

# 2016/17 National Tariff Payment System



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## 1. Introduction

1. This document is the national tariff, specifying the currencies, national prices, the method for determining those prices, the local pricing and payment rules, the methods for determining local modifications and related guidance that make up the national tariff payment system for 2016/17 (2016/17 NTPS).
2. This national tariff has effect for the period beginning on 1 April 2016 and ending on 31 March 2017 or the day before the next national tariff published under section 116 of the 2012 Act has effect, whichever is the later.
3. The document is split into 6 sections and 5 annexes. The 6 sections are:
  - a. the scope of the tariff
  - b. the currencies used to set national prices
  - c. the method for determining national prices
  - d. national variations to national prices
  - e. locally determined prices
  - f. payment rules

**Table 1: Annexes to the 2016/17 NTPS**

Annex	Description
A	The national prices and the national tariff workbook. This amalgamates a number of the separate annexes that were published in previous years.
B	Technical guidance and information for services with national currencies
C	The model used to set national prices
D	Technical guidance for mental health clusters
E	Evidence for efficiency for 2016/17

4. The national tariff is also supported by various supporting documents containing guidance and other information.

**Table 2: Supporting Documents to the 2016/17 NTPS**

Description
Guidance on setting locally determined prices
Guidance on mental health currencies and payments
A guide to the market forces factor
Guidance for commissioners on the Marginal Rate Emergency Rule and the 30 Day Readmission Rule

## 2. Scope of the 2016/17 National Tariff Payment System

5. The scope of services covered by the 2016/17 NTPS is the same as that under the 2014/15 NTPS.

### 2.1. Public health services

6. The national tariff does not apply to public health services<sup>1</sup>:
  - a. provided or commissioned by local authorities or Public Health England
  - b. commissioned by NHS England under its 'Section 7A' public health functions agreement with the Secretary of State.<sup>2</sup>

### 2.2. Primary care services

7. The 2016/17 NTPS does not apply to primary care services (general practice, community pharmacy, dental practice and community optometry) where payment is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the National Health Service Act 2006 ('the 2006 Act').<sup>3</sup>
8. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act then the 2016/17 NTPS rules on local price setting apply. For instance, local price setting rules apply to minor surgical procedures performed by GPs and commissioned by clinical commissioning groups (CCGs). The rules governing payments for these services are set out in Section 6.

### 2.3. Personal health budgets

9. A personal health budget (PHB) is an amount of money to support the identified health and wellbeing needs for a particular patient, planned and agreed between that patient and their local NHS.
10. There are three types of PHB:
  - a. Notional budget – no money changes hands. The patient and their NHS commissioner agree how to spend the money. The NHS will then arrange the agreed care.

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<sup>1</sup> See the meaning of 'health care service' given in section 64 of the 2012 Act; and the exclusion of public health services in section 116(11).

<sup>2</sup> For the section 7A agreement, see: [Public Health Commissioning in the NHS 2015 to 2016](#).

<sup>3</sup> See chapters 4 to 7 of the 2006 Act. For example, the Statement of Financial Entitlements for GP services, and the Drug Tariff for pharmaceutical services.

- b. Real budget held by a third party – an organisation legally independent of the patient and their NHS commissioner will hold the budget and pays for the care within the agreed care plan.
  - c. Direct payment for health care – the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.
11. Payment to providers of NHS services from a notional budget is within the scope of the 2016/17 NTPS. This will either be governed by national prices as set out in Annex A (including national variations set out in Section 5) or subject to the local pricing rules: see Section 6.4.1.
  12. In some cases a notional budget may be used to buy integrated health and social care services to facilitate more personalised care planning. Where these services and products are not NHS services, the 2016/17 NTPS does not apply.
  13. If a PHB takes the form of a direct payment to the patient or third party budget, the payments for health and care services agreed in the care plan and funded from the direct payment are not within the scope of the 2016/17 NTPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act<sup>4</sup>.
  14. The following are not within the 2016/17 NTPS, as they do not involve paying for the provision of healthcare services:
    - a. payment for assessing an individual's needs to determine a PHB
    - b. payment for advocacy – advice to individuals and their carers about how to use their PHB
    - c. payment for the use of a third party to manage an individual's PHB on their behalf.
  15. More information about implementing PHBs can be found on the [NHS Personal Health Budgets page](#).<sup>5</sup>

## **2.4. Integrated health and social care**

16. Section 75 of the 2006 Act makes provision for the delegation of a local authority's health-related functions (statutory powers or duties) to their NHS partner, and vice versa, to help meet partnership objectives and create joint funding arrangements.

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<sup>4</sup> See the National Health Service (Direct Payments) Regulations 2013 (SI 2013/1617, as amended) <http://www.legislation.gov.uk/uksi/2013/1617/contents/made>

<sup>5</sup> <http://www.england.nhs.uk/healthbudgets/>

17. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain within the scope of the 2016/17 NTPS even if commissioned by a local authority.
18. Payment to providers of NHS services that are jointly commissioned are governed either by a national price as set out in Annex A (including national variations set out in Section 5) where applicable, or by a local price (including a local variation in Section 6.2).
19. Local authority social care or public health services which are commissioned under joint commissioning arrangements are outside of the scope of the 2016/17 NTPS.

## 2.5. Contractual incentives and sanctions

20. Commissioners' application of CQUIN payments and contractual sanctions are based on provider performance, after a provider's income has been determined in accordance with the 2016/17 NTPS. If a contractual sanction changes the amount paid for the provision of an NHS service, this is permitted under the rules relating to the making of payments to providers under section 7.1.

## 2.6. Devolved administrations

21. The pricing provisions of the 2012 Act cover healthcare services in the NHS in England only. The devolved administrations (DAs) are responsible for the NHS in Scotland, Wales and Northern Ireland. If a patient from Scotland, Wales or Northern Ireland is treated in England or vice versa, then the 2016/17 NTPS applies in some but not all circumstances of cross-border provision of NHS healthcare services.
22. Table 3 summarises how the 2016/17 NTPS applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

**Table 3: How the 2016/17 National Tariff Payment System applies to devolved administrations**

Scenario	NTPS applies to provider	NTPS applies to commissioner	Examples
DA patient treated in England and paid for by commissioner in England	✓	✓	Scottish patient attends A&E in England
DA patient treated in England and paid for by DA commissioner	✗	✗	A Welsh patient, who is the responsibility of a local health board in Wales, has elective surgery in England which is commissioned and paid for by



Scenario	NTPS applies to provider	NTPS applies to commissioner	Examples
			that local health board
English patient treated in DA and paid for by DA commissioner	✗	✗	English patient, who is the responsibility of a CCG, attends A&E in Scotland
English patient treated in DA and paid for by commissioner in England	✗	✓	English patient has surgery in Scotland which is commissioned and paid for by CCG in England

23. In the final scenario above, the commissioner in England is bound to follow the prices and rules in the 2016/17 NTPS, but there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally within the country in question, or use a different currency from that mandated by the national tariff. In such cases, the commissioner must follow the rules for local pricing (see Section 6). If there is a national price for the service, a local variation would be required to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the commissioner should follow the rules for local price setting.
24. Providers and commissioners should also be aware of rules for cross-border payment responsibility set by other national bodies. [The England–Wales Protocol for Cross-Border Healthcare Services](#) sets out specific provisions for allocating payment responsibility for patients who live near the Wales–England border. NHS England also provides comprehensive [guidelines on payment responsibility in England](#).<sup>6</sup> The scope of the 2016/17 NTPS does not cover payment responsibility rules as set out in these documents. These rules should therefore be applied in addition to any applicable provisions of the 2016/17 NTPS.

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<sup>6</sup> This guidance is set out in [Who Pays? Determining responsibility for payments to providers](http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf), <http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf>



### 3. Currencies with national prices

25. Currencies are one of the 'building blocks' that support the NTPS. They include the clinical grouping classification systems for which there are national prices in 2016/17.
26. Under the Health and Social Care Act 2012 ('the 2012 Act'), the national tariff must specify certain NHS healthcare services for which a national price is payable.<sup>7</sup> The healthcare services to be specified must be agreed between NHS England and Monitor.<sup>8</sup> In addition, the 2012 Act provides that the national tariff may include rules for determining which currency applies where there is more than one currency and price for the same service.
27. We are retaining the HRG4 currency design and scope used under the Enhanced Tariff Option (ETO). This was based on an updated version of HRG4 used to in the 2014/15 NTPS.
28. This section should be read in conjunction with the information set out in the following annexes:
  - a. Annex A: National tariff workbook. This contains:
    - i. The list of national prices (and related currencies)
    - ii. Maternity data requirements and definitions
    - iii. The lists of high cost drugs and devices
  - b. Annex B: Technical guidance and information for services with national currencies

#### 3.1. Classification, grouping and currency

29. The NHS payment system relies on patient level data. To operate effectively, the payment system needs:
  - a. a way of capturing and classifying clinical activity – this enables information about patient diagnoses and healthcare interventions to be captured in a standard format
  - b. a currency – the large number of codes for admitted patient activity in the primary classification system makes it impractical as a basis for payment; instead casemix groupings are used as the currency for admitted patients, outpatient procedures and accident and emergency (A&E). For outpatient

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<sup>7</sup> 2012 Act, section 116(1)(a)

<sup>8</sup> 2012 Act, section 118(7)

attendances, the currency is based on groupings that relate to clinic attendance and categories.

30. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2016/17 NTPS relies largely on two standard classifications to record clinical data for admitted patients. These are:
  - a. the World Health Organization International Classification of Diseases, 10th revision (ICD-10) for diagnoses<sup>9</sup>
  - b. Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions.<sup>10</sup>
31. 'Grouping' is the process of using clinical information such as diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E only) to classify patients to casemix groups structured around Healthcare Resource Groups (HRGs). HRGs are groupings of clinically similar conditions or treatments that use similar levels of healthcare resources. The grouping is done using grouper software produced by the Health and Social Care Information Centre (HSCIC).<sup>11</sup> The HSCIC also publishes comprehensive documentation giving the logic and process behind the software's derivation of HRGs as well as other materials that explain and support the development of the currencies that underpin the national tariff.<sup>12</sup>
32. A 'currency' is a unit of healthcare for which a payment is made. Under the 2012 Act, a healthcare service for which a national price is payable must be specified in the national tariff. A currency can take one of several forms. For 2016/17, we use spell based HRGs as the currency to be used for admitted patient care and some outpatient procedures. The currencies for A&E services are based on A&E attendances.
33. The HRG currency design used for the 2016/17 NTPS is known as HRG4 and is arranged into chapters, each covering a body system. Some chapters are divided into subchapters. The specific design for the 2016/17 NTPS is that used to collect 2011/12 reference costs.

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<sup>9</sup> The 5th edition update of ICD-10 was published in April 2015.

<sup>10</sup> OPCS version 4.7 (which was introduced in April 2014) has been incorporated into the currency design used for 2016/17 prices.

<sup>11</sup> <http://www.hscic.gov.uk/casemix/payment>

<sup>12</sup> <http://www.hscic.gov.uk/casemix/payment>

34. The currency used for outpatient attendances is based on attendance type and clinic type, defined by Treatment Function Code. This is explained in more detail in Subsection 3.2.4.

### **3.2. Currencies for which there are national prices in 2016/17**

35. Section 3.2.1 describes the currencies for which there are national prices in 2016/17.
36. Details of the methods we have used to determine the national prices are provided in Section 4. The list of national prices and related currencies can be found in Annex A.
37. In specific circumstances we specify services in different ways, and attach different prices, for example, setting best practice tariffs to incentivise improved outcomes for particular cohorts of patients. As well as specifying the currencies, this section (in combination with Annex A and Section 2 of Annex B) provides the rules for determining which currencies and prices apply where a service is specified in more than one way.
38. The rules for the local pricing of services with mandatory currencies but no national prices – such as adult mental health and ambulance services – are set out in Section 6.

#### **3.2.1. Admitted patient care**

39. Spell-based HRG4 is the currency design for admitted patient care covering the period from admission to discharge. If a patient is under the care of one consultant for their entire spell<sup>13</sup>, this would comprise one finished consultant episode (FCE). Occasionally, a patient will be under the care of more than one consultant during their spell; this would mean that the spell had multiple FCEs.
40. National prices for admitted patient care cover the care received by a patient during their spell in hospital, including the costs of services such as diagnostic imaging. The national price to be applied is determined by date of discharge.
41. The costs of some elements of the care pathway are excluded from national prices, such as critical care and high cost drugs. These costs are reimbursed under the rules applicable to local pricing.
42. To promote movement to day case settings where appropriate, most elective prices are for the average of day cases and ordinary elective case costs, weighted according to the proportion of activity in each group.

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<sup>13</sup> A spell is a period from admission to discharge or death. A spell starts following the decision to admit the patient.

43. For a small number of HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This approach has been taken where a price that is independent of setting is clinically appropriate.
44. When a patient has more than one distinct admission on the same day<sup>14</sup> (eg the patient is admitted in the morning, discharged, then re-admitted in the afternoon), each admission is counted as the beginning of a separate spell, although a short stay adjustment may apply to the first admission.
45. Short stay emergency adjustments<sup>15</sup> and long stay payments<sup>16</sup> apply to admitted patient care. These are explained in detail below.

#### *Changes to the scope of services with national prices*

46. In 2016/17 we are adopting the scope of services set out in the ETO. This means an additional national price for Transcatheter Aortic Valve Implantation (EA53Z: TAVI). The cost of the device used in this procedure should be reimbursed as a high cost device under local pricing rules (See annex A and section 6).

#### *Short stay emergency adjustment*

47. The short stay emergency adjustment is a mechanism for ensuring appropriate reimbursement for lengths of stay shorter than two days, where the average HRG length of stay is longer. It applies whether the patient is admitted under a medical or a surgical specialty providing all of the following criteria are met:
- a. the patient's adjusted length of stay is either zero or one day
  - b. the patient is not a child, defined as aged under 19 years on the date of admission
  - c. the admission method code is 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented Commissioning Data Set (CDS) version 6.2)
  - d. the average length of non-elective stay for the HRG is two or more days

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<sup>14</sup> Calendar day not 24 hour period.

<sup>15</sup> Short-stay emergency adjustments ensure that emergency stays of less than two days, where the average length of stay of the HRG is longer, are appropriately reimbursed.

<sup>16</sup> For patients that remain in hospital beyond an expected length of stay for clinical reasons, there is an additional reimbursement to the national price called a 'long stay payment' (sometimes referred to as an 'excess bed day payment'). The long stay payment applies at a daily rate to all HRGs where the length of stay of the spell exceeds a 'trim point' specific to the HRG.

- e. the assignment of the HRG can be based on a diagnosis code, rather than on a procedure code alone, irrespective of whether a diagnosis or procedure is dominant in the HRG derivation.

48. The adjustment percentages applied are set out in the table below. These are a change to those set out in the 2014/15 NTPS.

**Table 4: HRG short stay emergency adjustment percentages**

HRG Average length of stay	2016-17 short stay percentages
< 2 days	100.0
2 days	65.0
3 or 4 days	40.0
≥5 days	30.0

49. The short stay emergency adjustment will apply to all best practice tariffs except for acute stroke care, fragility hip fracture and same-day emergency care.
50. Any adjustments to the tariff, such as specialised service top-ups,<sup>17</sup> are applied to the reduced tariff. Annex A lists the HRGs to which the reduced short stay emergency tariff is applicable.

#### *Long stay payment*

51. A long stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a specified trim point<sup>18</sup> specific to the HRG and point of delivery.
52. The trim point is defined in the same way as for reference costs, but is spell based and there are separate elective and non-elective trim points. The trim point for each HRG is shown alongside national prices in Annex A.
53. In 2016/17 we are continuing with the approach first adopted in 2011/12, whereby there is a trim point floor of five days.<sup>19</sup> For 2016/17, there will be two long stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs. This approach was first introduced in 2013/14.
54. If a patient is medically ready for discharge and delayed discharge payments have been imposed on local authorities under the provisions of the Community

<sup>17</sup> Specialised top-ups are paid to reimburse providers for the higher costs of treating patients who require specialised care. Further information is provided in Section 8.

<sup>18</sup> The trim point is defined as the upper quartile length of stay for the HRG plus 1.5 times the inter-quartile range of length of stay.

<sup>19</sup> For simplicity, we have shown a trim point floor of at least five days for all HRGs in the tariff spreadsheet, regardless of whether the HRG includes length of stay logic of less than five days.

Care (Delayed Discharges etc) Act 2003, commissioners should not be liable for any further long stay payment.

55. Long stay payments may only be adjusted when **Secondary Uses Services (SUS) Payment by Results (PbR)**<sup>20</sup> applies an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the Commissioning Data Set, by removing the number of days between the ready date and actual discharge date from any long stay payment. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that local authorities are being appropriately charged.

