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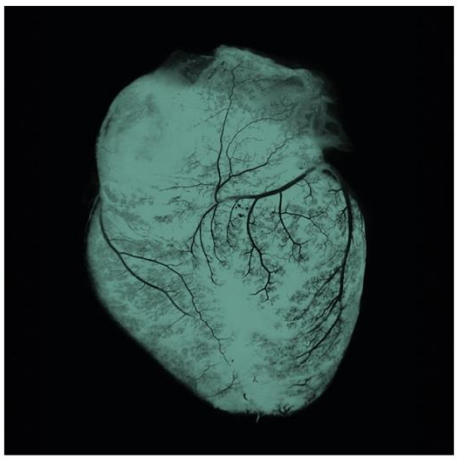

Best Practice Tariff Reporting Guidance: Using National Audit Data to Develop Validation Reports

(NHFA and MINAP)

Best Practice Tariff Report Guidance: Using National Audit Data to Develop Validation Reports

This guidance was written and compiled by NICOR to support the National Heart Failure Audit (NHFA) and NSTEMI (MINAP) BPT reports for commissioners. Updated November 2025.

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1. Introduction: What is a Best Practice Tariff

Best Practice Tariffs (BPTs) are priced and structured to incentivise care that is high quality and cost effective with the aim to reduce unexplained variation in the quality of care.

The BPT model will be developed and tailored to the characteristics of clinical best practice in each of the chosen clinical areas as well as the availability, quality and flow of data.

This guidance has been created for hospital trusts to produce their own summary reports to facilitate commissioner validation on the following BPTs; Heart Failure Best Practice Tariff and the NSTEMI Best Practice Tariff. This guidance should be read in conjunction with the following documents.

> NHS Payment Scheme: NHS England » NHS Payment Scheme
>
> Extra clarification is available in Annex C: 25-26NPS - amended Annex C Guidance on best practice tariffs (england.nhs.uk)

This guide will take you through step by step, enabling you to view data, export data and perform calculations required for the BPT reporting.

The guidance has been updated to add the inclusion of patients transferred between hospitals for the purpose of angiography for the NSTEMI BPT.

1.1 Technical details regarding the BPTs can be found in the National Tariff, Annex C, last amended in April 2025. We would recommend this is read in conjunction with this guide[1].

The two cardiac national audits selected to be part of the BPT are the National Heart Failure Audit (NHFA) and the Myocardial Ischaemia National Audit Project (MINAP).

1.2 What is the heart failure BPT?

The heart failure BPT was introduced in April 2015, to be an incentive to delivering specialist input into the care of heart failure patients admitted to secondary care as an emergency as outlined in the NICE clinical guidelines 108 'Chronic heart failure: Management of chronic heart failure in adults in primary and secondary care' and the clinical guideline 187 'Acute heart failure: diagnosing and managing acute heart failure in adults' and the chronic heart failure quality standard (QS9).

The heart failure BPT requires providers to meet the following criteria:

a. Hospitals are to submit at least 70% of all eligible records. The total number of eligible records need to be sourced either via Hospital Episode Statistics (HES), Secondary Uses Services (SUS) or locally via your hospital's patient administration system (Please refer to 3.2.2 for ICD- 10 codes).

b. Specialist input with a target rate of 60%. This means that at least 60% of all patients with confirmed HF diagnosis recorded in the NHFA have received face to face specialist input as defined by the NHFA.

   The latest HF BPT update, for those Trusts that are eligible, continues to pay an uplift where these criteria are met, but where they are not there is a financial penalty.

1. 23-25NPS - amended Annex C Guidance on best practice tariffs (england.nhs.uk)

1.3 What is the NSTEMI BPT?

The non-ST-segment elevation myocardial infarction (NSTEMI) BPT was introduced in April 2016 and aims to incentivise timely angiography (with follow on PCI if required) for patients admitted to hospital with NSTEMI.

