THE SCOTTISH OFFICE 11922 NHS MEL(1996)82

Department of Health

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG
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Dear Colleague

EXTRA-CONTRACTUAL REFERRALS: CHANGES IN NOTIFICATION REQUIREMENTS AND STEPS TO REDUCE VOLUME

Summary

1. This circular advises NHS purchasers and providers in Scotland of changes to the notification requirements for extra-contractual referrals (ECRs).

2. For admissions on or after **1 October 1996,** NHS Trusts are not required to notify purchasers in advance of invoice of:

- emergency extra-contractual referrals
- tertiary extra-contractual referrals

except:

- where the patient's stay is expected to exceed 28 days (early notification within this period will be good practice; failure to notify within 7 days of the end of the period will automatically cancel purchasers' obligation to pay)
- where the cost of the episode is expected to exceed £6000

September 1996

Addressees

For action:
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3. Annex A gives further background and supplementary guidance regarding these changes, and concerning steps that should be taken to reduce the volume of ECRs in future years. Annex B summarises invoicing arrangements for ECRs.

Action

4. **Health Boards should copy this circular to all GP Fundholders in their area.**

5. **Health Boards** and **GP fundholders** should ensure respectively, that all appropriate officers, involved in the administration of ECRs are aware of the changes in notification requirements from 1 October. They should monitor the impact (if any) of the changes on referring patterns.

6. **NHS Trusts** should ensure that systems are in place to avoid incorrect invoicing of purchasers, and to notify purchasers of long or expensive ECRs as above.

7. **Health Boards and GPs** should work together to widen the scope of contracts where possible, to achieve an overall reduction in ECRs; **NHS Trusts** should respond positively to such initiatives.

8. **Health Boards** should ensure they have appropriate consultation mechanisms with local GPs for reviewing referral patterns and set in place protocols to govern elective ECRs.

Yours sincerely

KEVIN J WOODS
Director of Purchasing

BACKGROUND AND SUPPLEMENTARY GUIDANCE

Introduction

1. The Department of Health has announced a decision to relax notification requirements for emergency and tertiary ECRs in England from 1 September. This circular announces similar arrangements for Scotland from 1 October.

2. The objective of these reforms is to reduce the administrative burden associated with ECRs, allowing managerial resources to be used more productively. Devoting resources to the design of contracts that better reflect clinical evidence and patient needs, capturing a greater proportion of activity, and minimising the need for ECRs, will help to ensure that a greater proportion of activity is purchaser - and patient-led.

Tertiary and Emergency ECRs

Definition

3. A tertiary extra-contractual referral is defined as a referral made by a medically or dentally qualified consultant to another medically or dentally qualified consultant outside an existing contract.

4. An emergency extra-contractual referral is an admission for emergency care (needed within 24 hours) resulting from an accident or referral by GP.

Maintaining budgetary control of purchasers

5. Some purchasers have expressed concern that providers will take advantage of the new system to take referrals that might otherwise have been queried following notification. The reduced notification requirements that have been retained for long and for expensive interventions will underpin budgetary control, and reduce the risk of abuse. These requirements will be kept under review: purchasers are asked to monitor the operation of the new system.

6. NHS Trusts are not entitled to additional payment for interventions that are covered by existing contracts with Health Boards, with GP fundholders or with secondary providers (subcontracts). **NHS Trusts should put systems in place to ensure that purchasers are not invoiced inappropriately.** Nor are NHS Trusts entitled to refer patients for interventions that have been explicitly excluded from their contracts by purchasers on grounds of ineffectiveness, or are otherwise against purchasers' expressed wishes.

7. The prompt sending of clinical letters by the referring consultant (and by subsequent referring consultants) aids GP fundholders in discharging both clinical and budgetary responsibilities (clinical letters should of course be sent equally promptly to non-fundholding GPs).

8. Where possible, invoices should inform the purchaser if an ECR is emergency, and/or if it is tertiary, and should give the source of tertiary referral.