### **3.2.2. Chemotherapy and radiotherapy**

#### *Chemotherapy*

56. HRG subchapter SB covers both the procurement and the delivery of chemotherapy regimens for patients of all ages. The HRGs in this subchapter are unbundled and include activity undertaken in inpatient, day case and non-admitted care settings.
57. Chemotherapy payment is split into three parts:
- a. a core HRG (covering the primary diagnosis or procedure) – this has a national price
  - b. unbundled HRGs for chemotherapy drug procurement – these have local currencies and prices
  - c. unbundled HRGs for chemotherapy delivery – these have national prices.
58. The regimen list that assigns activity to a delivery and procurement HRG is updated for the 2016/17 NTPS<sup>21</sup>.

#### *Radiotherapy*

59. HRG subchapter SC covers both the preparation and the delivery of radiotherapy for patients of all ages. The HRGs in this subchapter are for the most part unbundled and include activity undertaken in inpatient, day case and non-admitted care settings.
60. HRG4 groups for radiotherapy include:
- a. Radiotherapy Planning – for pre-treatment (planning) processes

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<sup>20</sup> <http://www.hscic.gov.uk/article/1922/SUS-Payment-by-Results>

<sup>21</sup> <http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/chemoregimens>

- b. Radiotherapy treatment (delivery per fraction) – for treatment delivered, with a separate HRG allocated for each fraction delivered.
61. The radiotherapy planning HRGs are intended to cover all attendances needed to complete the planning process. It is not intended that individual attendances for parts of this process will be recorded separately.
62. The planning HRGs do not include the consultation at which the patient consents to radiotherapy, nor any medical review required by any change in status of the patient.
63. The HRGs for radiotherapy treatment cover the following elements of care:
- a. external beam radiotherapy preparation – this has a national price
  - b. external beam radiotherapy delivery – this has a national price
  - c. brachytherapy and molecular radiotherapy administration – this has local currencies and prices.
64. Further information on the structure of the chemotherapy and radiotherapy HRGs and payment arrangements can be found in Annex B.

### **3.2.3. Post-discharge rehabilitation**

65. Post-discharge national currencies cover the entire pathway of treatment post discharge. They are designed to help reduce avoidable emergency readmissions and provide a service agreed by clinical experts to facilitate better post-discharge rehabilitation and reablement for patients.
66. Post-discharge currencies cover four specific rehabilitation pathways:
- a. cardiac rehabilitation<sup>22</sup>
  - b. pulmonary rehabilitation<sup>23</sup>
  - c. hip replacement rehabilitation
  - d. knee replacement rehabilitation.
67. For 2016/17, we are continuing with national prices for these four post-discharge currencies for the care of patients where a single provider provides both acute and community services. Where services are not integrated, the

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<sup>22</sup> Based on the pathway of care outlined in the Department of Health's 'Cardiac Rehabilitation Commissioning Pack'.

<sup>23</sup> Based on the pathway of care outlined in the Department of Health's 'Chronic Obstructive Pulmonary Disease (COPD) Commissioning Pack'.



national price does not apply; however, we encourage the use of these prices in local negotiations on commissioning of post-discharge pathways of care.

68. Degrees of service integration vary. Accordingly commissioners and providers will need to establish which health communities receive both acute and community services from a single provider to establish whether the post-discharge national prices should be used.
69. The post-discharge national prices must be paid on completion of a full rehabilitation pathway.
70. The post-discharge activity and national price will not be identified by the grouper or by SUS. Therefore, in deriving a contract for this service, commissioners and providers need to locally agree the number of patients expected to complete rehabilitation packages. This forecast should be reconciled to the actual numbers of packages completed at year end.
71. Further detail on all four post-discharge currencies, their scope and their specific rules can be found in Annex B.

#### **3.2.4. Outpatient care**

72. National prices for consultant-led outpatient attendances are based on clinic type categorised according to Treatment Function Code (TFC).<sup>24</sup> There are separate prices for first and follow-up attendances, for each TFC, as well as for single professional and multi-professional clinics.<sup>25</sup>
73. The outpatient attendance national price remains applicable only to pre-booked, consultant-led attendances. The pre-booking requirement is not limited to Choose and Book,<sup>26</sup> and may include local systems and accept patients based on GP letters or phone calls. Prices for other outpatient attendances that are not pre-booked or consultant led must be agreed locally.
74. When an attendance with a consultant from a different main specialty during a patient's admission replaces an attendance that would have taken place, it should attract a national price provided it is pre-booked and consultant led.
75. When a patient has multiple distinct outpatient attendances on the same day (eg one attendance in the morning and a second separate attendance in the

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<sup>24</sup> TFCs are defined in the NHS Data Model and Dictionary as codes for 'a division of clinical work based on main specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including consultants'.

<sup>25</sup> Multi-professional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. For more detail see Annex B

<sup>26</sup> Choose and Book is the national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

afternoon) each attendance is counted separately and will attract a separate national price unless a pathway price has been agreed with commissioners.

76. Outpatient attendances do not have to take place in hospital premises. Therefore consultant-led outreach clinics held in a GP practice or a children's centre should be eligible for the national price. For these clinics, it is important to make sure the data flows into SUS PbR to support payment for this activity. However, home visits are not eligible for the outpatient care national price and are instead subject to local price-setting.
77. If, following an outpatient attendance, a patient attends an allied health professional (eg a physiotherapist), the costs of the latter attendance are not included in the national price for the original attendance and these attendances will be subject to local negotiation on price (in accordance with the rules on local pricing).
78. Commissioners and providers should use the NHS Data Model and Dictionary to determine the categorisation of outpatient attendance and day case activity.<sup>27</sup> Furthermore, providers must ensure that the way they charge for activity is consistent with the way they cost activity in reference costs, and consistent with any conditions for payment that are included within contracts.
79. For some procedures that are undertaken in an outpatient setting, there are national prices based on HRGs. If more than one of these procedures is undertaken in a single outpatient attendance, only one price is applicable. The grouper software will determine the appropriate HRG, and the provider will receive payment at the relevant price.
80. Where a procedure-driven HRG is generated, SUS PbR determines whether the HRG has a mandatory national price and, if so, applies it. Outpatient procedures for which there is no mandatory HRG price will be paid according to the relevant outpatient attendance national price.
81. For TFCs with no national price, the price should be set through local negotiation between commissioners and providers (in accordance with the rules on local pricing). The national price for any unbundled diagnostic imaging associated with the attendances must be used in all cases. National prices for diagnostic imaging in outpatients are mandatory, regardless of whether or not the core outpatient attendance activity has a national price.

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<sup>27</sup> The [NHS Data Model and Dictionary Service](#) sets out the definitions to be applied. It provides a reference point for assured information standards to support health care activities within the NHS in England.

### **3.2.5. Direct access**

82. There are national prices for activity accessed directly from primary care, which are listed in Annex A. One example is where a GP sends a patient for a scan and results are sent to the GP for follow up. This is in contrast to such a service being requested as part of an outpatient referral.
83. A field was added to the outpatient Commissioning Data Set version 6.2 which can be used to identify services that have been accessed directly.<sup>28</sup>
84. Where direct access activity is processed through the grouper, both a core HRG and an unbundled HRG will be created. When the activity is direct access, the core HRG should not attract any payment but the direct access service should attract a payment.
85. In the case of direct access diagnostic imaging services for which there are national prices, the costs of reporting are included in prices. These costs are also shown separately in Annex A so that they can be used in case a provider provides a report but does not carry out the scan.
86. There is also a non-mandatory price for direct access plain film x-rays.

### **3.2.6. Urgent and emergency care**

87. There are national prices for A&E services and minor injury units, based on 11 HRGs (subchapter VB – Emergency and Urgent Care). The A&E currency is based on investigation and treatment.
88. Where a patient is admitted following an A&E attendance, both the relevant A&E and non-elective prices are payable. Please note that the tariff for patients who are ‘dead on arrival’ (DOA) should be that applying to VB09Z.
89. For 2016/17, Type 1 and Type 2 A&E departments continue to be eligible for the full range of A&E HRGs and corresponding national prices; Type 3 A&E departments are eligible for VB11Z only.
90. Services that are provided by NHS walk-in centres, which are categorised as Type 4 A&E services by the NHS Data Dictionary, will not attract national prices. Information on local price-setting can be found in Section 6.

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<sup>28</sup> SUS R16 release (April 2016) has a requirement to add new functionality to implement the CDS6.2 new data item ‘Direct access indicator’.

### 3.2.7. Best practice tariffs

91. A best practice tariff (BPT) is a national price that is designed to incentivise quality and cost-effective care. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review.<sup>29</sup>
92. The aim is to reduce unexplained variation in clinical quality and to spread best practice. BPTs may introduce an alternative currency to a HRG, including a description of activities that more closely corresponds to the delivery of outcomes for a patient. The price differential between best practice and usual care is calculated to ensure that the anticipated costs of undertaking best practice are reimbursed, while creating an incentive for providers to shift from usual care to best practice.
93. Where a BPT introduces an alternative currency, that currency should be used in the cases described here, and in Annex A and sub-section 2.5 of Annex B.<sup>30</sup>
94. Each BPT is different, tailored to the clinical characteristics of best practice for a patient condition and to the availability and quality of data. However, there are groups of BPTs that share similar objectives, such as:
  - a. avoiding unnecessary admissions
  - b. delivering care in appropriate settings
  - c. promoting provider quality accreditation
  - d. improving quality of care.
95. The service areas covered by BPTs are all selected as being:
  - a. high impact (that is, high volumes, significant variation in practice, or significant impact on patient outcomes)
  - b. supported by a strong evidence base and clinical consensus on what constitutes best practice.
96. A summary of the full 2016/17 BPT package and its evolution is provided in Table 3. The BPT prices can be found in Annex A, and further information is provided in sub-section 2.5 of Annex B.
97. For 2016/17 we have introduced a new mandatory BPT for non-elective admissions for heart failure, which is designed to incentivise improved

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<sup>29</sup> 'High Quality Care For All', presented to Parliament in June 2008.

<sup>30</sup> The provisions set out in this section, and those annexes, for determining when a BPT currency is to be used are rules made under section 116(6) of the 2012 Act (rules for determining, where a health service is specified in more than one way, which specification applies in any particular case or cases).

adherence to National Institute for Health and Care Excellence (NICE) guidance.

98. We have introduced a non-mandatory BPT designed to incentivise timely angioplasty for patients diagnosed with non-ST-elevation myocardial infarction (NSTEMI), a subtype of heart attack. Providers and commissioners may choose to implement this BPT locally for 2016/17, assuming that they comply with the local variation rules in Section 6.
99. We have also amended five existing BPTs: day-case procedures, stroke, outpatient procedures, endoscopy, and primary hip and knee replacement outcomes.
100. Further detail on the new and amended BPTs is included in Annex B.
101. Some BPTs relate to specific HRGs while others are more detailed and relate to a subset of activity within an HRG. The BPTs that are set at a more detailed level are identified by BPT 'flags', listed in Annex A. These BPTs will relate to a subset of activity covered by the high level HRG. There will be other activity covered by the HRG that does not relate to the BPT activity, and so a 'conventional' price is published for these HRGs to reimburse the costs of the activity unrelated to the BPT.
102. Top-up payments for specialised services and long stay payments apply to all of the relevant BPTs. The short stay emergency adjustment will apply to all BPTs except for acute stroke care, fragility hip fracture and same-day emergency care.

**Table 5: Summary of best practice tariffs**

BPT	Introduced	Additional changes since introduction	
Acute stroke	2010/11	2011/12 and 2012/13 2013/14  2016/17	Increased price differential  Currency split to differentiate by patient complexity Updated the criteria on brain imaging to be consistent with guidelines from the Royal College of Physicians.
Cataracts	2010/11	2013/14	Status changed from mandatory to non-mandatory
Fragility hip fracture	2010/11	2011/12 2012/13	Increased price differential Further increase in price differential and expansion of best practice characteristics
Day-case procedures	2010/11 (gall bladder removal only)	2011/12 2012/13	12 further procedures added Two further procedures added and breast surgery procedures amended

BPT	Introduced	Additional changes since introduction	
		2013/14	and revisions to some day-case rates One further procedure added and hernia and breast surgery procedures amended
		2016/17	Recalculated BPT prices based on revised transitional targets towards or at the British Association of Day Surgery (BADs) proportions for two procedures where national performance has improved operations to manage female incontinence and tympanoplasty
Adult renal dialysis	2011/12 (vascular access for haemodialysis)	2012/13	Incentives for home therapies
Transient-ischaemic attack	2011/12	2013/14	Magnetic resonance imaging payment removed in line with guidance on unbundling
Interventional radiology	2011/12 (two procedures introduced)	2012/13	Five further procedures introduced
Paediatric diabetes	2011/12 (activity-based structure – non-mandatory)	2012/13 2014/15	Year of outpatient care structure (mandatory) Updated to include inpatient care
Major trauma care	2012/13	2014/15	Best practice characteristics changed
Outpatient procedures	2012/13 (three procedures introduced)	2013/14 2016/17	Flexibility to encourage see-and-treat hysteroscopy Recalculated price for diagnostic hysteroscopy based on an increased transitional target towards the proportion thought to be achievable. Updated the calculation methodology not to apply an implicit efficiency assumption in our proposed prices
Same-day emergency care	2012/13 (12 clinical scenarios introduced)	2013/14	Seven new clinical scenarios introduced
Diabetic ketoacidosis and hypoglycaemia	2013/14		

BPT	Introduced	Additional changes since introduction	
Early inflammatory arthritis	2013/14		
Endoscopy procedures	2013/14	2016/17	Changed from a two tier to a three-tier payment system so that only level 1 accredited units will receive the BPT.
Paediatric epilepsy	2013/14		
Parkinson's disease	2013/14		
Pleural effusions	2013/14		
Primary hip and knee replacement outcomes	2014/15	2016/17	National Joint Registry thresholds increased to 85%
Heart failure	2016/17		Data submission to the NHFA with a target rate of 70%.  Specialist input with a target rate of 60%.
NSTEMI	2016/17		Non-mandatory BPT

### 3.2.8. Looked after children health assessments

103. Looked after children<sup>31</sup> are one of the most vulnerable groups in society.

104. One third of all looked after children are placed with carers or in settings outside of the originating local authority. These are referred to as 'out-of-area' placements.

105. When children are placed in care by local authorities, their responsible health commissioner has a statutory responsibility to commission an initial health assessment and conduct six-monthly or yearly reviews. When the child is placed out of area, the originating commissioner retains this responsibility but the health assessment should be done by a provider in the local area, to promote optimal care co-ordination for the child.

106. Usually, there are clear arrangements between commissioners and local providers for health assessments of looked after children placed 'in area'.

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<sup>31</sup> The National Society for the Prevention of Cruelty to Children (NSPCC) website on [Children in Care](#) states: "A child who is being looked after by the local authority is known as a child in care or "looked after."



However, arrangements for children placed out of area are variable, resulting in concerns over the quality and scope of assessments.

107. To address this variability in the arrangements for children placed out of area and to enable more timely assessments, a currency was devised and mandated for use by DH in 2013/14, including a checklist for the components that must be included in the assessment. The aim was to promote consistency and enable more timely assessments. Non-mandatory prices were made available for use in 2013/14, and national prices were introduced in 2014/15 for children placed out of area.
108. For 2016/17 national prices will continue to apply for children placed out of area. These prices are not mandatory for health assessments undertaken for children placed in area. A checklist for implementing the currency is included in Annex B.

### **3.2.9. Pathway payments**

109. Pathway payments are single payments that cover a bundle of services<sup>32</sup> which may be provided by several providers for an entire episode or whole pathway of care for a patient. These payments are designed to encourage better organisation and co-ordination of care across a pathway and among different healthcare providers. Improving the co-ordination of care, including across different settings of care (eg primary, secondary, community services and social care), has the potential to improve patient outcomes by reducing complications and readmissions.
110. There are two pathway-based payment systems. These relate to:
- a. maternity healthcare services
  - b. healthcare for patients with cystic fibrosis.

#### *Maternity pathway payment*

111. The maternity pathway payment system splits maternity care into three stages: antenatal, delivery and postnatal. For each stage, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each stage to cover the cost of care<sup>33</sup> the level of which depends on clinical factors that affect the extent and intensity of care a woman is expected to need.

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<sup>32</sup> 2012 Act, section 117 provides that a bundle of services may be specified as a single service (ie a currency) to which a national price applies, where those services together constitute a form of treatment.

<sup>33</sup> Antenatal care for uncomplicated pregnancies  
<https://www.nice.org.uk/guidance/cg62/chapter/guidance>

112. Women may still receive some of their care from a different provider for clinical reasons or to support a woman's choice. This care is paid for by the lead provider who will have received the entire pathway payment from the commissioner.
113. For 2016/17 we have added six clinical factors to the antenatal pathway. These changes allow the maternity pathway allocation to more closely reflect the experience of clinicians, and improve the way providers are reimbursed for the care they give. Details of the six clinical factors are listed in Table 6.

