Gateway Ref: 6058

Code of Conduct for Payment by Results

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Document Purpose	Directions to NHS Bodies and best practice guidance		
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Title	Code of Conduct for Payment by Results		
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Circulation List	GPs, Local Authority CEs		
Description	The Code of Conduct establishes core principles governing how the Payment by Results system will operate. The Secretary of State requires that all NHS Bodies comply with the Code		
Cross Ref	The Code of Conduct complements technical guidance on Payment by Results and the national tariff.		
Superseded Docs	n/a		
Action Required	The Boards of NHS Bodies operating Payment by Results should adopt the Code of Conduct.		
Timing	The PbR Code of Conduct will apply from April 2006		
Contact Details	Sebastian Habibi Payment by Results Team, DH QH Leeds LS2 7UE		
For Recipient's Use			

Contents

Introduction - the purpose of the Code of Conduct

1. The effective implementation of Payment by Results (PbR) will depend on constructive relationships between all parties operating within the system.

2. PbR introduces a degree of transparency in NHS financial flows that is almost unprecedented. The new system challenges organisations to manage successfully in a dynamic environment and creates incentives for increasing productivity and making efficient use of resources.

3. This Code of Conduct ('the Code') is aimed at all commissioners and providers – and other bodies with regulatory and/or performance management responsibilities – operating within the PbR system (as defined in the glossary of terms), but without prejudice to any future Government decision on extending the scope of PbR[1]. Its purpose is to establish the underpinning principles that should govern organisational behaviour under PbR and set expectations as to how the system should operate. In this way, the Code of Conduct should minimise as well as guide the resolution of disputes under PbR.

4. However, the Code must be effective both now and in the context of any future changes to roles and responsibilities in the NHS. Therefore, the Code will form part of the Operating Framework (as defined in the Glossary) and will be reviewed from time to time, subject to consultation in line with Cabinet Office guidelines.

5. PbR should be implemented according to the principles laid out in the Code and complying with relevant guidance. Moreover, it is essential for organisations operating under PbR to recognise their ongoing relationships as part of a wider healthcare system. This means taking a dynamic and long-term view that facilitates improvements to quality and service innovation, fitting with other key policy goals (e.g. transforming care pathways for people with long-term conditions).

6. Under PbR, activity is paid for on the basis of the number and complexity (i.e. casemix) of cases treated. Importantly, the casemix classifications, prices and payment rules are set at national level and are not subject to local negotiation except as specifically defined in PbR guidance. However, PbR does not negate the need for contracts between commissioners and providers, which must continue to specify the range of services commissioned as well as any referral or treatment protocols (i.e. care pathway description) and relevant performance criteria.

7. The Code is not intended to deal with outstanding policy issues or give detailed guidance although the Department recognises the need for consistency between the Code and the wider policy framework. Furthermore, the Code will rely on effective contractual, regulatory and performance management mechanisms for its enforcement.

[1] In 2006, PbR applies to acute services provided by NHS Trusts, NHS Foundation Trusts and to Independent Sector providers operating under the Extended Choice Network

The scope and objectives of Payment by Results (PbR)

8. PbR has been designed to contribute towards the achievement of several of the key objectives of health system reform. These objectives are complementary but at times need careful management to ensure they work together successfully in practice.

9. The key objectives are summarised as follows:

   9.1 improve *efficiency and value for money* through enhanced service quality, as both commissioners and providers can retain and invest surpluses and savings to improve services;

   9.2 facilitate *choice*, by enabling funds to go to the services chosen by patients;

   9.3 facilitate *plurality* and increase *contestability*, enabling funds to go to any provider (whether NHS or Independent Sector) who can treat patients at tariff[2] and at NHS standards, and enabling providers to compete on an equal basis to provide services;

   9.4 enable service *innovation* and improve *quality*, by rewarding providers whose services attract patients and focussing negotiations between providers and commissioners on quality and innovation, because the price is fixed;

   9.5 drive the introduction of *new models of care* closer to where people live and work, by enabling funds to go to providers offering care in non-traditional and community based settings;

   9.6 *reduce waiting times*, by rewarding providers for the volume of work done;

   9.7 make the system *fairer* and *more transparent*, through consistent fixed price payments to providers based on volume and complexity of activity; and

   9.8 *get the price 'right' for services*, by paying a price that ensures value for money for the taxpayer and incentivises the provision of innovative, high quality patient care.