The 28 day limit and £6000 threshold

9. In order to ensure that patients are cared for as close to home or to their support network as possible, and in order to afford purchasers control over very expensive cases, NHS Trusts **must** notify purchasers of ECRs (whether tertiary or emergency) where the patient's stay has exceeded 28 days from admission.

10. The following information should, where available, be included in notification: NHS Trust name and address, telephone and fax numbers, Patient Identifier, patient address and postcode, GP name and address (including whether or not a fundholder), responsible consultant, expected treatment, relevant ECR tariff and expected cost.

11. Notification of such cases must be made to purchasers within 7 days of the end of the 28 day period. Failure so to notify will remove the purchaser's obligation to pay for the whole of that care episode (even if it encompasses more than one finished consultant episode).

12. NHS Trusts should notify purchasers as soon as it becomes clear that the length of stay is likely to exceed 28 days.

13. Similarly, NHS Trusts should notify Health Boards if it becomes clear that the total cost of the hospital stay of an ECR will or is likely to exceed £6000.

14. Although failure to notify expensive cases will not automatically cancel payment obligations, NHS Trusts must meet this notification requirement.

Incorporating activity into contracts

15. Health Boards and GPs should strive to reduce ECRs in the coming year by expanding, where possible, the scope of contracts.

16. For tertiary interventions, this can be accomplished either by contracting directly with tertiary providers or by including funding for tertiary referrals in contracts with secondary providers, and inviting secondary providers to subcontract as appropriate. The latter model has the advantage of co-locating contracting and referring responsibility; however, purchasers will generally wish to specify the circumstances in which tertiary referrals are appropriate and to specify specialist centres.

17. NHS Trusts should respond positively to purchasers' efforts to reduce the level of ECRs by:

- minimising the number of contract exclusions that they seek to negotiate;
- agreeing contracts for services currently provided on an ECR basis;

- accepting sub-contracting arrangements for tertiary ECRs (elective or emergency) where purchasers consider this appropriate.

Invoicing

18. For ease of reference, a summary of invoicing arrangements can be found in Annex B. Adherence to this guidance should minimise the number of invoicing disputes requiring arbitration.

EXTRA-CONTRACTUAL REFERRALS - INVOICING ARRANGEMENTS

1. Providers are required to issue invoices to the responsible purchaser within 6 weeks of the end of the month during which an episode of care is completed.

2. Failure to issue invoices within the specified period provides the purchaser with a valid reason for refusing payment.

3. Purchasers must make payment within one month of the date on which the invoice was issued.

4. If an episode of care consists of more than one finished consultant episode (FCE) yet constitutes a single in-patient stay, the invoice deadline applies from the end of the episode of care, at which point several FCEs may be invoiced using a common invoice date.

5. Long stay ECR cases (emergency) where the charging basis is a daily rate (either for the entire episode or from day 29 or from the national trimpoint), should be invoiced on a monthly basis (unless an alternative agreement is reached with the purchaser). In such cases, the initial invoice must be issued within 6 weeks of the end of the calendar month in which the national trimpoint or the 29th in-patient day occurs. Failure to meet this invoicing deadline will delay in the starting point from which the provider can commence charging.

6. Deadlines for the issue and payment of invoices relate to the *issue date* of the invoice, not the date of receipt. However, purchasers are entitled to rely on invoice dates as indicators of issue and posting, so it would be exceptional for invoices to be received more than 3 or 4 working days after the issue date.

7. If the wrong purchaser is invoiced within the time limit and invoice only reaches the responsible purchaser after the invoicing deadline, the responsible purchaser is not normally obliged to pay.

8. Providers are required to ensure that full contract minimum data sets are available to the purchaser at the time of invoicing. However failure to supply a complete contract minimum data set within the 6 week invoicing time is <u>not</u> a valid reason for a purchaser to refuse payment altogether, although it may occasion delay whilst the purchaser's liability for the patient and treatment are established.