practice tariff (BPT)?**
   
   A best practice tariff (BPT) is a national tariff that has been structured and priced to incentivise and adequately reimburse care that is high quality and cost effective. A specific approach is developed for each BPT, tailored to the clinical characteristics of best practice and the availability and quality of data.

   A BPT that colleagues may have encountered is one for fragility fractures of the hip which rewards hospitals for operating promptly on hip fractures, and involving orthogeriatricians to facilitate rehabilitation and prompt discharge.

   *Equity and Excellence: Liberating the NHS* said that “we will rapidly accelerate the development of BPTs, introducing an increasing number each year, so that providers are paid according to the costs of excellent care, rather than average price.”

2. **Is there any evidence of the impact of BPTs?**

   There is evidence to show that where hospitals have taken up the BPT, it can improve processes and outcomes.

   An independent evaluation of the first year of the best practice tariffs was conducted by the Universities of Nottingham and Manchester. This reported that their introduction was associated with rapid improvements in the quality of care that patients receive for cholecystectomy and hip fracture. The same improvements were not seen in stroke management, which may reflect the challenge of reorganising complex clinical pathways.

3. **Why do we need a best practice tariff in rheumatology?**

   The British Society for Rheumatology and Arthritis Research UK were approached in March 2011 by the Department of Health to suggest areas that could be explored for rheumatology best practice tariffs (BPTs). Out of a number of suggestions the BPT for early inflammatory arthritis (EIA) was accepted, and will be implemented in April 2013, subject to the final DH consultation, currently underway.

   In developing this BPT, the British Society for Rheumatology contacted many rheumatology units around the UK and asked for their opinion on a possible BPT, and for data they might have on their own service that would inform the BPT. Consequently, we know that many centres operate EIA new patient and follow up services that already meet the criteria to qualify for this new proposed tariff. These units will be rewarded financially for what they already do.

   However, the National Audit Office and Rheumatology Futures reports, both published in 2009, remind us that best practice for EIA is not spread uniformly across the country. By creating a financial incentive, the BPT is intended to remove financial barriers and create an incentive for all units to follow best practice in EIA management. For these units struggling to achieve the resources required to achieve best practice, this BPT should encourage financial arguments in business cases to increase staff and facilities in departments where this has previously been the block to implementing best practice. This should decrease the variation in the quality of care for this element of rheumatology service across England.

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2. National Audit Office (July 2009) Services for people with rheumatoid arthritis
3. King’s Fund (Jan 2009) Perceptions of patients and professionals on rheumatoid arthritis care
A feature that makes the BPT attractive to all units is that patients seen in this scheme will not be subject to inclusion in calculations for new to follow up ratios. This simplistic bench-marking process has been forced on many rheumatology services to decrease the number of follow up appointments. This BPT allows EIA patients to be seen as frequently as clinical need dictates, and in line with best practice, an improvement that rheumatology units will welcome.

4. What criteria will services need to achieve to receive the proposed best practice tariff?
To earn the best practice tariff, it is proposed that services must meet four criteria for patients referred to their service with suspected early inflammatory arthritis:

- People referred with suspected early inflammatory arthritis (EIA) should have their first specialist appointment within three weeks of their referral date.
- Within six weeks of referral, diagnostic testing and any necessary clinical reviews should be completed. By the end of these six weeks, people who do not have EIA should be discharged back to the care of their GP, and people who have EIA should have received their first prescription for disease-modifying therapy.
- Every person diagnosed with EIA should receive an annual review, within one year of the date of referral.
- During their first year of care, people diagnosed with EIA should have regular clinical reviews with monitoring of disease activity, therapeutic benefit and treatment safety in line with published National Institute for Health and Clinical Excellence (NICE) and BSR guidance.

The draft guidance containing the criteria for each of the proposed best practice tariffs can be found here. Further, more detailed, clinical guidance will be published shortly by the BSR.

5. How will payments be structured for this tariff?
The proposed best practice tariff (BPT) for early inflammatory arthritis (EIA) includes three levels of payment. The proposed amounts can be found here.

The first level of payment applies where patients are referred to rheumatology services with suspected EIA and this is ruled out, with the patient assessed and discharged in accordance with the criteria outlined above.

The second level of payment applies to a full year of care for patients who are referred to rheumatology services with suspected EIA, and EIA is confirmed and appropriate treatment initiated. The BPT payment is mandatory for patients who meet the criteria outlined above for diagnosis, treatment and reviews.

The third level of payment is slightly higher than the second, and is for patients who proceed to treatment with biologic therapies in their first year. Like the second level it is a year of care tariff, with an increased price to reflect additional screening costs for patients requiring these treatments.

6. Which costs are covered by the tariff?
The price paid to providers includes the cost of clinical and non-clinical staff and associated overheads and assumes a mixture of nurse-delivered and consultant-delivered care. The costs of initial diagnostic testing including blood tests, X-rays and ultrasound for a proportion of patients, is also included. Prescription costs for disease modifying agents are priced in the tariff, as are the costs of safety bloods monitoring during the first year.
Adjustments in the price of the tariff may need to be negotiated in areas where primary care carries out some of these activities during the first year of care for people with early inflammatory arthritis. The drug costs, and any infusion costs, of biologic therapies are not included in the tariff and will continue to be paid by commissioners in the usual way. However, any additional costs of screening and outpatient clinical care for people receiving biologic therapies are included within the tariff.