10. PbR can and should be implemented in way that contributes towards achieving the above objectives. However, it is important that all parties operating in the system are also clear what the policy is not designed to achieve. This includes increasing the overall amount of cash in the system. The NHS works within fixed spending limits at national and local level. PbR is not, of itself, a mandate for providers to supply activity. The impact of PbR locally will therefore be on the technical efficiency of service provision and on the flow of funds under contracts between commissioners and providers.

[2] Through the development of its Competition Policy, the Department of Health will critically examine the 'fitness for purpose' of the current tariff as a pricing mechanism consistent with the overarching objective of creating a level playing field under Free Choice from 2008

Tariff Setting

11. The following principles shall apply to tariff setting:

    11.1. The Secretary of State will be responsible for maintaining the system of Payment by Results – including the tariff setting function – consistent with his/her obligations to provide a national health service in England and other applicable Law[3]

    11.2. The Department of Health will involve key stakeholders in establishing or reviewing the tariff setting function

    11.3. The remit and responsibilities of the tariff setting function will be set out in published Terms of Reference

    11.4. The tariff setting process shall be open and transparent

    11.5. The Department of Health will ensure that exercise of the tariff setting function involves key stakeholders

    11.6. In exceptional circumstances and only to the extent necessary in pursuit of his/her obligations to provide a health service in England, the Secretary of State may require particular, in-year changes to the national tariff and will ensure that:

    - proposals for such changes take account of input from key stakeholders;
    - the process for implementing such changes is open and transparent; and,
    - commissioners and providers are given reasonable notice of the details of such changes

12. For the purposes of this Code, 'key stakeholders' shall include a representative group of commissioners and providers as well as those bodies responsible for performance management and regulation, including Monitor and the Healthcare Commission.

[3] As defined under National Health Service Act 1977

General conduct of commissioners, providers and other organisations participating in Payment by Results (PbR)

13. PbR should support the provision of a service that is

    13.1. Responsive to the needs of patients and public

    13.2. Responsible and accountable to patients and public

    13.3. High quality, striving for excellence

    13.4. Efficient and effective in its use of resources

14. This means that all organisations operating PbR, and individuals working within them, will:

    14.1. Put patients' interests first, balancing the needs of individuals with those of the wider population served

    14.2. Ensure that patients get appropriate, responsive, high quality care, close to home where possible and when it's needed

    14.3. Ensure that patients have a choice when it is appropriate

    14.4. Provide appropriate and transparent information for patients, their carers and the wider public

    14.5. Ensure care is provided efficiently with the best possible outcome

    14.6. Work together to innovate, developing better services, closer to where people live and work

    14.7. Behave and treat each other transparently, openly and fairly

    14.8. Share information with each other wherever appropriate

    14.9. Work together to anticipate and resolve problems

    14.10. Consult and involve each other in decisions and changes wherever appropriate

15. In implementing PbR, commissioners and providers jointly will also observe the following principles:

    15.1. PbR is a national, rules-based system maintained by the Secretary of State and defined in Department of Health guidance as amended from time to time

    15.2. All casemix classifications, prices, payment rules, data definitions, information standards and reporting obligations applicable to PbR are as defined in national guidance, as amended from time to time

    15.3. PbR is a prospective payment system and therefore in individual cases, the applicable tariff will be greater or less than the actual cost of activity and such differences shall not prejudice the commissioning or provision of services under this Code.