**Table 6: Changes to the factors for the 2016/17 antenatal pathway**

Factor	Change
Cystic fibrosis	Add to the intensive pathway
Previous organ transplant	Add to the intensive pathway
Serious neurological conditions (not epilepsy as this is already in the intermediate pathway)	Add to the intensive pathway
Serious gastroenterological conditions	Add to the intermediate pathway
Body mass index (BMI) >49	Add to the intensive pathway
Low pregnancy-associated plasma protein A (PAPP-A) reading	Add to the intermediate pathway

114. Further information on the pathway payment approach can be found in Annex A and Annex B.

#### *Cystic fibrosis pathway payment*

115. The cystic fibrosis pathway currency is a complexity-adjusted yearly banding system with seven bands of increasing complexity of patient need. The tariff relates to a year of care. The pathway does not distinguish between adults and children.
116. The cystic fibrosis pathway currency was designed to support specialist cystic fibrosis multidisciplinary teams to provide care in a seamless, patient-centred manner, removing any incentives to hospitalise patients whose care can be well managed in the community and in their homes. Furthermore, it allows early intervention (following international guidelines) to prevent disease progression, for example, through the use of antipseudomonal inhaled/nebulised antibiotics and mucolytic therapy.

### **3.3. High cost drugs, devices and listed procedures**

117. Several high cost drugs, devices and listed procedures are not reimbursed through national prices. Instead they are subject to local pricing in accordance with the rules set out in Section 6.

118. For the 2016/17 NTPS we have updated the list of drugs, devices and procedures using the same criteria used in previous years.<sup>34</sup> Annex A sets out details of the high cost drugs, devices and listed procedures for 2016/17. The related local pricing rule (Rule 7), which has also been revised for 2016/17 to reflect the new arrangements for national procurement of devices, is set out in Subsection 6.4.3.

*New listed procedures: Molecular and Companion Diagnostics and personalised medicine*

119. It is the intention of NHS England to exclude a list of molecular diagnostic tests for three years. These tests are, therefore, excluded for 2016/17. Details of the excluded tests can be found under the heading of listed procedures on the high cost drugs, devices and listed procedures list in Annex A.

120. NHS England commissioners will agree local prices and activity volumes with providers for these tests in accordance with the rules on local pricing.

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<sup>34</sup> Further information about high cost drugs, devices and procedures may be found online via the high cost drugs, devices and chemotherapy portals <https://www.england.nhs.uk/resources/pay-syst/drugs-and-devices/>

## 4. Method for determining national prices

121. Our aim in setting prices is to support the highest quality patient care within the healthcare budget. The 2016/17 national prices are based on the prices adopted under the ETO, which were derived from the proposals set out in the statutory consultation notice on the 2015/16 NTPS, subject to some further adjustments. This section sets out the method we have used to determine the national prices in the 2016/17 NTPS. In particular it explains:

- a. our approach to producing the base prices, before applying cost uplifts, the efficiency factor and manual adjustments
- b. how we estimate cost inflation
- c. how we estimate the efficiency factor we use
- d. how we have made manual adjustments where appropriate.

### 4.1. Overall approach

122. We are setting national prices for 2016/17 based on the currencies and prices adopted under the ETO (rolled over prices) with adjustments for efficiency, cost uplifts and a small number of manual adjustments.

123. Under the ETO, the specialist top-up national variation was funded by a top-slice. This has been carried over, and adjusted by inflation and the efficiency factor, to 2016/17 national prices.

**Figure 1: Stages in our method for setting national prices**



124. For the 2016/17 tariff, our approach is to then adjust the ETO prices for:

- a. an efficiency factor of 2%
- b. our expectation of cost inflation, which we estimate at 3.1%
- c. uplifts specific to individual HRGs reflecting increases in costs of the clinical negligence scheme for trusts (CNST), equivalent to around 0.7% across all prices (however, actual adjustments vary by subchapter).
- d. make various manual adjustments.

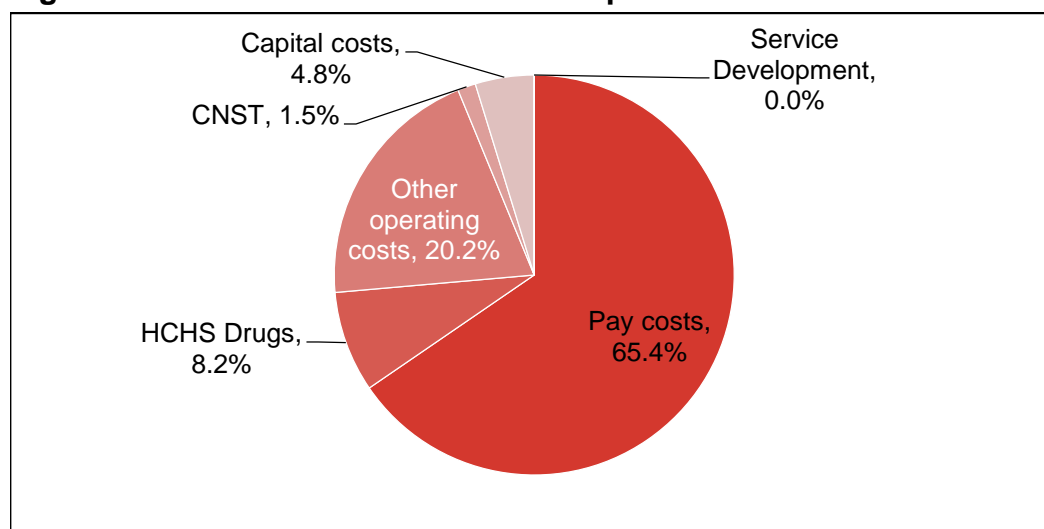
## 4.2. Cost uplifts

125. Our starting point for setting 2016/17 prices reflects 2015/16 cost levels. We have therefore updated these prices to reflect costs that are expected to be incurred by providers in the 2016/17 tariff year. We did this by applying a set of cost uplifts, which reflect changes in input costs between 2015/16 and 2016/17. These are outlined below.
126. Our approach to determining the cost uplift adjustment includes consideration of six categories of cost pressures. These are:
- a. pay costs
  - b. drugs costs
  - c. other operating costs
  - d. changes in the cost associated with CNST payment
  - e. changes in capital costs (ie changes in costs associated with depreciation and Private Finance Initiative payments)<sup>35</sup>
  - f. additional costs associated with NHS England's Mandate. We call these changes 'service development' costs. There are no adjustments from the Mandate for service development in 2016/17.
127. In setting the total cost uplift factor, each cost category has to be assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure obtained from DH's published 2014/15 financial accounts. Figure 2 shows the weights applied to each cost category.

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<sup>35</sup> In line with DH's past approach, we have included an estimate of how these payments will change in aggregate for 2016/17 as part of our cost uplifts.

**Figure 2: Breakdown of the tariff cost uplift**



Source: DH, with Monitor calculations

128. Below, we set out our method for estimating the level of each cost uplift component.

#### **4.2.1. Inflation in operating costs**

129. The categories of operational costs are:

- a. pay costs
- b. drugs costs
- c. other operating costs.

##### *Pay*

130. As shown in Figure 2, pay costs are a major component of providers' aggregate input costs, so it is important that we reflect changes in these costs as accurately as possible when setting national prices.

131. Pay-related inflation has three elements. These are:

- a. Pay settlements, which are the increase in the unit cost of labour reflected in pay awards for the NHS.
- b. Pay drift and staff group mix, which is the movement in the average unit cost of labour due to changes in the overall staff mix (eg the relative proportions of senior and junior staff, or the relative proportions of specialist and non-specialist staff). Pay drift also includes changes to the amount of overtime and other allowances paid to staff.
- c. Pensions, which takes account of changes to the cost of pension provision and results from a revaluation of required NHS pension contributions.

132. We are using DH's central estimates for these components. DH maintains the most accurate and detailed records of labour costs in the NHS, and is directly involved in pay negotiations.
133. The pay award is in-line with public sector pay policy announced in the summer budget which is 1%. The 1% pay award assumption is a limit to the average pay award set by HMT. A greater increase for lower paid staff would have to be offset by a lower increase for higher paid staff.
134. The pay drift inflation rate is 2.4%. Of this, 1.8% is the rate of pension including contracted out employer national insurance contribution rates. As a result, the pay drift is higher than recent years. Staff group mix effect is -0.04% which reflects expectations of skill mix decisions by hundreds of employers in the context of affordability expectations.
135. The current projection of the overall pay inflation rate is 3.3% in 2016/17. This translates into a 2.2% increase in national tariff prices.

#### *Drug costs*

136. Drugs cost uplift recognises the expected increase in cost associated with an increase in usage and/or cost of drugs. Although drugs costs are a relatively small component of total provider expenditure (approximately 8.2%), they have historically grown faster than other costs. This has made drugs costs one of the larger cost uplift components in some years.
137. Our approach is the same as previous years which is to differentiate the cost increase due to price increases and remove the increase in costs resulting from activity. This is because providers will be reimbursed for increased drugs usage due to activity through the increase in volumes and therefore payments.
138. To reflect the expected increase in drugs costs, we have used DH's estimate. This estimate is based on long-term trends and DH's expectation of new drugs coming to market, and other drugs that will cease to be provided solely under patent in the coming 12 months. DH has provided us with its best estimate of the increase in drugs unit costs for providers in 2016/17. This figure is 4.5% which translates into a 0.37% cost uplift once the weighting of the increase is taken into consideration.

#### *Other operating costs*

139. Other operating costs include general costs such as medical, surgical and laboratory equipment and fuel. For this category of cost uplift, we have used the forecast of the GDP deflator estimated by the Office of Budget Responsibility (OBR) as the basis of the expected increase in costs. The latest available OBR figure of 1.7% is from the Chancellor's Autumn Statement in November 2015.



This translates into an overall cost uplift of 0.34% once the weighting of the increase is taken into consideration.<sup>36</sup>

#### 4.2.2. Clinical Negligence Scheme for Trusts

140. CNST is an indemnity scheme for clinical negligence claims. Providers make a contribution to the scheme to cover the legal and compensatory costs of clinical negligence.<sup>37</sup> The NHS Litigation Authority (NHSLA) administers the scheme and sets the contribution that each provider must make to ensure that the scheme is fully funded each year.

141. Following the previous DH approach, we have allocated the increase in CNST costs to core HRG subchapters, to the maternity delivery tariff and A&E services in line with the average cost increases that will be paid by providers. This approach to the CNST uplift is different to other cost uplifts. While other cost uplifts are estimated and applied across all prices, the estimate of the CNST cost increase differs according to the mix of services delivered by providers. To reflect these differences in CNST payments, the cost uplift is differentially applied across HRG subchapter, A&E services and for the maternity delivery tariff. Each relevant HRG is uplifted based on the change in CNST cost across specialties mapped to HRG subchapters. This means that our cost uplifts reflect, on average, each provider's relative exposure to CNST cost growth, given their individual mix of services and procedures.<sup>38</sup>

142. The expected increase in CNST costs for 2016/17 is 17%. This reflects the CNST contribution increase estimated by NHSLA.

143. Table 7 below lists the percentage uplift that we have applied to each HRG subchapter to reflect the increase in CNST costs.

**Table 7: CNST tariff impact by HRG subchapter**

HRG subchapter	% uplift	HRG subchapter	% uplift	HRG subchapter	% uplift
AA	0.93%	GA	0.74%	JA	0.89%
AB	0.50%	GB	0.43%	JC	0.55%
BZ	0.73%	GC	0.74%	JD	0.39%
CZ	0.46%	HA	0.79%	KA	0.73%

<sup>36</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/480585/GDP\\_Deflators\\_Autumn\\_Statement\\_November\\_2015\\_update.csv/preview](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480585/GDP_Deflators_Autumn_Statement_November_2015_update.csv/preview)

<sup>37</sup> CCGs and NHS England are also members of the CNST scheme.

<sup>38</sup> For example, maternity services have been a major driver of CNST costs in recent years. For this reason, a provider delivering maternity services as a large proportion of its overall service mix would probably find that its CNST contributions (set by the NHSLA) have increased more quickly than the contributions of other providers. However, the cost uplift reflects this, since the CNST uplift is higher for maternity services. This is consistent with the approach previously taken by DH.

DZ	0.27%	HB	0.92%	KB	0.27%
EA	0.32%	HC	1.21%	KC	0.32%
EB	0.26%	HD	0.86%	LA	0.19%
FZ	0.59%	HR	1.00%	LB	0.34%
MA	-2.42%	QZ	0.72%	VB	1.79%
MB	-1.12%	RC	0.79%	WA	0.38%
PA	1.16%	SA	0.54%	Maternity*	7.37%
PB	0.00%	VA	0.81%		

Source: The NHS Litigation Authority. Note: \* Maternity is delivery element only

144. The vast majority of the increases in CNST costs are allocated at HRG subchapter level, maternity tariff or A&E, but a small residual amount (about £18.8 million out of a total £1.6 billion CNST cost) is unallocated at a specific HRG level. This unallocated figure is redistributed as a general uplift across all prices. We have calculated the uplift due to this pressure as 0.02% in 2016/17 (though this is given as 0.0% in the table below due to rounding).

#### 4.2.3. Capital costs (changes in depreciation and private finance initiative payments)

145. Providers' costs typically include depreciation charges and private finance initiative (PFI) payments. Like increases in operating costs, providers should have an opportunity to recover an increase in these capital costs.

146. In previous years, DH reflected changes in these capital costs when calculating cost uplifts, and we have adopted the same approach for the 2016/17 NTPS. Specifically, we have applied DH's projection of changes in overall depreciation charges and PFI payments.

147. In aggregate, DH projects PFI and depreciation to grow by 3.1% in 2016/17, which translates to a 0.1% uplift on tariff prices.

#### 4.2.4. Service development

148. The **final NHS mandate for 2016/17 has been published.**<sup>39</sup>

149. The service development uplift factor reflects the expected additional unit costs to providers of major initiatives that are included in the Mandate.<sup>40</sup> As part of the spending round, NHS England assessed the costs of implementing the requirements within the NHS mandate. We have concluded that the requirements do not justify a service development uplift for 2016/17.

<sup>39</sup> <https://www.gov.uk/government/publications/nhs-mandate-2016-to-2017>

<sup>40</sup> The Mandate to NHS England sets out objectives for the NHS and highlights the areas of health care where the Government expects to see improvements.

### 4.2.5. Summary of data for cost uplifts

150. Given the above, we estimate the overall inflation figure for 2016/17 national prices are 3.1% as shown in the table below. This excludes the targeted CNST adjustments.

**Table 8: Cost uplift factors**

Uplift factors	15/16 Weighted average estimate (uplift x weighting)
Pay costs	2.2%
Drugs costs	0.4%
Other operating costs	0.3%
Unallocated CNST	0.0%
Capital costs	0.1%
<b>Total</b>	<b>3.1%</b>

Notes: Unallocated CNST refers to CNST cost increases not associated with specific HRG subchapters (see paragraph 146). Numbers may not add up exactly due to rounding. Unallocated CNST is 0.02% but has been rounded down.

### 4.3. Efficiency factor

151. Over time, we expect healthcare providers to increase their efficiency (through, for example, technological changes or different ways of working), which in other parts of the economy would lead to downward price pressure. By applying the efficiency factor to determine prices, we reflect our expectations of the extent to which providers can deliver the same services, to the same level of quality or better, at a lower cost in 2016/17, compared with 2015/16.

152. Setting the efficiency factor is an inherently difficult task that requires a significant degree of judgement against a backdrop of imperfect information. We have therefore developed a framework for estimating the efficiency opportunity and setting the efficiency factor for 2016/17. It was developed with input from stakeholders over the course of the year, recognising current data limitations.

153. We consulted on the framework as part of the [2015/16 National prices methodology discussion paper](#)<sup>41</sup> and [2015/16 Tariff engagement document](#),<sup>42</sup> published as part of the engagement process for the 2015/16. It offers greater predictability and clarity for providers and commissioners. In turn, that should allow for better planning and, ultimately, better outcomes for patients.

154. The framework we have developed consists of three elements:

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<sup>41</sup> Available at: <https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201516-engagement-documents>

<sup>42</sup> <https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201516-engagement-documents>

- a. discussions with stakeholders
- b. econometric modelling and a review of relevant literature
- c. assessing the impact of the efficiency factors using financial modelling.

155. Evidence and input from these elements were then brought together and considered alongside our statutory duties to reach a view on the appropriate level of efficiency required to be delivered in 2016/17.

156. For 2015/16, Monitor proposed an efficiency factor of 3.8%. This would have meant that, all other things being equal, costs, and therefore prices, would be 3.8% lower in 2015/16 than they were in 2014/15. For the purposes of prices adopted under the ETO, this efficiency factor was revised to 3.5%. As the 2016/17 NTPS is published before the end of the 2015/16 financial year, it is not possible for us to set a final figure for the level of efficiency achieved in 2015/16, but our latest estimate is that it could be in the region of 1.4%.

### *Decision*

157. As noted, setting the efficiency factor requires us to exercise a significant degree of judgment. In doing this, we considered evidence from an independent study we commissioned<sup>43</sup> to provide an evidence base for our decision. We interpreted this evidence as revealing that, based on historical performance, the sector can achieve 1.2 to 2.5% efficiency in an average year. The feedback that we received from the sector on the 2015/16 national tariff consultation and from the adjustment workshop<sup>44</sup> supports this. Taking these and other relevant factors into account, we have set the efficiency factor for 2016/17 at 2%. While this is lower than has been the case in recent years, we consider that it is a challenging but fair level.