In a subsequent policy change (2017/19) the BPT became mandatory, and providers were required to include not only patients admitted directly to hospitals performing angiography but also patients who had initially been admitted elsewhere and then transferred between hospitals in order to receive an angiogram. In the cases of patients transferred between hospitals it is the time of arrival at the first hospital, not the receiving/second hospital that is used when calculating this metric. The MINAP database can be used to calculate the percentage of patients undergoing coronary angiography within 72 hours of admission. To do this, the parameters for the NSTEMI BPT to be measured are:

a. Number of people with NSTEMI, who receive angiography with 72-hours of either direct admission or inter-hospital transfer.
b. Number of people with NSTEMI receiving coronary angiography by provider trust during the index admission.

2 How to access audit data for your site.

2.1 Getting started:

Before you start you will need the following:

- Access to MINAP and Heart Failure Datasets of the NICOR Audit datasets can be found here Datasets - NICOR.
- Access to the NCAP application https://ncap.nicor.org.uk/
- The NCAP application user guide NCAP user guide | NICOR

2.2 About the NCAP application

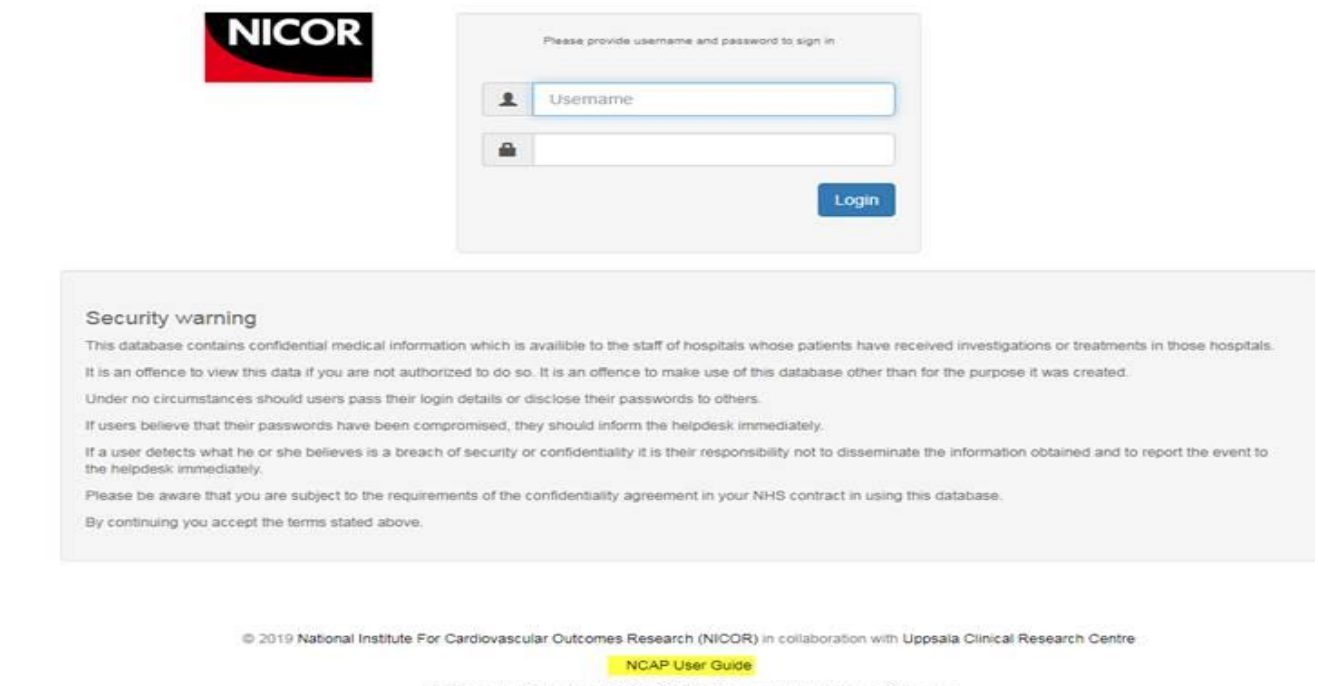
The NCAP application for the National Heart Failure Audit allows you to access the audit from any computer with a web browser, you will require NCAP application access in order to export data for the BPT reports. You will need to be a registered user to access the database.