15.4. The tariff is not intended to subsidise the cost of activities outside the scope of PbR. Equally, any funding for activities outside the scope of PbR shall not be intended to subsidise the costs of activity to which the tariff applies. The only exception to this general principle is where funding is agreed to reimburse specific costs that are incurred incidentally in the provision of services under PbR, but are excluded from the tariff, in line with national guidance (e.g. 'pass through' payments for new technologies).

15.5. Providers have the autonomy to retain and invest surpluses gained under PbR.

15.6. The national guidance that constitutes PbR is not subject to local negotiation, except for, and only to the extent afforded by, any local flexibilities specified in such guidance, including the Operating Framework.

Commissioner responsibilities

16. The following principles shall apply to commissioners under PbR:

16.1. 'Commissioning' is the process that determines how the health and healthcare budget is used and must result in a good deal, both for patients and taxpayers.

16.2. Commissioning will not be the responsibility of a single organisation, but will be a partnership between PCTs, general practice ('practices') and local government.

16.3. Commissioners will undertake regular health needs assessment and forecast demand for health services and keep these under review, taking account of advice from providers and the accuracy of previous assessments and forecasts

16.4. PCTs will collaborate with practices to ensure that taxpayers' money is used to best effect on behalf of patients. PCTs will carry out the analysis to support assessment of local needs and to provide the clinical and management information that will be needed by their practices.

16.5. Practices will look to identify gaps in existing services and pathways that need improvement. PCTs will use the aggregated intelligence of their practices and their local needs assessment to identify broader requirements for service change or development. PCTs will signal the future service needs to providers and engage with clinical networks to ensure effective delivery of complex care pathways.

16.6. PCTs will act as agents of their practices and secure contracts with providers for the provision of health services – including elective and unscheduled care – in line with their health needs assessment and demand forecasts having regard to patient preferences and the impact of Patient Choice. Such contracts will reflect minimum performance requirements as specified from time to time by the Department of Health in line with national standards and targets[4]

16.7. PCTs will remain responsible for the actions of their practices and other primary care professionals in referring patients to providers and for services under PbR

16.8. Commissioners will specify care pathways – including referral and treatment protocols – in line with patient preferences and on the basis of available evidence as to clinical and cost effectiveness

16.9. Commissioners will adhere to, and ensure that their agents adhere to, any specified care pathways in line with the principle set out above

16.10. Under PbR, PCTs will pay for all activity that is delivered on behalf of their populations and as per their contractual or statutory

[4] The Department of Health will develop a national template contract that will incorporate national standards (quality, safety and service levels), the national tariff and penalty schedules (*Health Reform in England: update and next steps*, Department of Health, December 2005; Annex D)

obligations (or as otherwise implied by the terms of previous contracts or by commissioners' actions)

16.11. Commissioners will not discriminate against or disadvantage particular patients or providers in exercising their responsibilities under this Code, including when contracting for services or authorising activity on behalf of their populations.

16.12. Participants who are both commissioners and providers of services will act transparently to avoid conflict of interests.

Provider Responsibilities

17. The following principles shall apply to providers under PbR:

17.1. Providers will remain responsible for developing and maintaining services and for the performance of those services

17.2. Providers will secure contracts with commissioners or otherwise obtain authority to provide services to patients as a condition of claiming payment under PbR. The exception to this general principle is for Non-Contract Activity as defined under national guidance as it applies to unscheduled care.

17.3. In consideration of the prices paid for services under PbR, providers will deliver high quality care in line with good clinical practice and any specific performance requirements enshrined in their contracts with commissioners (see 16.6 above)

17.4. Providers will specify any clinical criteria that they intend to apply systematically and in order to decline to treat particular groups of patients, either in their Directory of Services[5] where appropriate, or in contracts with commissioners. These criteria will be used to ensure the clinical appropriateness of referrals and treatments and should not be manipulated for purely financial reasons. Furthermore, providers should not make unilateral changes to such criteria without having agreed corresponding changes to contracts with commissioners.