## **4.4. Manual adjustments**

158. The 2013/14 DH PbR method involved making a number of manual adjustments to the modelled tariff. This was done to minimise the risk of setting implausible tariffs (tariffs that have illogical relativities) based upon reference cost data of variable quality. Manual adjustments were also part of the proposed methodology for the 2015/16 NTPS: these are explained in detail in Annex 5d

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<sup>43</sup> See the independent research paper on the NHS National Tariff Payment System 2015/16: engagement documents, [www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201516-engagement-documents](http://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201516-engagement-documents)

<sup>44</sup> More detail on this can be found in Section 4 of part A of the 2016/17 statutory consultation notice. <https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201617-a-consultation>

through Annex 5k of the 2015/16 statutory consultation notice<sup>45</sup>. This approach has been adopted in the 2016/17 NTPS.

159. The manual adjustments we have made fall into three categories:

- a. bariatric surgery
- b. endoscopy procedures, including wireless endoscopy
- c. some other adjustments to individual prices.

160. We have published details of all the manual adjustments in the table below.

**Table 9: Manual adjustments made to 2016/17 national prices**

HRG name	Adjustment made	Rationale	Implementation rule
FZ84Z, FZ85Z – Bariatric Surgery Prices	Increase the price for Bariatric surgery.	Ensure that the price covers the cost of the service	FZ84Z and FZ85Z price adjusted upwards
FZ42A, FZ42B – Wireless Capsule Endoscopy	Set price in outpatient procedure setting.	Ensure this is consistent with previous tariffs, to enable appropriate reimbursement for this service and for it to be delivered in an appropriate setting.	Set FZ42A and FZ42B to the DC/EL price for FZ42B in all settings
JC20Z, EA47Z and EA45Z – Some cardiology tests and skin therapy	Equalise the price between outpatient procedure and day case / elective setting.	The price for the outpatient procedure was illogical, as it was lower than the day case/elective price.	The OPROC prices are less than the DC/EL price, against policy intent. Set JC20Z, EA47Z and EA45Z DC/EL to same as OPROC price
FZ50Z, FZ51Z, FZ52Z, FZ54Z, FZ55Z, FZ57Z, FZ59Z, FZ60Z, FZ61Z – Various Endoscopy	Set the same price across day case, elective and outpatient procedures	For consistency with historic tariffs, and as the procedure can be carried out in any setting without differential costs.	Endoscopy prices are not setting independent, against policy intent. Set OPROC price equal to the DC/EL price for all these HRGs
RA69Z	Set the price of RA69Z to £203 with the cost of reporting set to £20	Feedback from the expert working group suggested that this should be set at £203	Set the price of RA69Z to £203 with the cost of reporting set to £20
HA11C	Price difference	The difference was due	Set HA11c base price

<sup>45</sup> Available at: <https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice>

HRG name	Adjustment made	Rationale	Implementation rule
	between BPT and base tariff to equal the additional payment	to rounding	to 2015/16 ETO price minus £0.50.

## 5. National variations to national prices

162. In some circumstances, it is appropriate to make national adjustments to national prices. For example, adjustments may reflect certain features of cost that the formulation of national prices has not taken into account, or share risk more appropriately among parties.
163. We refer to these nationally determined adjustments as ‘national variations’ to national prices. We refer to the price, after application of national variations, as the ‘nationally determined price’.
164. Specifically, each national variation aims to achieve one of the following:
- a. improve the extent to which the actual prices paid reflect location-specific costs
  - b. improve the extent to which the actual prices paid reflect the complexity of patient need
  - c. provide incentives for sharing the responsibility for preventing avoidable unplanned hospital stays
  - d. share the financial risk appropriately following (or during) a move to new payment approaches.
165. This section sets out the national variations specified in the 2016/17 NTPS.
166. The national variations for 2016/17 have changed from those set out in the 2014/15 NTPS in a number of areas:
- a. Marginal rate emergency rule – activity above the agreed baseline value will be reimbursed at 70 per cent of the standard tariff.
  - b. The removal of the variations introduced to support the transition to new payment approaches for maternity care, diagnostic imaging in an outpatient setting, chemotherapy delivery and external-beam radiotherapy. We have removed these variations on the basis that the sector has had sufficient time to adapt to the new payment arrangements.
167. National variations form one important part of an overarching framework, and sit alongside local variations and local modifications. Providers and commissioners should note that:
- a. National variations only apply to services with a national price.
  - b. If a commissioner and a provider choose to bundle services that have a mix of national prices and locally determined prices, national variations need not be applied. Instead the rules for local variations apply (see Subsection 6.2).

- c. In the case of an application or agreement for a local modification (see Section 6.3), the analysis must reflect all national variations that could alter the price payable for a service (ie it is the price after any national variations have been applied that should be compared with a provider's costs).
- d. Where a new service is commissioned that does not have a national price, rules for local price-setting apply (see Section 6.4).

168. The rest of this section covers four types of national variation to national prices:

- a. variations to reflect regional cost differences
- b. variations to reflect patient complexity
- c. variations to help prevent avoidable hospital stays
- d. variations to support transition to new payment approaches.

### 5.1. Variations to reflect regional cost differences: the market forces factor

169. National prices are calculated on the basis of average costs and do not take into account some features of cost that are likely to vary across the country. The purpose of the market forces factor (MFF) is to compensate providers for the cost differences of providing healthcare in different parts of the country. Many of these cost differences are driven by geographical variation in land, labour and building costs, which cannot be avoided by NHS providers, and therefore a variation to a single national price is needed.

170. The MFF takes the form of an index. This allows a provider's location-specific costs to be compared with every other organisation. The index, by construction, always has a minimum value of 1.00. The MFF payment index operates as a multiplier to each unit of activity. The example below explains how this works in practice.

A patient attends an NHS trust for a first outpatient attendance, which has a national price of £168.

The NHS trust has an MFF payment index value of 1.0461.

The income that the trust receives from the commissioner for this outpatient attendance is £176 (£168 x 1.0461).

171. Further information on the calculation and application of the MFF is provided in the supporting guidance document *A guide to the market forces factor*.

172. The 2014/15 MFF indices remain unchanged for 2016/17, except in cases where organisations have merged or are merging or are undergoing some other



organisational restructuring (such as dissolution). The 2016/17 MFF index values for each NHS provider can be found in Annex A.

173. Independent sector providers should adopt the MFF of the NHS trust or NHS foundation trust nearest to the location where the services are being provided.
174. Organisations merging or undergoing other organisational restructuring after 31 March 2016 will not have a new MFF set in-year; any MFF change will be calculated and should apply from 1 April 2017. Providers should notify Monitor by email ([pricing@monitor.gov.uk](mailto:pricing@monitor.gov.uk)) of any planned changes that might affect the MFF index that we have not identified above.

## 5.2. Variations to reflect patient complexity: top-up payments

175. National prices in this national tariff are calculated on the basis of average costs. They do not therefore take into account cost differences between providers that arise because some providers serve patients with more complex needs. The purpose of top-up payments for some specialised services is to recognise these cost differences and to improve the extent to which prices paid reflect the actual costs of providing healthcare, when this is not sufficiently differentiated in the Healthcare Resource Group (HRG) design. Only a small number of providers are commissioned to provide such care.
176. Specialised service top-ups have been part of the payment system since 2005/06. The current list of qualifying specialised services, and the design and calculation of specialised top-ups for these services, is informed by research undertaken in 2011 by the Centre for Health Economics (CHE) at the University of York.<sup>46</sup>
177. The levels and coverage of top-up payments for 2016/17 are the same as for 2014/15. These are set out in Table 10 along with the relevant specialised service code flag. With the exception of specialised orthopaedic services, eligibility for top-up payments is limited to specified providers.

**Table 10: Top-ups for specialised services**

	Top-up	Codes with SSC flags	Eligible provider only
Children – high	64%	93	Yes
Children – low	44%	91	Yes
Neurosciences	28%	8	Yes
Orthopaedic	24%	34	No
Spinal surgery	32%	6	Yes

SSC= specialised service code

<sup>46</sup> Estimating the costs of specialised care and Estimating the Costs of Specialised Care: Updated Analysis Using Data for 2009/10.

178. Annex A lists those providers eligible for specialised service top-ups. This list has not changed from that in the 2014/15 national tariff. Annex A also lists the top-up trigger codes.

### 5.3. Variations to help prevent avoidable hospital stays

#### 5.3.1. Marginal rate emergency rule

179. The marginal rate emergency rule was introduced in 2010/11 in response to a growth in emergency admissions in England that could not be explained by population growth and A&E attendance growth alone.<sup>47</sup> This growth in emergency admissions was made up primarily of emergency spells lasting less than 48 hours.

180. The purpose of the marginal rate rule is twofold. It is intended to incentivise:

- a. lower rates of emergency admissions
- b. acute providers to work with other parties in the local health economy to reduce the demand for emergency care.

181. The marginal rate rule sets a baseline monetary value (specified in GBP) for emergency admissions at a provider.<sup>48</sup> A provider is then paid a percentage of the national price for any increases in the value of emergency admissions above this baseline. Further guidance for commissioners on investing retained funds can be found [here](#).<sup>49</sup>

182. While the original design of the marginal rate rule set a national baseline expectation, our review of the policy in 2014/15 identified that in some localities, change is needed to ensure the policy works more effectively. For example, where there have been major changes to the pattern of emergency care in a local health economy, or where there has been insufficient progress towards demand management and discharge management schemes. In 2014/15 we therefore updated the marginal rate rule to:

- a. require baseline adjustment where necessary to account for significant changes in the pattern of emergency admissions faced by providers in some localities

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<sup>47</sup> Over 70% of emergency admissions are patients who are admitted following an attendance at A&E.

<sup>48</sup> As defined in the [NHS Data Model and Dictionary](#). These codes are: 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented CDS 6.2).

<sup>49</sup> <https://www.gov.uk/government/publications/nhs-national-tariff-payment-system-201617-a-consultation-supporting-documents>

- b. ensure retained funds from the application of the rule are invested transparently and effectively in appropriate demand management and improved discharge schemes.

183. The rule for 2016/17 continues to include the changes to local baseline setting and reinvestment transparency introduced in 2014/15, but also includes one further change – the marginal rate to be applied is 70%, not 30%.

184. This change is being made in recognition of the efforts that providers have made to manage the pressures of rising numbers of emergency admissions and also seeks to address some of the financial challenges for smaller providers where emergency admissions are a significant share of their activity.

185. The 2014/15 changes to baseline setting and reinvestment transparency are discussed, in turn, below.

#### *Setting and adjusting the baseline*

186. A provider's total baseline value must be assessed as the value of all emergency admissions at the provider in 2008/09 according to current 2016/17 national tariff prices.<sup>50</sup> A contract baseline value must be calculated for each contractual relationship.

187. We recognise that changes to HRGs since 2008/09 and the introduction of BPTs<sup>51</sup> cause difficulties in setting baseline values. Therefore, we expect providers and commissioners to take a pragmatic approach in agreeing a baseline value, for example, by applying an uplift to a previously agreed baseline to reflect average changes in price levels.

188. We know that some providers have seen material changes to the volume and value of emergency admissions. Where changes to admission volumes and values result from changes in the local health economy, adjustments to the baseline value continue to be necessary for 2016/17. Examples of relevant changes to consider include:

- a. a service reconfiguration at a nearby hospital
- b. a change in the local population because of a newly built housing development or retirement community

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<sup>50</sup> Some emergency activity is excluded from the marginal rate rule and should not be included in the calculation of baseline values, including: activity which does not have a national price, non-contract activity, activity covered by BPTs (with the exception of the BPT that promotes same-day emergency care), A&E attendances, outpatient appointments, and contracts with commissioners falling within responsibility of devolved administrations.

<sup>51</sup> Activity reimbursed by BPTs is not subject to the marginal rate, with the exception of the BPT for same-day emergency care.

- c. a change in the relative market shares of local acute providers, where an increase in admissions at one provider is offset by a decrease at another.

189. Making local adjustments may therefore be necessary to ensure a balance between maintaining the positive incentives to manage demand and ensuring providers receive sufficient income to provide safe and sustainable emergency care. Baseline values must therefore be set according to 2008/09 activity levels, but where a provider requests a review of the baseline, a joint review must be undertaken involving both the provider(s) and the commissioner(s). Following a review, baseline adjustments must be made where there have been material changes in the patterns of demand for or supply of emergency care in a local health economy, or when material changes are planned for 2016/17.
190. Baseline values (specified in £s) should then be updated to account for material changes that the affected provider cannot directly control. For example, a change in demand at a provider resulting from a reduction of a nearby hospital's A&E department opening hours will be considered a change outside the control of the provider and hence may require an adjustment to the baseline. On the other hand, changes in the number of admissions that result from a reduction in consultant presence in the A&E department will not necessitate an adjustment to the baseline.
191. When assessing supply and demand for emergency admissions, commissioners should consider the factors set out in Table 11.

**Table 11: Examples of where adjustments to baseline values may be required**

Driver of change	Reason for change	Adjustment necessary?
Change in demand for admissions at a provider	Movement of demand between acute providers, resulting in altered market shares	Yes, if material and off-setting between providers
	Movement of demand between out-of-hospital care and acute care, or between secondary and tertiary providers	Yes, where it reflects a change in commissioning patterns <sup>52</sup>
	Change in total demand in the locality due to demographics	Yes, if exceptional and demonstrable
Changes in the provision of	Changes in clinical threshold for admissions for certain procedures, for	No, unless this reflects a change in

<sup>52</sup> We expect commissioning patterns to reflect best clinical practice, including where this results in the decommissioning of any out-of-hospital activity (eg closure of a walk-in centre) or a change in the arrangements of emergency after-care for post-discharge complications by tertiary providers (eg of cancer patients).

Driver of change	Reason for change	Adjustment necessary?
emergency services at a provider	example due to increased risk-aversion in clinical assessment in A&E <sup>53</sup>	commissioning patterns
	Changes in the emergency services commissioned by CCGs (eg designation as trauma centre or hyperacute stroke unit)	Yes, if material
	Changes in the method for coding or counting emergency admissions	Yes, recalculate 2008/09 activity according to new method

192. When calculating baseline values, both increases and decreases in the value of activity should be considered equally according to the criteria in Table 11.
193. Where emergency activity moves from one provider to another in a local health economy (for example, due to service reconfiguration, changing market share or changes in commissioning patterns), the baseline of each provider should be adjusted symmetrically so that, as far as possible, the sum of their baseline values remains constant, all other things being equal.
194. The agreed baseline value (specified in £s) must be explicitly stated in 2016/17 NHS Standard Contracts and in the plans that set out how retained funds are to be invested in managing demand for emergency care. A rationale for the baseline value should also be set out clearly, along with the evidence used to support agreement, for example the support from their local system resilience group.
195. Acute providers or other parties in the local health economy should raise any concerns about baseline agreements with NHS England, through its local offices. Where local consensus cannot be reached, the local NHS England office will provide mediation, in the context of NHS England's CCG assurance role, to ensure CCG plans are consistent with this guidance. Where necessary, Monitor and NHS England will consider enforcing the rules set out in this guidance through their enforcement powers. Where the local NHS England office is the commissioner, the NHS England regional team will provide mediation. In all cases, Monitor must be notified (via [pricing@monitor.gov.uk](mailto:pricing@monitor.gov.uk)) where concerns have been raised, and whether (and how) plans were changed as a result.

<sup>53</sup> We recognise that establishing a definitive change to clinical practice may be difficult. We suggest that providers and commissioners examine available data, for example any trends in the casemix or age-adjusted conversion rate, admissions patterns by time of day, or changes to staffing levels or patterns (eg use of locums, consultant cover for A&E). Clinical audits and/or insight from the local system resilience group may also help facilitate agreement.

### *Application of the rule*

196. The marginal rate rule is applied individually to each contractual relationship. It is applied to any contract where the value of emergency admissions has increased above the baseline value for that contract.
197. Some providers may have seen an overall reduction in their emergency admissions against their baseline value; this reflects a reduction in admissions in some contracts that is offset by small increases in admissions in other contracts. Such small increases may be due to annual fluctuations in admission numbers over which the provider has limited control. Therefore, small contracts<sup>54</sup> are not subject to the marginal rate rule, provided that the overall value of emergency admissions at the provider has decreased relative to their overall baseline value across all of their contracts.
198. The marginal rate should be applied to the value of a provider's emergency admissions after the application of any other national adjustments for MFF, short-stay emergency spells, long-stay payments, or specialised service top-ups. Where more than one commissioner is involved in a particular contractual relationship, arrangements should be agreed locally according to the payment flows to each commissioner set out in the contract.
199. The marginal rate does not apply to:
- a. activity which does not have a national price
  - b. non-contract activity
  - c. activity covered by BPTs, with the exception of the BPT that promotes same-day emergency care<sup>55</sup>
  - d. A&E attendances
  - e. outpatient appointments
  - f. contracts with commissioners falling within responsibility of devolved administrations.

### **5.3.2. Emergency readmissions within 30 days**

200. To provide the most suitable care for patients when they leave hospital, providers need to have robust discharge planning arrangements in place.