7. How much of the care should be delivered by consultant rheumatologists?
Clinical care should be delivered by the appropriate member of the multidisciplinary team, under the leadership and supervision of consultant rheumatologists. The price of the tariff assumes a mixture of nurse-delivered and consultant-delivered care. While this will vary from patient to patient according to clinical need, substantially different practice may require negotiation and agreement with local commissioners.

8. Who will collect the data to support the tariff?
This will vary from unit to unit. For many units this will be clinicians (rheumatologists or nurse specialists), and in recognition of this we have endeavoured to make the necessary data collection as succinct as possible. For other units it may organised for administrative support staff to assist with data collection. Data collection will be minimal for patients who are found not to have EIA. For those that do, a brief pro-forma will need to be completed for each visit to show compliance with the tariff, and to qualify for payment. Colleagues should be reminded that this data collection only applies to EIA patients in their first year of care, and not to the many other patients seen in rheumatology services.

9. Does a provider have to meet all elements of the criteria to be eligible for the tariff payment?
Yes, to be eligible for any given level of the best practice tariff payment, all elements of the best practice tariff criteria for that level need to be achieved.

10. Who determines whether a service is in line with best practice?
It is the responsibility of the provider to satisfy the commissioner that care has been delivered in line with best practice. The British Society for Rheumatology and Arthritis Research UK are working with the Department of Health to develop a model of a brief pro-forma containing the minimum dataset required to demonstrate the criteria in the tariff. This will be piloted by the British Society for Rheumatology Regional Chairs in April 2013. We would suggest that providers and commissioners agree locally what information is required.

11. Which rheumatology services will take part?
All rheumatology services are encouraged to participate. The criteria used in developing the BPT are consistent with NICE rheumatoid arthritis management guidelines. The best practice tariff payment is payable to any / all provider(s) where the service to an individual patient is delivered in line with best practice. Payment of the best practice tariff in these circumstances is mandatory (subject to satisfactory supporting information being presented to the commissioner).
12. What happens to units who are unable to implement the best practice tariff?

Providers who are unable to or who choose not to implement the best practice tariff will continue to be paid the standard tariffs for new and follow up appointments. The levels of these tariffs have not been affected by the new best practice tariff proposals. No rheumatology services will be worse off than before if they do not implement the best practice tariff. Those units that do not implement this BPT will be denying themselves the opportunity to increase income to their trusts, and to provide a service that is consistent with NICE rheumatoid arthritis management guidelines.

13. Why doesn’t the best practice tariff focus on problems in primary care?

Tariffs are the payments that hospitals receive for the work they do. Best practice tariffs are therefore only able to be a financial incentive for the work done by specialist providers, and not by primary care. The accompanying guidance to this tariff does, however, set out the expectation that primary care should aim to refer patients with suspected early inflammatory arthritis (EIA) to rheumatology services within six weeks of symptom onset. Other payment mechanisms, such as the Quality and Outcomes Framework (QOF), do provide financial incentives for improved primary care services, and this will include rheumatoid arthritis in the near future.

14. How were the timelines for diagnosis and treatment chosen?

To prevent long term pain and disability, previous guidance has emphasised the importance of beginning treatment within 12 weeks of symptom onset. Barriers to this include people holding off seeing their doctor, GPs not referring quickly enough, delays in accessing rheumatology services, and time taken to complete specialist diagnostic investigations. In developing the best practice tariff, we recognised that the 12 weeks must include time for people to decide to seek medical care and for GPs to assess and refer. This tariff therefore assigns half of the responsibility for the 12 week window to specialist care, with a “three week rule” to first appointment and a further three weeks to complete initial investigations and make a diagnosis.

15. Could this lead to inappropriate diagnosis of rheumatoid arthritis?

The purpose of the best practice tariff is to prevent long term pain and disability by providing an incentive for urgent initial assessment and appropriate initiation of disease modifying therapy in people with confirmed early inflammatory arthritis (EIA). Six weeks are allotted from date of referral to the decision to discharge or treat. This allows enough time to meet the current European League Against Rheumatism (EULAR) classification criterion for persistence. However, due to the time people typically take to consult their GP, and for their GP to refer them to Rheumatology, the vast majority of people will have had their symptoms for well over six weeks by the time they are first seen in rheumatology clinic.

16. When is the tariff due to be implemented?

The best practice tariff for early inflammatory arthritis (EIA) is proposed as part of the 2013/14 payment by results (PBR) package which will operate from 1 April 2013. From that date, it will be mandatory for commissioners to pay the best practice tariff for patients with EIA whose care meets the criteria set out in the guidance. The final decision about inclusion of the BPT for EIA in the PBR package will be made in February, once any feedback from the recent consultation has been considered.