17.5. Providers will adhere to, and ensure their agents adhere to, any specified care pathways in line with their contractual obligations and consistent with commissioners' responsibilities set out above

17.6. In support of the commissioners responsibilities regarding health needs assessment and demand forecasting, providers will supply information about demand and activity, including demand for unscheduled care, in line with their contracts.

17.7. Providers will be responsible for the timeliness and accuracy of data required as part of the transaction process under PbR and in support of commissioners responsibilities in reviewing health needs assessment and demand forecasts

17.8. Providers will not discriminate against or disadvantage particular patients or commissioners when operating PbR, including when accepting or declining to treat individual patients and in the provision of services generally.

17.9. Participants who are both commissioners and providers of services will act transparently to avoid conflict of interests.

[5] A provider's Directory of Services must therefore include any Service Specific Booking Guidance to be used to determine the eligibility of patients for services

Information sharing

18. The following principles shall apply to all parties within the system:

18.1. Commissioners will give patients the support and information they need to make the right healthcare choices and providers will support commissioners in this by maintaining an up-to-date Directory of Services.

18.2. The Department of Health and commissioners will make available to all providers, including Independent Sector providers, the same information about forecast demand, capacity and performance requirements, proposed service changes/developments, and other procurements to ensure equity of access across the system.

18.3. Providers will make available to commissioners information about capacity and quality, in accordance with their contracts.

18.4. Providers may implement changes to clinical coding and counting (i.e. classifications) practices in pursuit of improvements in data quality and the accuracy of transactions under PbR.

18.5. Changes to coding and counting practices will be implemented in good faith and at all times comply with national data definitions and information standards.

18.6. Providers will notify commissioners of the details of any proposed changes to coding and counting practices in advance and confirm the date from which such changes are implemented.

18.7. Any changes to coding and counting practices by individual providers shall not affect the information basis upon which contracts have been agreed or result directly in claims for additional payment, or loss of income, under PbR until the start of the next financial year.

18.8. The Department of Health will keep under review the risk of activity inflation (i.e. volume or casemix) associated with improved coding and counting.

Activity Specification, Demand Management and Capacity

19. The following principles shall apply to commissioners and providers operating PbR:

    19.1. Demand Management is a joint responsibility. Decisions on the use of healthcare resource should be made in the best interests of patients, the public, and not the financial interests of individual organisations.

    19.2. It is the commissioner's responsibility to manage demand from primary care referrals and attendances at A&E. Providers should co-operate with commissioners in this and will take steps to mitigate the risk of supplier-induced demand[6], including:

    - periodically reviewing admission/intervention thresholds, length of stay and consultant-to-consultant referrals; and,
    - by participating in periodic utilisation reviews.

    19.3. Providers are responsible for managing their capacity, for honouring patient appointments and for their obligations in meeting demand for unscheduled care. Commissioners should co-operate with providers in this and will be responsible for the accuracy of their demand forecasts and keep these under regular review to mitigate the risk of 'under-commissioning'. In addition, PCTs will be responsible for the actions of their agents both in referring patients to hospital and in providing unscheduled or 'out of hours' care as these affect the accuracy of demand forecasts and therefore capacity management and risk across the system.

    19.4. Under PbR, planned activity volumes are important management tools, but will not determine payment or the allocation of financial risk between commissioners and providers. Nevertheless, the Department of Health may seek to mitigate the risk of demand volatility by setting a differential tariff for activity above and/or below a pre-defined threshold. In such cases, both the differential tariffs and the thresholds will be set nationally in line with the principles outlined at Paragraph 11 above.

    19.5. The use of 'caps and floors' on activity is inconsistent with the fundamental principle of PbR that payment should be based on the number and complexity of cases treated.