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<sup>54</sup> A small contract is one where the baseline value is less than 5% of the provider's total baseline value across all contracts.

<sup>55</sup> The marginal rate policy will apply to activity covered by the BPT for same-day emergency care only. Although the BPT is designed to encourage providers to care more quickly for patients who would otherwise have had longer stays in hospital, it may also create an incentive for providers to admit patients for short stays who would otherwise not have been admitted.

Planning may include co-ordinating with the patient's family and GP regarding medication or arranging post-discharge equipment, rehabilitation or reablement with a community or social care provider.

201. The 30-day readmission rule was introduced in 2011/12 in response to a significant increase in the number of emergency readmissions over the previous decade. The rule provides an incentive for hospitals to reduce avoidable unplanned emergency readmissions within 30 days of discharge. Hospitals may reduce the number of avoidable emergency readmissions by investing in, for example, better discharge planning, more collaborative working and better co-ordination of clinical intervention with community and social care providers.
202. We are retaining this national variation for 2016/17. The rest of this section defines an emergency readmission for the purpose of the readmission rule and sets out how the rule should be applied. Further guidance for commissioners on investing retained funds can be found [here](#).<sup>56</sup>

#### *Definition of an emergency readmission*

203. The definition of an emergency readmission is any readmission that:<sup>57</sup>

- a. happens up to 30 days from discharge from initial admission
- b. has an emergency admission method code<sup>58</sup>
- c. has a national price.

204. For 2016/17 there will continue to be exclusions from this policy that apply to emergency readmissions following both elective and non-elective admissions. These exclusions were informed by clinical advice on scenarios in which it would not be fair or appropriate for payment to be withheld. Commissioners should continue to reimburse providers for readmitted patients when any of these exclusions apply. The excluded readmissions are:

- a. any that do not have a national price
- b. maternity and childbirth<sup>59</sup>
- c. cancer, chemotherapy and radiotherapy<sup>60</sup>

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<sup>56</sup> <https://www.gov.uk/government/publications/nhs-national-tariff-payment-system-201617-a-consultation-supporting-documents>

<sup>57</sup> That is, any readmission irrespective of whether the initial admission has a national price, is to the same provider or is non-contract activity and irrespective of whether the initial admission or the readmission occurs in the NHS or independent sector.

<sup>58</sup> As defined in the [NHS Data Model and Dictionary](#).

<sup>59</sup> Where the initial admission or readmission is in HRG subchapter NZ (obstetric medicine).

- d. patients receiving renal dialysis
- e. patients readmitted after an organ transplant
- f. young children (under four years old at the time of readmission)
- g. patients who are readmitted having self-discharged against clinical advice<sup>61</sup>
- h. emergency transfers of an admitted patient from another provider, where the admission at the transferring provider was an initial admission<sup>62</sup>
- i. cross-border activity – where the initial admission or readmission is in Northern Ireland, Scotland or Wales.

### *Application of the rule*

205. To implement the 30-day emergency readmission rule, providers and commissioners must:

- a. undertake a clinical review of a sample of readmissions. Providers and commissioners are not required to undertake a clinical review for 2016/17 where there continues to be local agreement on the readmissions threshold.
- b. set an agreed threshold (informed by the clinical review), above which readmissions will not be reimbursed
- c. determine the amount that will not be paid for each readmission above the threshold.

### *Step 1 – clinical review*

206. Acute providers and commissioners must work together to clinically review a sample of readmissions to determine the proportion that could have been avoided. The review team should recognise that some emergency readmissions are, in effect, planned for and therefore should not be considered avoidable unplanned readmissions.<sup>63</sup>

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<sup>60</sup> Where the initial admission or readmission includes a spell first mentioned or primary diagnosis of cancer (ICD-10 codes C00-C97 and D37-D48) or an unbundled HRG in subchapter SB (chemotherapy) or SC (radiotherapy).

<sup>61</sup> Included in discharge method code 2 in the initial admission.

<sup>62</sup> Emergency transfers are coded by admission method code 2B (or 28 for those providers who have not implemented CDS 6.2). Codes 2B and 28 include other means of emergency admission, so providers may wish to adopt additional rules to flag emergency transfers.

<sup>63</sup> For example, following an operation, a patient may be discharged from hospital and, with appropriate care in the community setting and provision of information, this may be the best course



207. The review team must be clinically led and independent, and reviews must be informed by robust evidence. Relevant clinical staff from the provider trust and primary care services must be included as well as representatives from the commissioning body, local primary care providers and social services. Appropriate consideration should be given to information governance with regard to protecting the confidentiality of patient medical records.<sup>64</sup>
208. For each patient in the sample, the review team should decide whether the readmission could have been avoided through actions that might have been taken by the provider, the primary care team, community health services or social services, or a body contracted to any of these organisations.<sup>65</sup>
209. The aim is not to identify poor quality care in hospitals but to identify actions by any appropriate agency that could have prevented the readmission. The analysis should also look at whether there are particular local problems and promote discussion on how services could be improved, who needs to take action, and what investment should be made.

### *Step 2 – setting the threshold*

210. The clinical review (step 1) will inform local agreement of a readmissions threshold, above which the provider will not receive any payment. Separate thresholds can be set for readmissions following elective admissions and readmissions following non-elective admissions.

### *Step 3 – determining the amount not to be paid*

211. The amount that will not be paid for any given readmission above the agreed threshold is the total price associated with the continuous inpatient readmission spell,<sup>66</sup> including any associated unbundled costs, such as critical care or high cost drugs.
212. Where a patient is readmitted to a different provider (from that of initial admission), the second provider must be reimbursed. However, the commissioner will deduct an amount from the first provider.<sup>67</sup>

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of care for that patient even while acknowledging that there is a possibility of an emergency readmission occurring within 30 days of discharge.

<sup>64</sup> Further information can be found on the HSCIC's Information Governance website.

<http://systems.hscic.gov.uk/infogov>

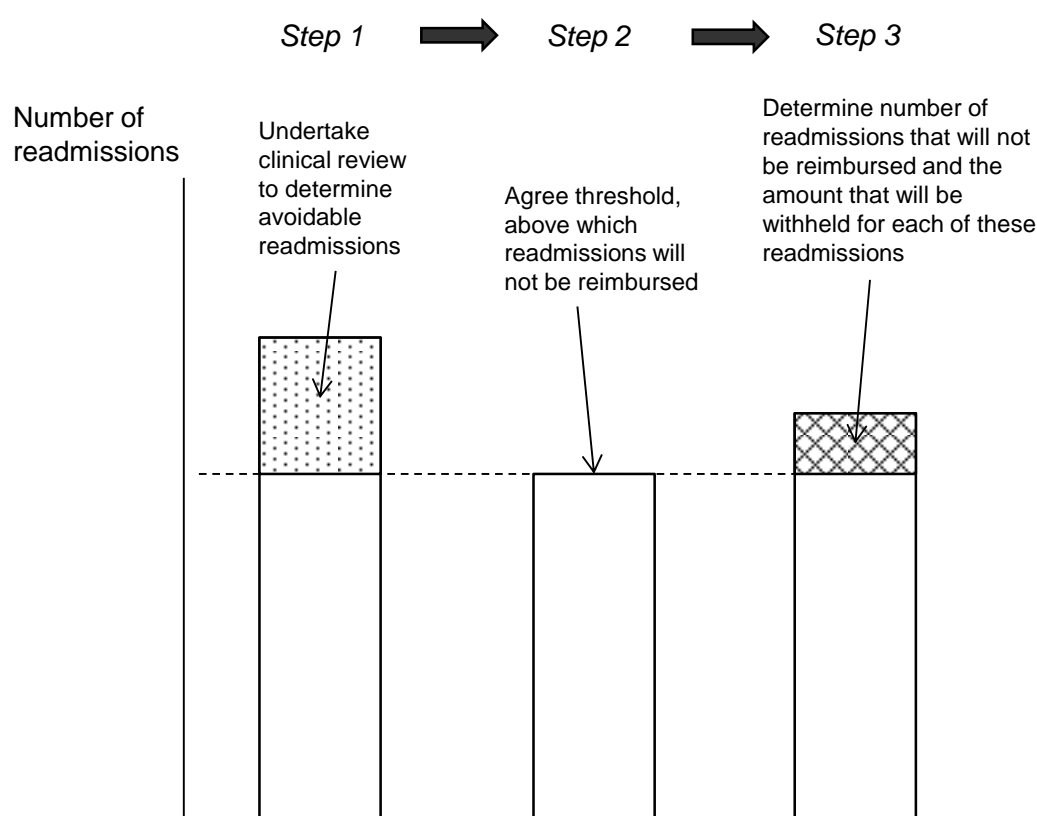
<sup>65</sup> The King's Fund paper [Avoiding hospital admissions – what does the research evidence say?](#) illustrates some examples of interventions which are more likely and less likely to succeed in reducing readmissions.

<sup>66</sup> The spell in this context includes all care between admission and discharge, regardless of any transfers which may take place.

<sup>67</sup> The amount to be deducted from the first provider should be considered as equivalent to what would have been deducted had the patient been readmitted to the first provider, but with the

213. The three steps for implementing the readmission rule are summarised in Figure 3. This illustrates how the clinical reviews inform the proportion of readmissions that could have been avoided; in turn, this informs an agreed threshold above which readmissions will not be reimbursed. Total non-payment is equal to the numbers of readmissions above the threshold multiplied by the price of each readmission.

**Figure 3: Implementing the emergency readmissions rule**



#### 5.4. Variations to support transition to new payment approaches

214. New or changing payment approaches can alter provider income or commissioner expenditure within the financial year in which the new arrangements come into force. For some organisations, the financial impact can be significant and could be difficult to manage in one step. A number of national variations were previously introduced to help mitigate the risk of a potentially destabilising change in income or expenditure caused by new payment approaches. For 2016/17 we are removing three national variations that apply to the payment approaches for:

- a. the maternity pathway currency

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second provider's MFF applied. This also applies where the readmission includes an emergency transfer.

- b. diagnostic imaging in outpatients
- c. chemotherapy delivery and external beam radiotherapy.

215. These national variations no longer apply in 2016/17 because we believe that there has been a sufficient period of time for the sector to adapt to these payment approaches. Commissioners and providers may agree local variations where an alternative payment approach promotes patient interests (see Subsection 7.2).

#### **5.4.1. Best practice tariff for primary hip and knee replacements**

216. Section 4 sets out details of the primary hip and knee replacement BPT introduced in 2014/15 with the aim of promoting improved outcomes for patients.

217. In 2016/17 we will retain the approach adopted in 2014/15 which recognised that there are circumstances in which some providers will be unable to demonstrate that they meet all of the best practice criteria, but where it would be inappropriate not to pay the full BPT price. These circumstances are:

- a. when recent improvements in patient outcomes are not yet reflected in the nationally available data
- b. when providers have identified why they are an outlier on patient reported outcome measures (PROMs) scores and have a credible improvement plan in place, the impact of which is not yet known
- c. when a provider has a particularly complex casemix that is not yet appropriately taken into account in the casemix adjustment in PROMs.

218. Under this national variation, commissioners must pay the full BPT if the provider can show that any of the above circumstances apply. The rationale for using a variation in these three circumstances is explained below.

##### *Recent improvements*

219. Because of the lag between collecting and publishing data, recent improvements in patient outcomes may not show in the latest available data. In these circumstances, providers will need to provide other types of evidence to support a claim that their outcomes have improved since the published data was collected.

##### *Planned improvements*

220. Where providers have identified shortcomings with their service and can show evidence of a credible improvement plan, commissioners must continue to pay

the full BPT. This is necessary to mitigate the risk of deteriorating outcomes among those providers not meeting the payment criteria.

221. In this situation, the variation would be a time-limited agreement. Published data would need to show improvements for reimbursement at the BPT level to continue.

222. There are many factors that may affect patient outcomes, and is for local providers and commissioners to decide how improvements are achieved. However, the following suggestions may be useful for providers and commissioners discussing improvements:

- a. Headline PROMs scores can be broken down into individual domain scores.  
If required, providers can also request access to individual patient scores through the HSCIC. Providers might look at the questions on which they score badly to see why they are an outlier, for example, those relating to pain management.
- b. Individual patient outcomes might also be compared with patient records to check for complications in surgery or comorbidities that may not be accounted for in the formal casemix adjustment. It would also be sensible to check whether patients attended rehabilitation sessions after being discharged from hospital.
- c. Reviewing the surgical techniques and prostheses used against clinical guidelines and National Joint Registry recommendations is another way providers might try to address poor outcomes. As well as improving the surgical procedure itself, scrutinising the whole care pathway can also improve patient outcomes by ensuring that weakness in another area is not affecting the patient outcomes after surgery.
- d. Providers may also choose to collaborate with those providers that have outcomes significantly above average to learn from their service design. Alternatively, providers can consider conducting a clinical audit. This is a quality improvement process that seeks to improve patient care and outcomes through a systemic review of care against expected criteria.

### *Casemix*

223. Providers that have a particularly complex casemix and cannot show they meet the best practice criteria may request that the commissioner continues to pay the full BPT. Although the PROMs results are adjusted for casemix, a small number of providers may face an exceptionally complex casemix that is not fully or appropriately accounted for. These providers will therefore be identified as outliers in the PROMs publications. Commissioners are likely to already be aware of such cases and must agree to pay the full BPT. We anticipate that any

such agreement will only be valid until the casemix adjustment in PROMs better reflects the complexity of the provider's casemix.

## 6. Locally determined prices

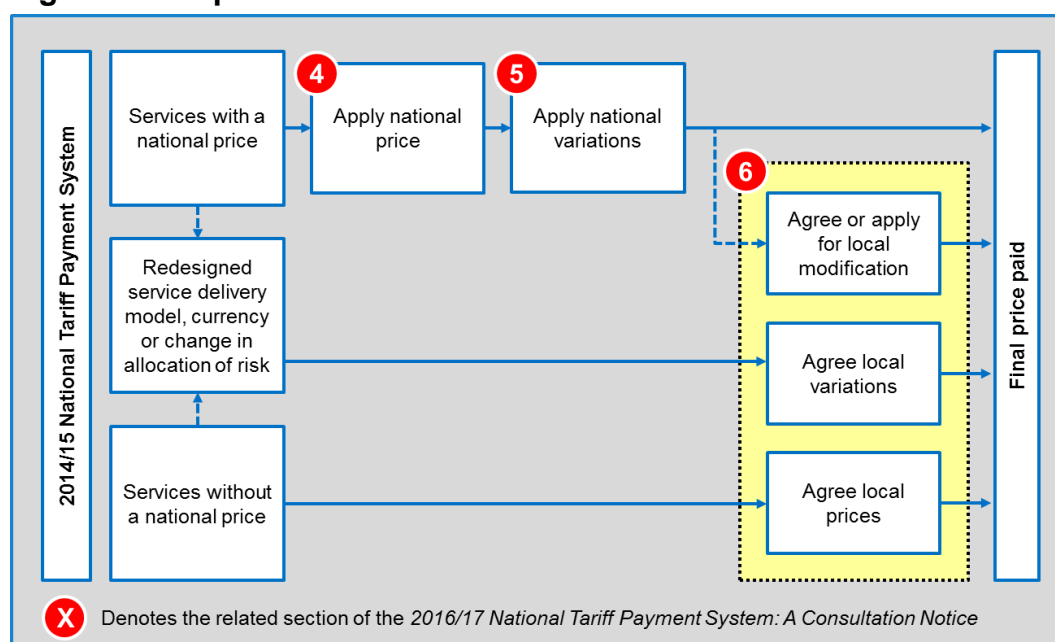
224. Of approximately £70 billion of NHS commissioned activity about half is covered by locally determined prices.

225. National prices can be sometimes be adjusted through local variations or, where they do not adequately reimburse efficient costs because of structural issues, through local modifications.

226. This section sets out the principles that apply to all locally determined prices (Section 6.1). It contains the rules for local variations (Sections 6.2) and the methods used by Monitor to assess local modification agreements and applications (Sections 6.3). In addition it contains rules on local prices (Section 6.4). This Section also contains guidance on the application of the principles, rules and methods set out in this section.<sup>68</sup>

227. The following diagram sets out the scope of Section 6.

**Figure 4: Scope of Section 6 of the national tariff**



228. This section is supported by the following annexes:

- a. Annex A which lists high cost drugs, devices and procedures.
- b. Annex B which provides detail on national currencies for ambulance services as well as nationally specified currencies for acute services with no national price.

<sup>68</sup> Commissioners have a duty to have regard to such guidance – 2012 Act, section 116(7).

- c. Annex D, the technical guide for mental health clusters.

229. It is also supported by the following documents:

- a. *Guidance on locally determined prices for 2016/17* which is supported by:
  - i. The local variations template (relevant to section 6.2)
  - ii. The local modifications template and worked example (relevant to section 6.3)
  - iii. The local prices template (relevant to section 6.4).

### Summary of locally determined prices

**Local variations** are adjustments to a national price or a currency for a nationally priced service, agreed by a commissioner(s) and the provider(s) of that service. The intention is to give commissioners and providers an opportunity to innovate in the design and provision of services for patients (see Section 6.2).