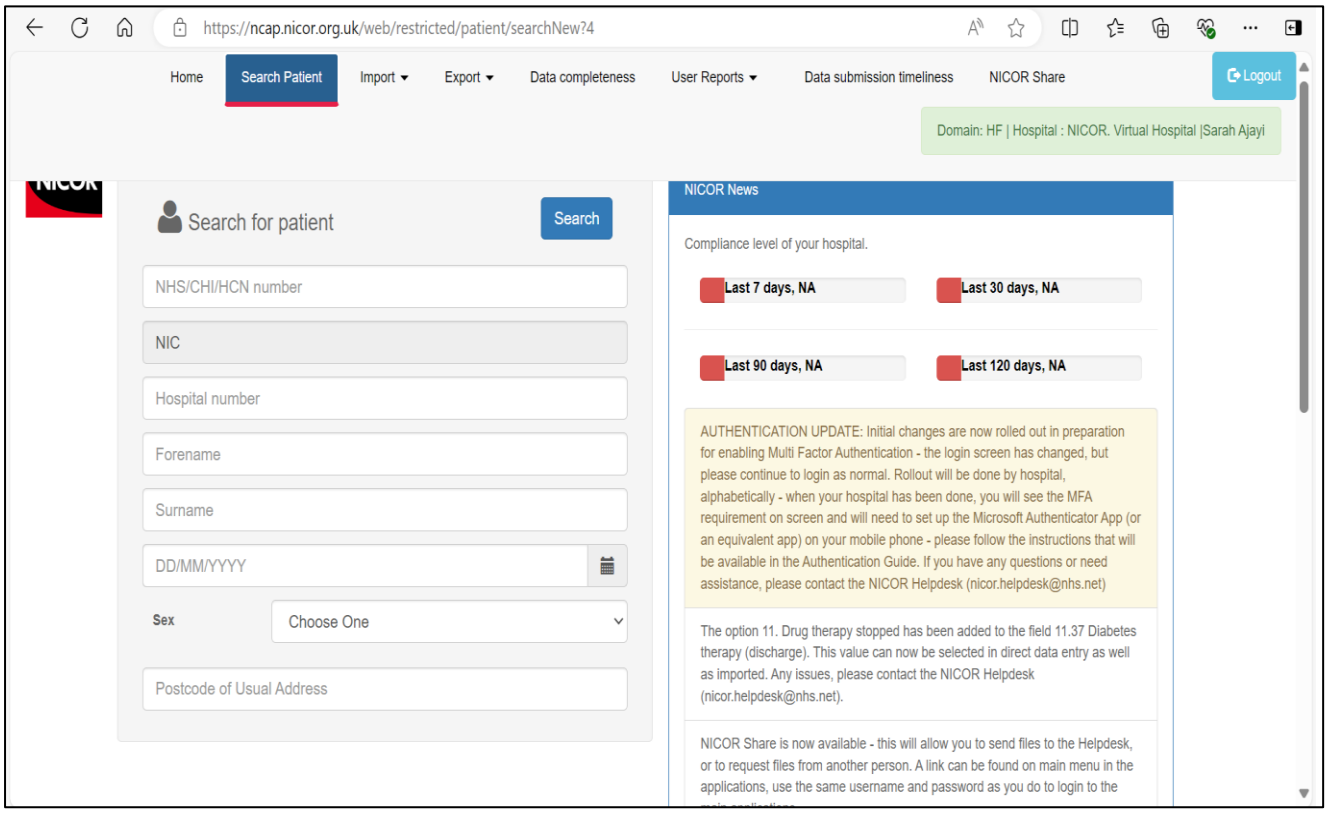
Please contact the NICOR helpdesk if you require web access to the NCAP applications.

2.2.2 Logging in

Your username for the NICOR NCAP application follows this format:

First name Surname/NICOR hospital code/NICOR. For example: **John Doe/ADD/NICOR**.





If you do not know your NICOR hospital code, please contact NICOR helpdesk if you are unable to login Heart Failure BPT procedure/process.