    19.6. Instead, PCTs will establish demand management strategies. The aim will be to enhance quality and efficiency and to ensure that budgets are not breached. The tools of demand management are likely to include:

    - benchmarking information for all GP practices;

[6] Supplier-induced demand may include any lowering of admission or treatment thresholds and/or non-compliance with referral and treatment protocols

- clinical pathways and protocols that are developed by local clinicians, covering areas vulnerable to volatile demand or supplier-induced demand;
- clinical advice and support for struggling GP practices;
- facilitating clinical groups to agree training and development, and clinical protocols reflecting agreed clinical priorities locally;
- appropriate use of preventative intervention strategies to improve health and efficiency;
- target conversion ratios from outpatient to inpatient/day case lists for specific procedures and agreement on a sustainable and affordable profile for reducing overall waiting list size.

19.7. It is good practice for commissioners and providers to specify trigger points in the monitoring of activity as part of an overall strategy for managing demand and capacity. Where activity levels exceed these trigger points, commissioners and providers should work together to identify the causes of excess demand and commissioners should revise their forecasts and demand management strategies accordingly. Where activity levels significantly exceed these trigger points, commissioners and providers should work together to prioritise patients on the basis of clinical need. Such action may include changes to referral and treatment protocols to ensure that limited resources are targeted effectively. However, such action shall not extend to withholding payment to providers for activity duly delivered.

20. While these principles will continue to apply as PbR is expanded to cover emergency, ambulance, long-term conditions and mental health, it is important to bear in mind that appropriate casemix classifications may not always be based on individual patient attendances, procedures or hospital admissions.

Patient choice, referrals and treatment thresholds

21. Under payment by results (PbR) in 2006/7, patient choices for elective care, and where patients are treated in emergencies, will determine how around 30% of NHS funds are spent.

22. The following principles shall apply to all parties within the system:

    22.1. Providers may offer a restricted range of services to patients only to the extent this is consistent with their contracts with commissioners and based on the provider's Directory of Services on the date the contract was agreed or subsequently amended. For NHS Foundation Trusts any restrictions on the range of services offered to patients must be consistent with their Terms of Authorisation.

    22.2. For services provided under Patient Choice, once a patient appointment has been booked this must be honoured and appropriate treatment subsequently provided – in line with contracts – irrespective of whether the tariff covers the costs of doing so. Furthermore, patients choosing a particular provider must be treated by that provider as long as this is in the patient's interest.

    22.3. Finally, providers will work with commissioners to monitor treatment thresholds and ensure patients are treated appropriately.

Innovation to improve access to, or quality of, services

23. The following principles shall apply to all parties operating within the system:

23.1. Commissioners and providers will collaborate to innovate in services and care pathways.

23.2. The Tariff is a fixed price and should not be subject to local negotiation. However, certain 'local flexibilities' may be provided for under PbR guidance and should be used to support technical innovation and/or improved access to services in the interest of NHS patients.

23.3. Examples of local flexibilities under PbR may include:

- **Tariff sharing** (i.e. 'unbundling) to support improved access to services (e.g. by funding elements of acute care outside a hospital setting)
- **Pass through payments** to support the use of new technology (e.g. minimally invasive procedures)
- **'One stop shop' payments** for outpatient clinics involving multi-disciplinary or multi-specialty teams and/or multiple diagnostic tests.

23.4. As a point of principle, local flexibilities under PbR must be applied as defined in national guidance as amended from time to time.

23.5. Moreover, such arrangements should only occur if they

- are agreed in advance;
- have agreed, quantified outcomes;
- define who carries the financial risk if planned changes are not delivered with standard tariff applying in default.

23.6. The procurement of services by commissioners under PbR must be open and transparent to ensure contestability and equity of access among providers.

23.7. Commissioners and providers will make information available about services procured using local flexibilities under PbR to inform patients' choices (e.g. as part of a commissioner's advice to patients about the choice of services available and in a provider's Directory of Services) and will publish the tariffs used for local flexibilities to ensure transparency across the system.