Under the 2012 Act local variations to a nationally determined price or currency must follow the rules set out in this section.

**Local modifications** are adjustments to national prices. All local modifications must be agreed by Monitor. The intention is to ensure that healthcare services can be delivered where they are required by commissioners for patients if the nationally determined price for those services would otherwise be uneconomic (see Section 6.3). There are two types of local modifications:

- Agreements are where a provider and one or more commissioner agree a proposed increase to a national price for a specific service and apply to Monitor for the increase (see Section 6.3.3).
- Applications are where a provider is unable to agree an increase to a national price with one or more commissioner and instead applies to Monitor for an increase to that price (see Section 6.3.4).

Note that the methods applicable to local modifications are distinct from the rules relating to local variations.

**Local prices** apply to services that do not have a national price. Some of these services may have nationally specified currencies, but others do not (see Section 6.4).

### 6.1. Principles applying to all local variations, local modifications and local prices

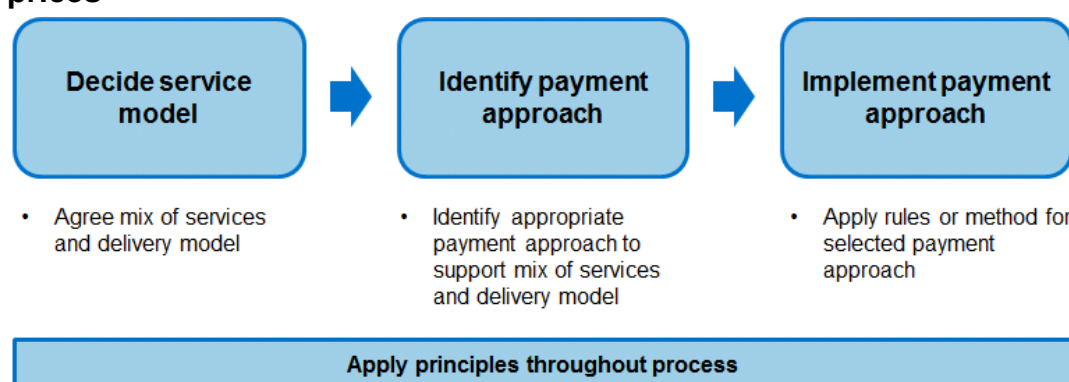
230. Commissioners and providers should apply the following principles when agreeing a local payment approach:

- a. the approach must be in the **best interests of patients**
- b. the approach must **promote transparency** to improve accountability and encourage the sharing of best practice, and
- c. the provider and commissioner(s) must **engage constructively** with each other when trying to agree local payment approaches.

231. These principles are explained in more detail in Sections 6.1.1 to 6.1.3 and are additional to other legal obligations on commissioners and providers. These include other rules set out in the national tariff, and the requirements of competition law, regulations under section 75 of the 2012 Act,<sup>69</sup> and Monitor's provider licence.

232. The principles should be applied throughout the process of agreeing all local variations, local modifications or local prices. Figure 5 summarises the process.

**Figure 5: Process for agreeing local variations, local modifications and local prices**



### 6.1.1. Best interests of patients

233. Local variations, modifications and prices should support a mix of services and delivery models that are in the best interest of patients today and in the future. This means that in agreeing a locally determined price commissioners and providers should consider:

- a. **quality** – how will the agreement maintain or improve the outcomes, patient experience and safety of health care today and in the future?
- b. **cost effectiveness** – how will the agreement make health care more cost effective, without reducing quality, to enable the most effective use of scarce resources for patients today and in the future?

<sup>69</sup> See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (S.I. 2013/500).



- c. **innovation** – how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interests of patients today and in the future?
- d. **allocation of risk** – Will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

### 6.1.2. Transparency

234. Local variations, modifications and prices should be transparent. Increased transparency will make commissioners and providers more accountable to each other, patients, the general public and other interested stakeholders. Transparent agreements also mean that examples of best practice and innovation in service delivery models or payment approaches can be shared more widely. Commissioners and providers should therefore consider:

- a. **accountability** – how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the general public and other stakeholders?
- b. **sharing best practice** – how will innovations in service delivery or payment approaches be shared in a way that spreads best practice.

### 6.1.3. Constructive engagement

235. Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that delivers the best value for patients in their local area. This process should involve clinicians, patient groups and other stakeholders. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time, as constructive engagement is intended to support better and more informed decision-making in both the short and long term. Commissioners and providers should therefore consider:

- a. **framework for negotiations** – have the parties agreed a framework for negotiating local variations, modifications and prices that is consistent with the existing guidelines in the NHS Standard Contract?<sup>70</sup>
- b. **information sharing** – are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?

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<sup>70</sup> The NHS Standard Contract is used by commissioners of health care services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models.

- c. **involvement of clinicians and other stakeholders** – are clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
- d. **short-term and long-term objectives** – are there clearly defined short and long-term strategic objectives for service improvement and delivery agreed before starting price negotiations?

236. Guidance on constructive engagement is set out in the supporting document *Guidance on locally determined prices for 2016/17*.

## 6.2. Local variations

237. Local variations are adjustments to a national price<sup>71</sup> or a currency for a nationally priced service, agreed by a commissioner and provider(s). The intention is to give commissioners and providers an opportunity to innovate in the design and provision of services for patients. For example, allowing them:

- a. to offer innovative clinical treatments, deliver integrated care pathways or deliver care in new settings
- b. to bundle or unbundle existing national currencies to design a new service
- c. to design a new integrated service that combines service elements with national and local currencies
- d. to support wide-scale reconfiguration and integration of primary, secondary and social care services with payment aligned to patient outcomes.
- e. to amend nationally specified currencies or prices to reflect significant differences in casemix compared with the national average
- f. to share contracting risks and gains between commissioners and providers to incentivise better care for patients.

238. However, it is not appropriate for local variations to be used to introduce price competition that could create risks to the safety or the quality of care for patients. Further information on the use of local variations is set out in the supporting document *Guidance on locally determined prices for 2016/17*.

### 6.2.1. Required process for agreeing local variations

239. Local variations can be agreed between one or more commissioners and one or more providers. Local variations only have effect for the services specified in the agreement, and for the parties to that agreement. We encourage agreements by multiple commissioners, or a lead commissioner acting on behalf of multiple

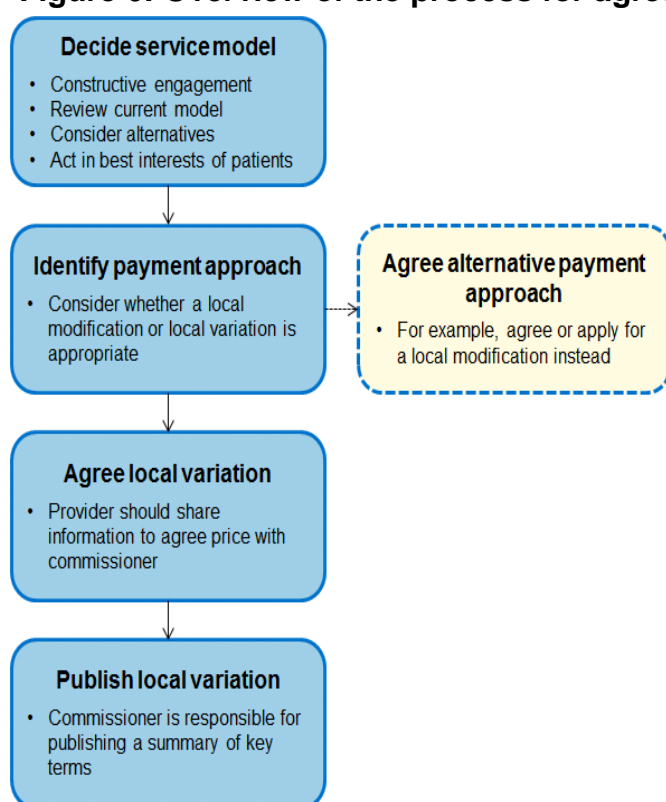
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<sup>71</sup> Local variations are covered by sections 116(2), 116(3) and 118(4) of the 2012 Act.

commissioners, and multiple providers acting to provide integrated care services that benefit patients. A local variation can be agreed for more than one year, although the duration must not be longer than the duration of the relevant contract. Each variation applies to an individual service with a national price (i.e. an individual HRG). However, commissioners and providers can enter into agreements which cover multiple variations to a number of related services.

240. To agree a local variation, commissioners and providers must apply the principles set out in Subsection 6.1 when deciding an appropriate service model and payment approach. The process for agreeing a local variation is summarised in Figure 6 below

**Figure 6: Overview of the process for agreeing local variations**



## 6.2.2. Rules for local variations

241. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.<sup>72</sup>

<sup>72</sup> The rules in this section are made pursuant to the 2012 Act, section 116(2).

## Rules for local variations

1. The commissioner and provider must apply the principles set out in section 6.1 when agreeing a local variation.
2. The local variation must be documented in the commissioning contract between the commissioner and provider for the service to which the variation relates.<sup>73</sup>
3. The commissioner must use the summary template provided by Monitor when preparing the written statement of the local variation, which must be published as required by the 2012 Act.<sup>74</sup>
4. The commissioner must also submit a written statement of the local variation (using the local variation template) to Monitor. The deadline for submitting the statement is 30 June 2016. For local variations that are agreed after this date, the deadline is 30 days after the agreement.

242. Guidance for complying with Rules 2 to 4 is contained in section 6.2.4.

243. Monitor may take enforcement action in cases of non-compliance with these rules.<sup>75</sup> We may also request further information about any local variation from commissioners and providers. This information can be required under Monitor's statutory powers.<sup>76</sup>

### 6.2.3. Evaluation and sharing of best practice

244. We encourage commissioners and providers to use the Rules set out in this Section as a basis for considering how they can improve the payment system, especially where care is being delivered in a new way. We are interested in learning from commissioners and providers that are implementing new payment approaches to enhance system-wide incentives, for example, to focus on prevention, integration of care, improved outcomes and improved patient experiences. Such payment approaches might include pathway, capitation or outcomes-based payments.

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<sup>73</sup> The NHS Standard Contract is used by commissioners of health care services (other than those commissioned under primary care contracts) and is adaptable for use for a broad range of services and delivery models.

<sup>74</sup> As required by the 2012 Act, section 116(3).

<sup>75</sup> See [Monitor's Enforcement of the National Tariff](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300865/Enforcement_of_the_national_tariff.pdf).  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300865/Enforcement\\_of\\_the\\_national\\_tariff.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300865/Enforcement_of_the_national_tariff.pdf)

<sup>76</sup> Monitor may require NHS England, clinical commissioning groups and providers to provide documents and information which it considers necessary or expedient to have for the purposes of its statutory pricing functions – see the 2012 Act, section 104. In addition, providers that hold a Monitor provider licence must supply information on request in accordance with the licence standard conditions.

245. To determine whether local variations have achieved their desired objectives, and to inform future decision-making, we recommend that commissioners and providers plan to evaluate the success of new payment approaches. We encourage commissioners and providers to share the results of any evaluation processes they complete.
246. These recommendations also apply to local modifications and local price setting.
247. In addition, NHS England and Monitor may conduct evaluations and analysis of agreed approaches for local prices, variations and modifications to identify those that appear to be most successful and most relevant for the development of the payment system.

#### **6.2.4. Publication guidance for local variations**

##### *Commissioners' responsibility for publishing local variations and submitting information to Monitor*

248. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.<sup>77</sup> Commissioners should publish each statement by 30<sup>th</sup> June 2016 or if the variation is agreed after this date, within 30 days of the variation agreement. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.<sup>78</sup> Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.
249. The rules on local variations (see Section 6.2.2) require a commissioner to use Monitor's template when preparing the written statement and to submit that statement to Monitor. Commissioners should refer to the instructions in the guidance on locally determined prices for information on how to submit a statement for publication.
250. NHS England requires commissioners to include their written statement of each local variation in Schedule 3 of their NHS Standard Contracts.

##### *Requirements for completing a written statement*

251. Monitor's requirements for a written statement on a local variation are set out in Monitor's template for local variations.
252. Guidance on local variations is set out in the supporting document *Guidance on locally determined prices for 2016/17*.

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<sup>77</sup> 2012 Act, section 116(3).

<sup>78</sup> 2012 Act, section 116(3)(b).

### 6.3. Local modifications

253. Local modifications are intended to ensure that healthcare services can be delivered where they are required by commissioners for patients, even if the nationally determined price for the services would otherwise be uneconomic.<sup>79</sup> There are two types of local modification:

- a. **Agreements** are where a provider and one or more commissioners agree a proposed increase to a nationally determined price for a specific service (see Section 6.3.3)
- b. **Applications** are where a provider is unable to agree an increase to a nationally determined price with one or more commissioners and instead applies to Monitor to increase that price (see Section 6.3.4)

254. Local modifications differ from local variations in that:

- a. **Local modifications** are subject to approval (in the case of local modification agreements) or grant (in the case of local modification applications) by Monitor.
- b. **Local variations** are not subject to approval or agreement by Monitor but they must comply with the rules outlined in Section 6.2.2.
- c. **Local modifications** can only be used to increase the price for an existing currency or set of currencies.<sup>80</sup>
- d. The methods for determining **local modifications** are distinct from the rules relating to **local variations**.<sup>81</sup>

255. Under the 2012 Act, Monitor is required to publish in the national tariff its methods for deciding whether to approve local modification agreements or grant local modification applications. These are set out in Section 6.3.1 to 6.3.4.

256. Monitor's methods provide that local modifications will be only be approved or granted if they meet specified conditions. For both agreements and applications, Monitor must be satisfied that it would be uneconomic for the provider to provide

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<sup>79</sup> The legislation governing local modifications is set out in the 2012 Act, Part 3, Chapter 4. The legal framework for local modifications is principally described in sections 116, 124, 125 and 126.

<sup>80</sup> Each local modification applies to a single service with a national price (e.g. a HRG). In practice a number of related services may be uneconomic and face similar cost issues. In such case, we would encourage providers and commissioners to submit agreements/applications that cover multiple services where these services face a similar cost issue.

<sup>81</sup> Local variations are covered by sections 116(2) and (3) of the 2012 Act; local modifications are covered by sections 116(1)(d) and 124 to 126.

one or more specific service without a local modification.<sup>82</sup> If Monitor is not satisfied, we will not approve a local modification agreement or grant a local modification application.

257. See Figure 7 for a summary of the principal differences between local modifications and local variations.

**Figure 7: Principal differences between local modifications and local variations**

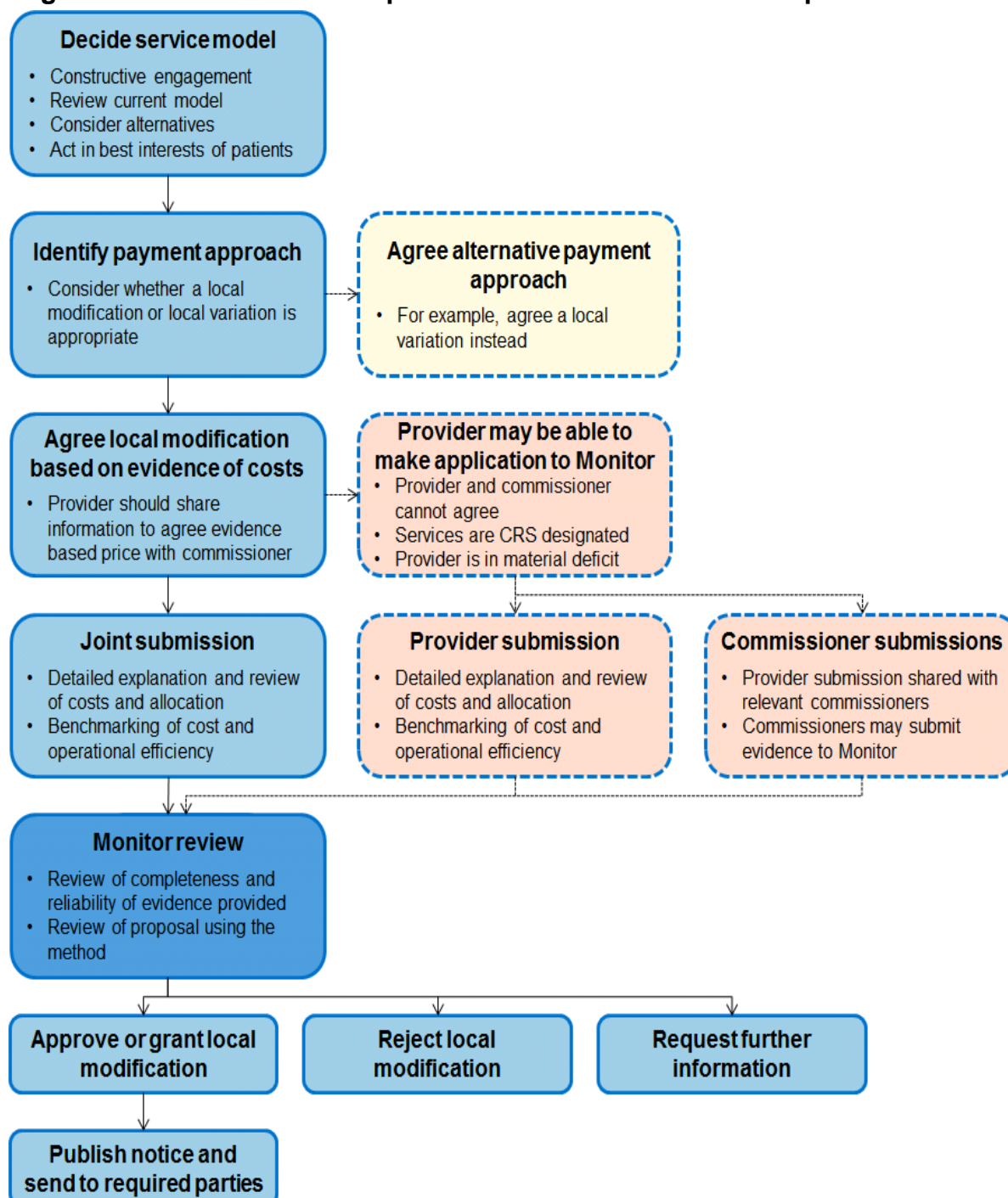
	Policy objective	Criteria	Funding	Examples
Local variations	<b>Driving better value for patients</b> The payment system should support clinical best practice, innovation, service redesign and sustainable reconfiguration	<b>Change in service delivery model or currency</b> Support improvement to the way specific services are delivered or the mix of services that are delivered, including across providers and settings	<b>In-year:</b> Must be agreed by commissioner. Paid out of existing budget	Support innovation in clinical practice
				Redesign or reconfigure services within or across providers
			<b>Long-run:</b> Must be agreed by commissioner. Paid out of existing budget	Improve currency by bundling or unbundling
				Address non-average case mix (simple or complex)
Local modifications	<b>Ensuring specific services are delivered where they are required</b> Services that are required by commissioners should be economically viable for providers to protect quality	<b>Provider faces unavoidable, structurally higher costs for specific services</b> Local modifications should set prices at the cost of delivering services efficiently, given the structurally higher costs	<b>In-year:</b> LM Agreements: must be approved by Monitor LM Applications: must be granted by Monitor	Support specific sub-scale services that are required in a particular location by a commissioner
				Address increased costs due to rural location for specific services
			<b>Long-run:</b> National prices could be adjusted to remove the effect of local modifications	Address more costly case mix due to unavoidable population characteristics