3.1 Data Cleaning

Ensure your data extract does not include duplicates. The data entry system includes automatic checks to minimise the number of duplicate entries, but some may remain. It is important these are removed.

In the new system, you will need to create your imports as **one file to include patient information as well.** There will no longer be separate 'Patient', 'Admission' and 'Readmission' imports, there will instead be a 'procedure' import – a standard term across all the audits.

- Open the 'BPT HF admission and readmission data extracted.
- To check for duplicate entries, filter by hospital identifier and check to make sure date of admission is different. Duplicate records are identified in instances where the NHS number, date of admission and date of discharge are identical. Please check the duplicates to confirm they are in fact duplicate entries. If you are uncertain you may need to review local records. REMOVE all duplicates.
- Other checks for the exclusion criteria:

  a. Records with a missing or invalid hospital identifier.

  b. Patients <18 years old.

  c. Patients without a discharge date.

  d. Date of discharge precedes date of admission

  e. Date of admission and discharge are the same *.

  (These patients are tracked for mortality only.)

  f. Patients with a normal echocardiogram unless the heart rhythm is atrial fibrillation or flutter

  *Patients admitted and discharged on the same day with a primary diagnosis of heart failure should still be submitted as they count towards the metrics for completeness of reporting. The outcomes of these patients will be tracked through HES/PEDW and ONS track and may be reported in the future.

  h. Patients in whom the answer Yes to Field 2.02 Is this an elective admission for HF?

3.2 Analysis

Hospitals must submit data to the NHFA with a target rate of 70%. This means that at least 70% of all eligible records need to have been submitted to the NHFA. This is a numerical comparison.

This calculation is based on audit data (numerator) and trust level data (denominator) e.g., HES, SUS or an agreed local data source.

3.2.1 Numerator

- Use the 'BPT HF admission and readmission data extracted cleaned data' file.
- Filter by Field 15.10: Date of discharge AND Field 14.00: Confirmed diagnosis of heart failure AND Yes to: Is this an emergency admission for HF? Field 2.01 dataset 5.
- Count the 'n' number of patients.
- This provides the numerator. Insert the numerator into your local BPT report (Appendix).

3.2.2 Denominator

The denominator for this calculation is the number of emergency admissions discharged with a coded primary diagnosis of heart failure within the relevant quarter. Heart Failure is designated by the following ICD-10 codes:

- I11.0 Hypertensive heart disease with (congestive) heart failure
- I25.5 Ischaemic cardiomyopathy
- I42.0 Dilated cardiomyopathy
- I42.9 Cardiomyopathy, unspecified
- I50.0 Congestive heart failure
- I50.1 Left ventricular failure
- I50.9 Heart failure, unspecified
- This needs to be sourced either via HES, SUS or locally via your hospital's patient administration system. The codes used in the heart failure audit to identify heart failure patients are wider than the set of codes that map to the Heath Resource Groups (HRGs) that are used as a basis of payment for the BPT, codes I50.0, I50.1 and I50.9. At a national level, these diagnostic codes account for over 90% of coded heart failure activity. This means that the quality of heart failure care is measured through a wider set of diagnostic codes while payment is based on the HRG codes that are used as the basis of payment.

Calculation:

% = (Numerator [from 3.2.1] /Denominator [from 3.2.2] x 100

Insert the figure into column A (% of confirmed HF cases submitted to the audit)

Specialist input with a target rate of 60%. This means that at least 60% of all patients recorded in the heart failure audit have received face to face specialist input as defined by the NHFA.

Use the 'BPT HF admission and readmission data extracted cleaned data' file.

Filter field 2.04ai, 'specialist input'. Deselect '4. Other' and '9. Unknown'. Then count the 'n' number of patients that had specialist input (A). This will give you the number of patients seen by a specialist for that quarter.

Filter Field 14.00 –select those with confirmed HF '1. Yes'- confirmed HF. This will provide you with the number of patients with confirmed HF. Count the 'n' number (B).