Billing and Payment

24. The following principles shall apply to all parties operating within the system:

    24.1. Billing and payments will be prompt, fair and accurate.

    24.2. Providers and commissioners will agree definitions of activity, and timescales within which activity is paid for, through contracts.

    24.3. Providers will code and bill for activity fairly, accurately and promptly in line with national guidance on reporting under PbR. This guidance will be reviewed annually and reporting timescales will be reduced in support of the principle that billing and payment should be 'right first time'.

    24.4. Commissioners will pay invoices promptly, as defined in their contracts. Any queries raised about an invoice shall be confined to specific items and should not delay payment for the remaining items. Any query that remains outstanding at the point an invoice becomes due shall be referred to dispute resolution and will not be grounds for delaying payment of the undisputed amount.

    24.5. Commissioners and providers will agree processes for resolving disputes in line with the cross-government pledge on alternative dispute resolution, as illustrated by national model contracting arrangements.[7]

    24.6. Commissioners and providers will collaborate to resolve disputes in a timely fashion and by the end of the next quarterly billing period or after three separate monthly billing periods as appropriate to their contracts. Regulators and performance managers will monitor instances of dispute and take action to address risks associated with organisations involved in frequent or protracted disputes.[8] In addition, the Department of Health will consider the merits of collecting data on disputes so that details of organisations involved in frequent or protracted disputes may be made public.

    24.7. The number of payment disputes will be kept to a minimum.

    24.8. Disputes should not take place where the financial sums or other matters concerned are not material.

    24.9. When a payment is disputed, the undisputed amount should be paid forthwith and only the disputed amount should be held in an escrow account until the dispute has been resolved. In addition, contracts

[7] The process for resolving disputes should be set out in contracts. SHAs will be the final arbiter of disputes between NHS Trusts. For disputes involving NHS Foundation Trusts, the national model contract includes a dispute resolution procedure. Looking ahead, the Department will introduce a national template that will form the basis of contracts for all providers of NHS services (*Health Reform in England: Update & Next Steps*; Department of Health, December 2005)

[8] The monitoring of disputes will be at the discretion of regulators and performance managers and any subsequent intervention against organisations will be proportionate to the risk to either the commissioning or provision of NHS services or the wider public interest in minimising NHS transaction costs

may provide for payment of interest on such sums, for the period held in an escrow account, as part of any settlement of a dispute and in favour of either the commissioner or provider.

25. As a general principle, billing and payment should not be disputed in bad faith or to manage cash flow.

Enforcement

26. The following principles shall apply to all parties operating within the system:

    26.1. It is an overarching principle of this Code that it should be enforceable through contracts and embedded in NHS regulatory and performance management arrangements

    26.2. The Department of Health will work with the Healthcare Commission and Monitor to explore how compliance with the Code may be included in assessment criteria for *Standards for Better Health* standards on corporate governance.

    26.3. The boards of all participants in PbR should formally adopt the Code. In particular, all organisations providing and commissioning care for NHS patients will comply with this Code.

    26.4. Contracts for services provided under PbR should be consistent with this Code.

    26.5. The Secretary of State requires compliance with the Code by all NHS Bodies operating PbR, including Health Authorities, NHS Trusts and PCTs. The Department of Health will therefore ensure that compliance with the Code is integrated into performance management arrangements and may publish details of non-compliance on an exception basis. Moreover, organisations responsible for performance management will be expected to take action to address non-compliance. Persistent non-compliance by individual NHS Trusts or PCTs may be penalised through intervention and/or direction on behalf of the Secretary of State[9].

    26.6. Independent Sector providers will sign up to the Code as part of any relevant accreditation or procurement process and so that compliance with the Code is a condition of their contracts to provide NHS services.

