Best Practice Tariff for Emergency Laparotomy FAQs – March 2023

1. ***What is the Emergency Laparotomy Best Practice Tariff (EL BPT) 2023-2025?***

This means there is an enhanced tariff payable to Trusts in England that deliver care considered to be best practice to their patients requiring emergency general abdominal surgery. If care does not meet those standards, Trusts will be paid at a lower rate. The specific aim of the EL BPT 2023-2025 is to improve the proportion of patients who receive both a formal mortality risk assessment before surgery AND input by peri-operative teams experienced in the management of frail older patients.

2. ***Why have improved risk assessment and improved peri-operative care been chosen as the BPT metrics?***

The BPT metrics are set by NHS England, and are not chosen by NELA. Many processes are important in optimising care for patients, but early recognition that a patient is at increased risk of complications postoperatively is essential if the required standards of clinical care are to be met. Improving care for older and frail patients remains one of the worst performing metrics within NELA, but is of significant clinical importance. The NELA Year 8 report, which included data from 1 Dec 2020 until 30 Nov 2021, shows that less than a third of elderly and/or frail patients benefitted from elderly care input postoperatively. The same report showed an association between elderly care input and a halving of mortality risk. Improving elderly care resources requires a financial investment in many hospitals – and the decision was made by NHS England to reward those Trusts that prioritise this area.

3. ***What are the specific targets for EL BPT?***

The previous metrics of ensuring direct consultant-delivered anaesthetic and surgical care for high-risk patients in theatre as well as critical care admission are still considered best practice, but BPT will now focus on:

- Risk assessment – proportion of patients who receive a documented assessment of risk as part of the decision to operate. Target: 85% of all NELA patients
- Peri-operative team input – proportion of patients aged 80 or over, or 65 or older and frail (CFS≥5), who receive input by peri-operative teams experienced in the management of older patients. Target: 40% in 2023-24, increasing over time.

4. ***Does a hospital need to meet both criteria (risk assessment and improved peri-operative input) to receive the BPT?***

Yes. If either metric falls below the target (85% and 40% of eligible patients respectively) the BPT will not be payable.

5. ***What exactly does "input by peri-operative teams experienced in the management of older patients" mean?***

Guidance published in 2021 is available from the Centre for Perioperative Care (CPOC), which notes that "all hospitals should have a perioperative frailty team with expertise in Comprehensive Geriatric Assessment and optimisation, providing care throughout the pathway [for frail and elderly patients]". The perioperative frailty team should be multidisciplinary and have expertise in comprehensive geriatric assessment and optimisation methodology to deliver:

- preoperative assessment and optimisation of frailty, cognitive disorders and multimorbidity
- prognostication and shared decision making
- assessment and management of postoperative medical complications, hospital acquired deconditioning, postoperative cognitive disorders
- rehabilitation, goal setting and discharge planning with onward referral to community services
- treatment escalation and advance care planning
- effective communication with patients and carers throughout the perioperative pathway
- streamlined care working with other disciplines and specialities

NHS England have indicated that a patient will have received appropriate input if they have been seen in the post-operative period by a geriatrician-led service, or by a perioperative medicine-led team with established referral pathways to geriatrics. The BPT will not have been met if patients have only had an intensivist or anaesthetic review whilst on critical care, PACU or as part of an outreach service.

6. ***An agreed pathway for emergency laparotomy patients is required as a pre-condition for accessing the BPT. What does this mean?***

Trusts need to have agreed multidisciplinary pathways of care in place, agreed by key stakeholders within the Trust who are involved in delivering care, including emergency departments, elderly care, anaesthesia, critical care and surgery. As a minimum these pathways should cover a diagnostic pathway as well as a laparotomy pathway once a decision to operate has been made.

7. ***How can I find out how my Trust is performing?***

NELA provides reports at hospital level covering a number of process measures. However, BPT is assessed at Trust level, and this might be important if your Trust has more than one hospital performing emergency abdominal surgery. NELA will produce Trust level reports specifically around BPT performance.