Now divide the no. of patients that received specialist input (A) by the total number of patients with confirmed diagnosis of HF (B) and then multiply by 100 to give you the % of patients that received specialist input.

*Confirmed diagnosis of HF is defined as the diagnosis of heart failure that is confirmed by imaging during the admission or in the preceding 12 months, with or without BNP testing. Patients in

documented Atrial Fibrillation or Atrial Flutter with normal echocardiography are included in the HF Audit. This refers to the emergency admissions for HF and not elective admissions.

Additional HF BPT reporting requirements.

Local commissioners may request additional information, but any additional requirements need to be negotiated locally. **Please be aware sharing patient identifiable data between hospitals and commissioners is not permissible under current information governance regulations**.

You will now have completed the report ready to send to the commissioners for validation of the heart failure BPT.

4 NSTEMI BPT procedure/process

4.1 The Analysis

4.1.1 Part one

Ensure your data extract does not include duplicates. The data entry system includes automatic checks to minimise the number of duplicate entries, but some may remain. It is important these are removed.

In the system, you will need to create your imports as **one file to include patient information as well.** There will no longer be separate 'Patient', 'Admission' and 'Readmission' imports, there will instead be a 'procedure' import – a standard term across all the audits.

- Select the correct time period when creating the export or if a larger period has been selected you can filter for the required period.
- The analysis is based on NSTEMI records, so you need to filter for these by selecting **option 4** ACS (trop+)/NSTEMI in **Discharge diagnosis field (4.02).**
- The NSTEMI BPT from 2017/18 onward includes both direct admission for coronary angiography and patients transferred between hospitals for the purpose of angiography. For the field '**2.39 Admission method', select options 1 to 4**: (1. Direct admission; 2. Self-presentation; 3. Already in hospital; 4. Inter-hospital transfer)
- Filter field **'4.13.Coronary.Angio'** further by selection **option '1**. Protocol driven investigation performed in this hospital' **and '2**. Symptom driven investigation performed in this hospital'.
- For date and times select all four of the following fields:
    - 3.06 date/time arrival at hospital
    - 3.01 Date/time of symptom onset
    - 3.46 Date/time of arrival at non-interventional hospital
    - 4.18 Angio date/time

4.1.2 Part two

- Time to angiography can be calculated as follows for each admission type:

  For direct admission via emergency services and self-presenters to this hospital: (2.39 options 1 and 2)

  The difference between field '4.18 Angio date/time' and '3.06 date/time arrival at hospital'. The latter variable is available for all procedures. Please ensure that when calculating this difference that the time is formatted in hh:mm (please see section 5.2).

  For inter-hospital transfer for specific treatment: (2.39 option 4)

  The difference between field '4.18 Angio.date/time' and '3.46 Date/time of arrival at non-interventional hospital'. To be calculated as above in hh:mm. [Do not use 3.06 for these

patients for the aim is to express the interval between admission to the first hospital and angiography in your hospital.]

For patients already in this hospital: (2.39 option 3)

The difference between field '4.18 Angio date/time' and '3.01 Date/time of symptom onset'. To be calculated as above in hh:mm.

- The time to angiography can now be filtered to select those entries with a time difference of <= 72 hours and those >72 hours. The percentage of records with 72 hours is calculated as all =<72 divided by all records with a time for the angiography procedure. Please see section 5.2 for an example of report template for NSTEMI.

Additional NSTEMI BPT reporting requirements.

Local commissioners may request additional information, but any additional requirements need to be negotiated locally. **Please be aware sharing patient identifiable data between hospitals and commissioners is not permissible under current information governance regulations**.

You will now have completed the report ready to send to the commissioners for validation of the NSTEMI BPT. Please Note that if dates and or times for coronary angiography are missing this will be considered as having missed the 72hr target for the NSTEMI BPT.

5 Further Information

If there is anything that is not currently included in this document that you think should be covered, please get in touch with the project manager.

Technical enquiries should go to the NICOR helpdesk.

Email: **nicor.helpdesk@nhs.net**

All other HF or MINAP BPT enquiries should be sent to **nicor.auditenquiries@nhs.net**