### 6.3.1. Required process for agreeing local modifications

258. Monitor's method requires that commissioners and providers apply the principles set out in Section 6.1, determine whether the services in question are uneconomic and comply with our conditions for agreements and applications, and submit evidence to Monitor to support the proposed local modification. Figure 8 summarises the required process for commissioners and providers.

<sup>82</sup> Sections 124(4) and 125(3) of the 2012 Act, provide that a local modification to the price for a specific service can only be approved or granted by Monitor if Monitor is satisfied that provision of the service at the nationally determined price is uneconomic.

**Figure 8: Local modification process for commissioners and providers**



CRS = commissioner requested service

### 6.3.2. Method for determining whether services are uneconomic

259. The 2012 Act provides that an agreement may be approved or an application granted only if Monitor is satisfied that without the local modification the provision of a service at the nationally determined price would be uneconomic. Under Monitor's method, for a service or group of services to be considered uneconomic for the purposes of a local modification, the provider must demonstrate that:



- a. Its average cost of providing each service is higher than nationally determined price
- b. Its average costs are higher than the nationally determined prices as a result of structural issues that are:
  - i. **specific** – the structurally higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable
  - ii. **identifiable** – the provider must be able to identify how the structural issues it faces affect the cost of the services
  - iii. **non-controllable** – the higher costs should be beyond the direct control of the provider, either currently or in the past<sup>83,84</sup>
  - iv. **not reasonably reflected elsewhere** – the costs should not be adjusted for elsewhere in the calculation of national prices, rules or variations, or reflected in payments made under the Sustainability and Transformation Fund
- c. It is reasonably efficient when measured against an appropriate group of comparable providers, given the structural issues it faces.<sup>85</sup>

260. This means that Monitor will not consider a service to be uneconomic if the average costs of a service or group of services are higher than the nationally determined price as a result of inefficiency that could be reduced without unreasonable risk to the quality of care for patients.<sup>86</sup>

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<sup>83</sup> This means that higher costs as a result of previous investment decisions or antiquated estate are unlikely to be grounds for a local modification. Our method is intended to identify cases where a provider faces higher average costs due to unavoidable structural issues. Previous investment decisions that continue to contribute to high costs for particular services may reflect choices by management that could have been avoided. Similarly, antiquated estate may reflect a lack of investment rather than a structural feature of the local health care economy. In both such cases, we will not normally consider the additional costs to be unavoidable. Our policy intention here is that we do not want local modifications to insulate providers from the consequences of their decision-making, as this could reduce their incentive in future investment decisions to undertake careful consideration of all relevant risks. Other mechanisms exist within the system, including Monitor's continuity of services framework, to protect patients in cases where a provider gets into financial distress.

<sup>84</sup> Monitor considers CNST costs to be controllable and will not consider them to be costs arising from structural issues.

<sup>85</sup> If a provider is not reasonably efficient when measured against an appropriately defined group of comparable providers, it would have to demonstrate that its costs would still be higher than the nationally determined price, even if it were reasonably efficient.

<sup>86</sup> For example, a hospital may be able to reduce the costs of providing services by improving the quality of its management or implementing cost improvement programs. It could also be possible to provide the services required using an alternative service delivery model.

### *Can other cost factors justify a local modification?*

261. Only structurally higher costs which a provider cannot avoid will justify a local modification. Determining whether the provision of a service is uneconomic therefore requires a detailed understanding of why average costs exceed nationally determined prices.<sup>87</sup> It also requires analysis of whether the provider could reduce its costs while still delivering the quality of patient care required.
262. The provider (and, in the case of an agreement, supported by the commissioner) should therefore provide sufficient evidence to enable Monitor to determine whether the service is uneconomic<sup>88</sup>. Where possible, we expect providers to rely on existing information sources, including management and service line reporting. This information should be supported by additional analysis as required. We encourage providers and commissioners to submit evidence that applies to multiple services, in cases where more than one service is affected in the same way by a particular structural issue or issues.
263. Further information on the type of evidence that should be provided is set out in the supporting document *Guidance on locally determined prices for 2016/17*.

### *Conditions for local modification agreements*

264. Under the method for local modification agreements, the following three conditions must be satisfied:
- a. The agreement must specify the services that will be affected, the circumstances or areas in which the modification is to apply, the start date of the local modification and the expected volume of activity for the period of the proposed local modification (which must not exceed the period covered by the national tariff).<sup>89</sup>
  - b. The commissioner and provider must be able to demonstrate that it is uneconomic for the provider to provide the relevant NHS services, based on the criteria set out above

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<sup>87</sup> Our approach to the assessment and allocation of costs for the purpose of costing patient care is set out in Monitor's *Approved Costing Guidance*, published on 12 July 2013. We expect providers and commissioners to have regard to this guidance when preparing supporting evidence for local modifications.

<sup>88</sup> 2012 Act, section 124(4), requires that an agreement submitted to Monitor must be supported by such evidence as Monitor may require.

<sup>89</sup> The start date for a local modification can be earlier than the date of the agreement, but no earlier than the date the national tariff takes effect (as required by the 2012 Act, section 124(2)). We may increase the maximum duration of local modifications in the future as we continue to develop the national tariff.

- c. The commissioner and provider must be able to demonstrate that the proposed modification reflects a reasonably efficient cost, given the structural issues faced by the provider.
265. When an agreement covers modifications to multiple services, there may be differences in the level or structure of each modification. It is also possible to propose a modification that is contingent on the volume of activity. For example, a provider and commissioner could agree a modification which involves a higher price increase at lower volumes of activity, to take into account fixed costs associated with providing certain services.
266. For local modification agreements Monitor requires commissioners and providers to prepare joint submissions. Monitor will then decide whether or not to approve the agreement, using the criteria set out above.
267. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate) once they are agreed between the provider and commissioner. If the terms of a local modification agreement are included in the commissioning contract before the local modification is approved by Monitor, the contract may provide for payment of the modified price pending a decision by Monitor. But if Monitor subsequently decides not to approve the modification, the modification would not have effect and the national price applies. The provider and commissioner must then agree a variation to the commissioning contract to stop the modification, and may agree a mechanism for adjustment and reconciliation in relation to the period before the refusal, or possibly a local variation to the national price.<sup>90</sup>
268. It is important that the cost to providers and commissioners of preparing evidence in support of a local modification agreement does not exceed the expected benefits to patients. As a guideline, we suggest that providers and commissioners should only agree local modifications when the expected increase in revenue for the specified services is greater than £1 million.
269. Monitor may take into account previously agreed local modifications when considering an agreement to extend a local modification, in cases where it can be demonstrated that the underlying issues have not changed.
270. Monitor may also take into account any payment received by a provider under the Sustainability and Transformation Fund when determining the amount of the local modification to be approved.

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<sup>90</sup> Providers and commissioners should refer to the latest available guidance on the NHS Standard Contract. See [guidance on the variations process for the NHS Standard Contract for 2013/14](#).

### 6.3.3. Conditions for local modification applications

271. Local modification applications can only be made when a provider has not reached an agreement on a local modification with its commissioner.<sup>91</sup> Under our method, Monitor will only grant applications in cases where the provider has first engaged constructively with its commissioners to consider alternative service delivery models and, if those alternatives are not appropriate, tried to agree a local modification agreement.<sup>92</sup>
272. If an application for a local modification is successful, Monitor will determine the date from which the modification will take effect. In most cases, applications will be effective from the start of the following financial year, subject to any changes in national prices, to allow commissioning budget allocations to take account of decisions.<sup>93</sup> In addition, Monitor will determine the circumstances or locations in which the modified price is to be payable by all commissioners that purchase the specified services from the provider (subject to any restrictions on the circumstances or areas in which the modification applies).
273. To comply with our method for local modification applications, the applicant provider must:
- a. Specify the services affected by the proposed local modification, the circumstances or locations in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the current financial year
  - b. Demonstrate that it has first engaged constructively with its commissioners to try to agree alternative means of providing the services at the nationally determined price and, if unsuccessful, has engaged constructively to reach a local modification agreement before submitting an application to Monitor<sup>94</sup>
  - e. Demonstrate that the services are **commissioner-requested services** (CRS)<sup>95</sup> or, in the case of NHS trusts or other providers who are not licensed, the provider cannot reasonably cease to provide the services.

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<sup>91</sup> See the 2012 Act, section 125(1).

<sup>92</sup> Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.

<sup>93</sup> In exceptional cases (and in particular where the delay of the local modification would cause unacceptable risk of harm to patients), Monitor will consider making the modification effective from an earlier date.

<sup>94</sup> Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.

<sup>95</sup> See: 'Guidance for commissioners on ensuring the continuity of health care services; 'Designating commissioner requested services and location specific services', 28 March 2013.

- d. Demonstrate that it has a deficit equal to or greater than 4% of revenues at an organisation level in 2015/16 (the previous financial year to an application submitted during 2016/17 for modified prices).
- e. Demonstrate that it is uneconomic for it to provide the services required by its commissioners for the purposes of the NHS at the nationally determined prices, based on the criteria set out in Section 6.3.2.
- f. Propose a modification to the nationally determined prices of the specified services and be able to demonstrate that the proposed modification reflects a reasonably efficient cost of providing the services, given the structural issues faced by the provider
- g. Submit the application to Monitor by 30 September 2016, unless there are exceptional circumstances (for example, where there is a clear and immediate risk to patients).

274. Monitor reserves the right to grant an application, in exceptional circumstances, even if the conditions set out above have not been met.

275. Applications must be supported by sufficient evidence to enable Monitor to determine whether a local modification is appropriate, based on our method. For further guidance see our *Guidance on locally determined prices for 2016/17*.

276. Monitor may also take into account any payment received by a provider under the Sustainability and Transformation Fund when determining the amount of the local modification to be granted.

#### **6.3.4. Publication of local modifications**

277. Promoting transparency is one of the three principles that apply to all local variations, modifications and prices. As required by the 2012 Act, Monitor is required to publish key information on all local modification agreements and applications that are approved.<sup>96</sup> Monitor will also publish key information on local modification agreements and applications that are rejected, unless the circumstances of the case make it inappropriate.

278. The key information published will include:

- a. Whether the local modification is an agreement or application
- b. The name and location of the provider and commissioner or commissioners covered by the local modification

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<sup>96</sup> Monitor is required to send a notice to the Secretary of State for Health and such clinical commissioning groups, providers and other persons as it considers appropriate, which states the modification and the date it takes effect. This notice must be published. See the 2012 Act, Sections 124(6) to (8) and 125(6) to (8).

- c. A list of the services affected and the changes to their prices as a result of the local modification, including the circumstances or services for which the modification applies (or would have applied)
- d. In the case of an approved agreement or granted application, the start date and duration of the local modification
- e. An explanation of the structural issues faced by the provider and why a local modification was proposed
- f. Any other information that Monitor considers relevant.

### **6.3.5. Notifications of significant risk**

279. Under the 2012 Act, if Monitor receives an application from a provider and is satisfied that the continued provision of CRS (by the applicant or any other provider) is being put at significant risk by the configuration of local healthcare services, Monitor is required to notify NHS England and any CCGs it considers appropriate.<sup>97</sup> These bodies must then have regard to the notice from Monitor when deciding on the commissioning of NHS health care.

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<sup>97</sup> 2012 Act, section 126(1) to 126(3).

## 6.4. Local prices

280. For many NHS services there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to set prices for these services. The 2012 Act confers on Monitor the power to set rules for local price-setting of such services, as agreed with NHS England, including rules specifying national currencies for such services.<sup>98</sup> We have set both general rules and rules specific to particular services. There are two types of general rule:

- a. Rules that apply in all cases when a local price is set for services without a national price. These are set out and explained in Section 6.4.1.
- b. Rules that apply only to local price-setting for services with a national currency (but no national price). These are set out and explained in Section 6.4.2.

281. In addition to the general rules, there are rules specific to particular services. These are set out and explained in Section 6.4.3 to 6.4.7.

### 6.4.1. General rules for all services without a national price

282. The following rules apply when providers and commissioners set local prices for services without national prices. The rules apply irrespective of whether or not there is a national currency specified for the service.

#### Local pricing rules: General rules for all services without a national price

**Rule 1:** Providers and commissioners must apply the principles in Section 6.1 when agreeing prices for services without a national price.

**Rule 2:** Commissioners and providers should have regard to the efficiency and cost uplift factors adopted under the ETO for 2015/16 and the efficiency and cost uplift factors for 2016/17 (as set out in Section 4 of this document) when setting local prices for services without a national price for 2016/17.<sup>99</sup>

283. Where prices are determined locally, it is the responsibility of commissioners to negotiate and agree prices having regard to relevant factors, including opportunities for efficiency and the actual costs incurred by their providers. NHS England has now included an adjustment in commissioner allocations to reflect the unavoidable pressures of rurality and sparsity. When adjusting prices

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<sup>98</sup> 2012 Act, section 116(4)(b) and (12) and section 118(5)(b).

<sup>99</sup> The efficiency factor and cost uplift factors under the ETO were -3.5% and 1.9% respectively. This leads to an overall adjustment of -1.6% for 2015/16. For 2016/17, the efficiency factor is 2% and the cost uplift factor is 3.1%. This gives a net increase of 1.1%.

agreed in previous years, commissioners and providers may agree to make price adjustments that differ from the adjustments for national prices where there are good reasons to do so. In addition, commissioners should ensure that local prices are in the best interests of patients, that there is transparency and that they engage constructively when setting local prices, in accordance with the principles set out in Rule 1.

284. These principles apply to both whole year agreements and any adjustments to prices during the course of the year. Monitor will consider taking compliance action, under its enforcement policy, where there is evidence of non-compliance with the rules in this section. For further details see Monitor's guidance on *Enforcement of the National Tariff*.<sup>100</sup>

285. Rule 2 requires commissioners and providers to have regard to national price adjustments. In effect they should be used as a benchmark to inform local negotiations. However, these are not the only factors that should be considered.

286. Relevant factors may include, but are not restricted to:

- a. commissioners agreeing to fund service development improvements
- b. additional costs being incurred as part of service transformation
- c. taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)
- d. comparative information (eg benchmarking) about provider costs and opportunities for efficiency gains
- e. Differences in costs incurred by different types of provider, for example differences in indemnity arrangements (such as contributions to the Clinical Negligence Scheme for Trusts); or other provider specific costs (such as the effects of changes to pensions and changes to the minimum wage)

#### **6.4.2. General rules for services with a national currency but no national price**

287. The following rules apply when providers and commissioners are setting local prices for services for which there is a national currency specified but no national price.