8. ***How will my Trust be assessed for payment of BPT?***

BPT compliance will be assessed directly through data submitted to NELA. However payment will be based on HRG codes that represent common (but not all) emergency laparotomy operations, regardless of whether or not these are entered into the NELA registry, and regardless of the patient's age or frailty profile. Hence the BPT is paid for ***all***

patients with those HRG codes, not just those that are aged 80 or over, or 65 or older and frail. Commissioners are likely to consider whether overall NELA case ascertainment rates are high enough before approving BPT payments.

9. What are the timelines for submitting and locking NELA cases to be eligible for BPT payments?

The BPT will be payable quarterly. Cases need to be entered and locked in the NELA database within 60 days of surgery in order to appear in the BPT report. It is not possible to retrospectively add patients to a previous quarter in order to receive the BPT for that previous quarter.

10. Who should I contact in my trust to help with the BPT?

Your medical director, leadership and finance teams and NELA clinical leads in surgery, medicine and anaesthesia will want to know about this BPT, as it may alter income for the Trust. They may wish to make enhancements to clinical services to facilitate enhanced income. It is important to note that the tariff for those Trusts that do not meet the BPT criteria will be lower: Trusts may need to include any potential shortfall in their business planning.

11. What support should I look for from my Trust?

Given the financial benefit that arises from the BPT, we would expect Trusts to support those involved in co-ordinating NELA data entry within hospitals, including job planned time for clinical leads, audit facilitators and clinical coding teams.

Your Trust could target BPT metrics to bring extra income into the Trust helping to fund the Trust's quality improvement/service improvement aspirations.

12. What is the difference in price between the lower and enhanced tariff?

The difference varies according to HRG code as shown in the table below. The average difference is about £900, so a Trust undertaking 100 HRG-code eligible procedures per year might see a potential income difference of £90,000. These HRG codes can be passed to your own coding departments who will be able to model the financial implications for your own Trust.

HRG code	HRG name	Best practice tariff: Non-elective (£)	Non-best practice tariff: Non-elective (£)
FF21A	Very Major Small Intestine Procedures, 19 years and over, with CC Score 8+	14,094	12,712
FF21B	Very Major Small Intestine Procedures, 19 years and over, with CC Score 5-7	10,491	9,462
FF21C	Very Major Small Intestine Procedures, 19 years and over, with CC Score 2-4	8,482	7,651
FF21D	Very Major Small Intestine Procedures, 19 years and over, with CC Score 0-1	6,977	6,293

FF31A	Complex Large Intestine Procedures, 19 years and over, with CC Score 9+	15,679	14,142
FF31B	Complex Large Intestine Procedures, 19 years and over, with CC Score 6-8	12,706	11,460
FF31C	Complex Large Intestine Procedures, 19 years and over, with CC Score 3-5	10,905	9,836
FF31D	Complex Large Intestine Procedures, 19 years and over, with CC Score 0-2	9,363	8,445
FF32C	Proximal Colon Procedures, 19 years and over, with CC Score 0-2	7,905	7,130
FF51C	Major General Abdominal Procedures, 19 years and over, with CC Score 3-5	7,195	6,490
FF51D	Major General Abdominal Procedures, 19 years and over, with CC Score 1-2	5,424	4,893
FF51E	Major General Abdominal Procedures, 19 years and over, with CC Score 0	4,133	3,728

13. How should the income from the enhanced BPT be used?

The BPT is intended to support improved services for emergency laparotomy patients. Some Trusts have indicated they will use the enhanced tariff to support increased elderly care capacity, or improved access to perioperative medical input for frail and elderly patients.

14. What case ascertainment rates does a Trust need to achieve in order to qualify for BPT?

This is a decision for commissioners to make, as they will need to decide whether case ascertainment is sufficient to represent Trust activity.

15. Where can I find out more about BPTs?

NHS England guidance on all current BPTs is available here:
https://www.england.nhs.uk/wp-content/uploads/2022/12/23-25NHSPS_Annex-DpC-Best-practice-tariffs.pdf
(page 54 for emergency laparotomy BPT)

HRG coding and financial detail is available to download from here:
https://www.england.nhs.uk/publication/2023-25-nhsps-consultation/
("Annex DpA NHS payment scheme prices workbook, 2023-24" spreadsheet available to download)