

The Best Practice Tariff and National Audit Returns

There is now a best practice tariff (BPT) programme for heart failure. At the time of writing (July 2016), we're in the second year of the tariff: the first year was voluntary (running from April 2015 to March 2016) for individual Trusts, but starting April 2016, participating in the BPT has become compulsory.

For the financial year 2016–2017, the tariff is worth a 5% uplift in the amount your Trust is paid for each and every admission. It is an 'all-or-none' phenomenon: either you get the BPT for every admission, or for none of them. It is *not* calculated for each individual patient.

To meet the requirements for the BPT, you have to meet 2 criteria:

1. 60% of your patients must have had input into their in-patient care from the heart failure specialist team as recorded in your national audit return; and
2. 70% of the patients coded (in the first position) in your Trust's HES statistics as having had an admission for heart failure must be entered into the heart failure national audit.

Note the central importance of the national audit returns. Another item of note is that hospital level mortality statistics will be published for the next report (ie based on the data being collected between April 2015 and March 2016). Outliers – that is, those who lie more than 3 standard deviations from the mean for in-patient mortality – will be identified by name. Outliers include those who are returning zero % in-hospital mortality: such a thing is not plausible and suggests that patients who die are not being entered into the audit. A huge amount is going on behind the scenes to make sure that the reporting will be *fair* and corrected for all relevant variables.

For this to work, feedback between the various parties is going to be much faster. A weak link (and the reason for delays in publication of the national audit reports) has been the connection between the audit and HES. That will change:

1. reports will be delivered quarterly, so you will know how well your Trust is performing against various benchmarks (such as β -blocker use)
2. you'll need to make your entries into the audit much more frequently than heretofore: you should perhaps be thinking of altering your systems to allow weekly or even live in-putting of data
3. the software used by the national audit is going to change to allow web-based data entry

In the mid-term, the audit is going to be extended to include patient reported experience (PREMs) and patient reported outcomes (PROMs). The 12 question version of the KCCQ is likely to be used.

It's likely that these changes will require different working patterns and an increase in the resources required for the national audit at local level. You need to be aware of the changes now, and think about approaching the leaders of your service to get the resources you need. The carrot, of course, is the uplift provided by meeting the requirements for the BPT: this should encourage your trust to support you appropriately. It is possible that in future years that there may be a bigger penalty for not meeting the BPT.