    26.7. Non-compliance will be addressed through the relevant mechanisms outlined above and in a manner proportionate to the extent and impact of the non-compliance.

    26.8. An assurance framework will be established to underpin improvements to data quality under PbR and will include an appropriate audit regime

    26.9. Any cases of suspect fraud involving an organisation operating PbR activity will be referred to and dealt with by the appropriate authorities.

[9] The question of sanctions is under active consideration and will be the subject of a separate statement early in the new financial year.

Glossary of Terms

All parties operating within the system
Parties include all commissioners and providers (as defined below) the tariff setting body, Department of Health, and all other bodies involved in the administration of PbR and/or with relevant regulatory or performance management responsibilities.

Caps and floors
The term 'cap' refers to a pre-agreed limit on the amount of activity for which a commissioner will pay a provider. The term 'floor' refers to a pre-agreed minimum amount of activity for which a commissioner commits to pay a provider.

Code (i.e. 'the Code)
The PbR Code of Conduct as amended from time to time

Commissioners
The term commissioners covers all organisations operating under PbR to the extent they participate in the procurement of services for NHS patients including Primary Care Trusts, Primary Care Practices participating in Practice Based Commissioning, Local Authorities and their authorised agents, including Commissioning Consortia and any Procurement Agency (e.g. Shared Service)

Contracts
These are relationships of rights and obligations between (at least) two parties operating under PbR and normally including a commissioner and a provider. A contract is formed by the parties (or their authorised agents') offer and acceptance (i.e. agreement) and its terms and conditions may be specified in writing, or otherwise defined by the parties' actions, and amended from time to time by agreement. For the purposes of this Code, contracts shall include Service Level Agreements (SLAs) subject to arbitration by the Secretary of State and/or a delegated authority (i.e. NHS Contracts as defined under the NHS and Community Care Act 1990); and, legally binding contracts subject to determination in the courts.

Directory of Services
A list and description of each provider's services – including any Service Specific Booking Guidance – compiled and made available to commissioners and patients to underpin the operation of Patient Choice and as required by Department of Health guidance as amended from time to time.

Independent Sector Providers
All providers other than NHS Trusts, PCTs, NHS Foundation Trusts or other statutory body providing NHS services

Law
The law in England, including any enforceable community right within the meaning of S2 (1) European Communities Act 1972

Monitor
The independent regulator of NHS Foundation Trusts established under the Health & Social Care (Community Health & Standards) Act 2003

Operating Framework
From 06/07, an annual statement will be published on the 'rules' governing how the system should operate during implementation of Health Reform in England (*Health Reform in England: Update & Next Steps;* Department of Health, December 2005)

PCT (Primary Care Trust)
Any Primary Care Trust in England

Providers
The term providers covers all organisations who either currently, or in future may provide services within the scope of PbR, including: NHS Acute Trusts, NHS Foundation Trusts, Mental Health Trusts, Consultants, Independent Sector Providers, Primary Care Practices, GPs, Pharmacies, community services, social services and the voluntary sector.

Service Specific Booking Guidance
Guidance for use by commissioners and their agents in making referrals and bookings on behalf of patients that details any criteria to be used systematically by a provider to determine patients' eligibility for specific services.

SHA (Strategic Health Authority)
A Strategic Health Authority in England

Stakeholders
The term stakeholders covers all parties operating within the system, and groups within those stakeholders, including clinicians and managers. It also includes patients and members of the public.

Tariff sharing
Tariff sharing refers to the splitting of the fixed tariff price between one or more providers who are providing different elements of the treatment covered by the fixed price.

Terms of Authorisation
The terms under which NHS Foundation Trusts may be authorised to provide services under the Health and Social Care

Treatment thresholds
Treatment thresholds refer to the clinical threshold above which a specific treatment is judged appropriate for a specific condition.

Trigger points
The term trigger points refer to pre-agreed levels of referrals and/or activity, indicating unplanned increases in demand.