288. Services that have national currencies but no national price are:

- a. Working age and older people **mental health services**

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<sup>100</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300865/Enforcement\\_of\\_the\\_national\\_tariff.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300865/Enforcement_of_the_national_tariff.pdf)



**b. Ambulance services**

**c. The following acute services**

- i. specialist rehabilitation (25 currencies based on patient complexity and provider/service type)
- ii. critical care – adult and neonatal (13 HRG-based currencies)
- iii. HIV adult outpatient services (three currencies based on patient type)
- iv. renal transplantation (nine HRG-based currencies)

### **Local pricing rules: General rules for services with a national currency but no national price**

#### **Rule 3:**

- (a)** Where there is a national currency specified for a service, the national currency must be used as the basis for local price-setting for the services covered by those national currencies, unless an alternative payment approach is agreed in accordance with Rule 4 below.
- (b)** Where a national currency is used as the basis for local price-setting, providers must submit details of the agreed unit prices for those services to Monitor using the standard templates provided by Monitor.
- (c)** The completed templates must be submitted to Monitor by 30 June 2016.
- (d)** The national currencies specified for the purposes of these rules are the currencies specified in Annex B Section 6.4.4 (mental health services) and section 6.4.5 (ambulance services).

#### **Rule 4:**

- (a)** Where there is a national currency specified for a service, but the commissioner and provider of that service wish to move away from using the national currency, the commissioner and provider may agree a price without using the national currency.

When doing so, providers and commissioners must adhere to the requirements (b), (c), (d) and (e) below, which are intended to mirror the requirements for agreeing a local variation for a service with a national price, set out in Section 6.2.

- (b)** The agreement must be documented in the commissioning contract between the commissioner and provider which covers the service in question.
- (c)** The commissioner must maintain and publish a written statement of the agreement, using the template provided by Monitor, within 30 days of the relevant commissioning contract being signed or in the case of an agreement during the term of an existing contract, the date of the agreement.
- (d)** The commissioner must have regard to the guidance in Section 6.2.3 when preparing and updating the written statement.
- (e)** The commissioner must submit the written statement to Monitor.

289. The templates referred to in Rule 3 are published as supporting documents to the 2016/17 National Tariff Payment System. The templates include guidance on completion.

### 6.4.3. Acute services with no national price

290. Where acute services do not have a national price, providers and commissioners are required to set prices locally. For some of those services, the rules specify a national currency which should be used as the basis for setting local prices. For others, there is no nationally specified currency. Both cases are covered in the rules below.

291. In addition, there is a rule relating to high cost drugs, devices and listed procedures that are not reimbursed through national prices.

#### *Acute services without national currencies*

292. In addition to Rules 1 and 2 set out in Section 6.4.1, the following rule applies:

#### **Local pricing rules: Rule for acute services without national currencies**

**Rule 5:** For acute services with no national currencies, the price payable must be determined in accordance with the terms and service specifications set out in locally agreed commissioning contracts.

#### *Acute services with national currencies*

293. The national currencies for acute services without national prices are set out in Section 6.4.2. Currency specifications and the guidance around using these currencies are set out in annex B

#### **Local pricing rules: Rule for acute services with national currencies**

**Rule 6:** Providers and commissioners must use the national currencies specified in Annex B as the basis for structuring payment for acute services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 4 in Section 6.4.2

#### *High-cost drugs, devices and listed procedures*

294. A number of high-cost drugs, devices and listed procedures are not reimbursed through national prices. Instead, they are subject to local pricing in accordance with the rule below. Annex A sets out the updated list of excluded drugs, devices and procedures for the 2016/17 NTPS that are subject to local prices.

## Local pricing rules: Rules for high-cost drugs and listed procedures

### Rule 7:

- (a)** As high-cost drugs, devices and listed procedures are not national currencies, Rules 3 and 4 in section 6.4.2, including the requirement to disclose unit prices, do not apply.
- (b)** Local prices for high-cost drugs, devices or listed procedures must be paid in addition to the relevant national price for the currency covering the core activity. However, the price for the drug, device or procedure must be adjusted to reflect any part of the cost already captured by the national price.
- (c)** The price agreed should reflect the actual cost to the provider or the nominated supply cost, whichever is lower. The “nominated supply cost” is the cost of the device which would be payable by the provider if the device was supplied in accordance with a requirement to use a supplier or intermediary, or via a framework, specified by the commissioner, pursuant to a notice issued under SC 36.50 of the NHS Standard Contract for 2016/17 (nominated supply arrangements).
- (d)** As the price agreed should reflect either the actual cost <sup>101</sup> or the nominated supply cost, the requirement to have regard to efficiency and cost uplift factors detailed in Rule 2 does not apply

295. Specified high-cost drugs, devices and listed procedures are not included in the national prices for one or more of the following reasons:

- a. The treatment or intervention was new and not captured in national prices
- b. The design of the currencies have not yet been developed or adjusted for the use of the treatment or intervention
- c. The treatment or intervention was specialist and carried out by a small number of providers and represents a disproportionate cost.

296. In all cases, their use tends to be disproportionately concentrated in a relatively small number of providers, rather than evenly spread across all providers providing services covered by the relevant currency. As a result of this and their relative high cost, a provider using one of these drugs, devices or procedures more frequently than average could face significant financial disadvantage if they were included in national prices, because the national price would not reflect the specific higher costs faced by the provider.

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<sup>101</sup> Actual cost should reflect the prices paid by the provider less any discounts and rebates which are secured by the provider

297. High-cost drugs, devices and listed procedures meet standard criteria, and we have taken advice from providers, commissioners, the National Institute for Health and Care Excellence (NICE) and other experts to assure which drugs and devices are included on the list.<sup>102</sup> We encourage providers to procure these drugs and devices from suppliers at the most economical price possible. Commissioners may want to incentivise providers to do this by agreeing gain-sharing arrangements with providers.<sup>103</sup>
298. Paragraphs (c) and (d) of the rule deal with the price to be agreed by the commissioner and provider. The price should reflect the lower of the actual cost incurred by the provider, or the cost which would be payable by a provider if they had used a supply or procurement framework nominated by the commissioner under the relevant provision of the NHS Standard Contract. This is a new provision to support the national arrangements for procurement of devices, under which prices may be set by national arrangements rather than local agreements. The commissioner can require the provider to use the national arrangement, and under Rule 7 would only be required to reimburse the applicable price, not any higher price agreed by the provider outside those arrangements. In accordance with the Standard Contract a commissioner must give reasonable notice, and in deciding whether to impose such a requirement must have regard to the terms of any existing supply arrangement entered into prior to 1 October 2015 pursuant to a lawful procurement process.

#### **6.4.4. Mental health services**

299. All locally agreed payment arrangements for mental health care must use care clusters to set local prices in 2016/17, unless an alternative payment approach (for example capitation) better meets patient needs. Rollover of historic and poorly specified contracts that are not based on robust and up to date data and evidence are not acceptable.
300. The local payment rules permit providers and commissioners to implement the episodic/year of care or capitated payment approaches in 2016/17(Rule 4). The rules also promote the building blocks relating to robust data collection and use, which are needed to inform evidence-based, patient centred care. Where able, we encourage all sites to implement or shadow our proposed payment approach for 2017/18 during 2016/17.

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<sup>102</sup> Further information about high-cost drugs, devices and procedures may be found online via the [High cost drugs, devices and chemotherapy portals](#).

<sup>103</sup> Under a gain-sharing agreement, if a provider is successful in reducing the price it pays to a supplier, the provider would be allowed to keep a proportion of that saving.

**Table 12: Mental health care clusters and associated maximum review periods**

Cluster number	Cluster label	Cluster review period (maximum)
0	Variance	6 months
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	6 months
6	Non-psychotic disorders of overvalued Ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
9	Blank cluster	Not applicable
10	First-episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness)	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	Annual
19	Cognitive impairment or dementia (moderate need)	6 months
20	Cognitive impairment or dementia (high need)	6 months
21	Cognitive impairment or dementia (high physical need or engagement)	6 months

## **Local pricing rules: Rules for mental health services**

### **Rule 8**

#### **Using the mental health care clusters**

**(a)** All providers of services covered by the care cluster currencies must use the mental health clustering tool (Annex 7C) and Mental Health Clustering Booklet to assign a care cluster classification to patients.

### **Rule 9**

#### **Local prices for mental health**

**(a)** The 21 care clusters specified in Table 12 must be used as the currencies for agreeing local prices for the services covered by the clusters, unless an alternative payment approach has been agreed in accordance with Rule 4. For example, this could include a capitated payment approach.

**(b)** Where the 21 care clusters are used as the currencies for setting local prices for the services covered by the clusters, initial assessment must be treated as a standalone currency and paid for separately. At the end of an initial assessment, a patient's interaction with a provider may end or continue. If the patient's interaction with the provider continues, all ongoing assessments and reassessments form part of the allocated cluster.

**(c)** Providers and commissioners must ensure that any agreed payment approach enables appropriate patient choice.

### **Rule 10**

#### **Mental health reporting requirements**

**(a)** All providers of services covered by the care cluster currencies must record and submit the cluster allocation's data to the Health and Social Care Information Centre (HSCIC) as part of the Mental Health Services Dataset, whether or not they have used the care clusters as the basis of payment.

**(b)** Once agreed, the local prices for the care clusters must be submitted to Monitor by providers in accordance with the requirements of Rule 3.

#### **Quality indicators for mental health**

**(c)** For each care cluster, quality indicators must be agreed between providers and commissioners.

**(d)** The agreed quality indicators must be monitored on a quarterly basis by both providers and commissioners.

301. All mental health providers and commissioners must adhere to the rules set out in Sections 6.4.1 (Local prices) and 6.4.2 (General rules for all services without a national price). In addition, all providers and commissioners providing mental health services, covered by the mandatory currencies (care clusters), must comply with Rule 8, 9 and 10.
302. The requirements outlined in Rule 8 and Rule 10 apply in all cases, regardless of the payment approach agreed locally or the degree to which it uses care clusters as the basis for local payment arrangement.
303. Where mental health services are not covered by the currencies, providers and commissioners must adhere to the general rules set out in Section 6.4.1 for all health services not covered by national tariffs (local prices). For clarity, a list of mental health services not captured by the currencies can be found in our mental health guidance, 'Guidance on mental health currencies and payment'.
304. The updated rules covering mental health also include references to the new Mental Health Services Dataset (MHSDS), which replaced the Mental Health and Learning Disabilities Dataset (MHLDDS) in January 2016. Further information on how to access, report and use data this data can be found in our mental Guidance for Mental Health Currencies and Payment.

#### *Compliance and enforcement*

305. We are aware that some providers and commissioners are not adhering to the rules at present, and that there may be some confusion in the sector about what is expected. To provide clarity to the sector, in the following sections we provide further guidance for the rules. Further, from 2016, Monitor are undertaking detailed audits and site visits to:
- Ensure compliance with the rules outlined in Section 6.4.1, 6.4.2 and Rules 8, 9 and 10.
  - Offer guidance and support to the sector to ensure adherence to the rules.
  - Understand sector progress in areas of payment development (e.g. in developing and testing currencies, collecting, reporting and using accurate data for analysis and payment development).
306. Where the rules are not applied by either commissioners or providers, we will address any non-compliance on a case-by-case basis in accordance with Monitor's enforcement policy. This may include formal enforcement action.

#### *Guidance on application of principles for setting local prices for mental health*

307. All mental health providers and commissioners must adhere to the general rules and principles set out in Sections 6.4.1 and 6.4.2 by ensuring that locally agreed prices for mental health:



- a. **Are in the best interest of patients:** In the context of mental health care, the requirement is to ensure that patients in the local health economy have access to high quality, timely and evidence based care (at a minimum NICE concordant care) that meets their needs. Providers and commissioners can link payment to achievement of agreed outcomes to help ensure care is patient focused and is delivering the right results for patients. Providers and commissioners may also use gain/loss sharing mechanisms, particularly during transitional periods where new baselines for demand and/or costs have not fully been established. This can support stability, continuity and improvement of safe, high quality and effective care for patients. The Guidance on Mental Health Currencies Local Payment Examples and other material to support local payment development for mental health care provides further information on this.
- b. **Promotes transparency:** Within the context of mental health, this ensures that contracts clearly outline accountability for delivering services and care, as well as for the outcomes that need to be achieved. A transparent approach to payment development also ensures that data and information is used to understand likely demands for care and associated costs.
- c. **Is agreed through constructive engagement between providers and commissioners:** Data and information should also inform development of innovative and effective service designs that meet local care needs and support the objectives set out in the Five Year Forward View. Providers and commissioners should constructively engage with local stakeholders – including clinicians and patients - to (i) understand care needs; (ii) develop service delivery models that meet these needs; and (iii) develop local prices that support the agreed service model. To achieve this it is vital to ensure that accurate data collection, data reporting and data flows are in place. This includes sharing data with clinical staff as well as data sharing between providers, commissioners and other parties. Training may be needed to help staff interpret and analyse data, and data sharing may be facilitated by information sharing agreements, where existing national datasets cannot be used. Providers and commissioners should also actively share best practices where appropriate.

*Further details on Rule 8*

308. The 21 mental health care clusters are the national currencies for most adult mental health services. Whether or not the clusters form the basis of payment, providers must still cluster each patient in accordance with Rule 8 (a). Providers must ensure that clinicians cluster patients using the Mental Health Clustering Toolkit and that this is consistent with the guidance and procedures outlined in the Mental Health Clustering Booklet. This includes the requirement to review patients regularly in line with the maximum cluster review periods (Table 12),

appropriately assign patients to clusters, and only use cluster 0 when it is not possible to determine which cluster should be assigned to a patient at the end of the initial assessment.

309. Incorrect clustering will result in providers having an inaccurate view of patient needs and/or being incorrectly reimbursed. It can also result in incorrect data submissions to the HSCIC, which affects the degree to which this data and evidence can be used as an accurate benchmark for national or local use. Providers should ensure adequate training and quality assurance processes are in place for clinicians to accurately assign patient to the correct care cluster -and ensure consistency with the Red Rules.<sup>104</sup>

*Further details on Rule 9*

310. Rule 9 provides the basis for agreeing local prices for mental health services. Rule 9 (a):

- a. **Requires that providers and commissioners use the 21 care clusters** (set out in Table 12) as the currencies for agreeing local prices in 2016/17. Additional data and information (eg public health data) should also be used to better understand patient need and the resources required which will help inform local prices.
- b. **Allows providers and commissioners to agree local prices that are based on an alternative payment approach**, if this is in the best interest of patients. This may include, for example, a capitated payment approach. A range of (or combinations of) other payment approaches may also be used. For example, payment arrangements that are linked to achievement of outcomes or implementation of best practice pathways, or approaches that facilitate an increased focus on integrated care. These alternative payment arrangements must be in accordance with Rule 4, and the general local price setting principles outlined in Sections 6.4.1 and 6.4.2. Any payment approach covering care that falls under the care clusters should be informed by care cluster data, as well as other data and information that helps understand patient needs. The Guidance on Mental Health Currencies and Payment and Local Payment Examples provides further information on the different payment models that may be adopted<sup>105</sup>. It remains necessary to comply with Rules 8 and 10 even if a different payment approach is adopted.

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<sup>104</sup> The Red Rules set out the rules and guidance for ensuring that patients are assigned to the correct mental health care cluster. Further information on this can be found in the Mental Health Clustering Booklet.

<sup>105</sup> Local Payment Examples can be accessed here:  
<https://www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models>

### *Further details on Rule 10*

311. Rule 10 (a) sets out the requirement for all providers to submit data into the MHSDS via the HSCIC. This requirement to all providers regardless of the payment approach they have in place.
312. Rule 10 (b) requires providers to submit the agreed local prices to Monitor by 30 June 2016. This must be submitted using Monitor's standard format. This applies where providers and commissioners use the care clusters as the basis for setting local prices. If an alternative payment arrangement is used (ie where care clusters are not used for setting local prices) then commissioners are required to record the local prices and submit it to Monitor, in accordance with Rule 4.
313. Rule 10 (c) and (d) require providers and commissioners to agree quality indicators for each of the care clusters, which must also be monitored on a quarterly basis. Quality indicators could include outcomes measures and should be aligned to system wide objectives (e.g. Five Year Forward View) and promote high quality, evidence based and timely care that meet patient needs. The Mental Health Guidance on Currencies and Payment provides further information on how providers and commissioners could use both local and national level data to develop quality measures and link them to payment.

### **6.4.5. Payment rules for ambulances services**

314. This section sets out the rules for local price setting for ambulance with and without national currencies, including the rules that providers and commissioners must follow if they do not wish to use the national currencies.

#### *Ambulance services with national currencies*

315. The national currencies for ambulance services introduced in April 2012 were developed and tested by providers of ambulance services and commissioners. The development of the currencies partly responds to the need for financial incentives to support integrated urgent care provision.
316. The four national currencies for ambulance services are:
- a. urgent and emergency care calls answered
  - b. hear and treat or refer to other services
  - c. see and treat or refer to other services
  - d. see, treat and convey to hospital

317. The details of these currencies – including how to determine what to include and exclude when applying them – are set out in full in Annex B. Any services not specified above are not subject to a national ambulance currency.

318. In addition to the general rules in Sections 6.4.1 and 6.4.2, providers and commissioners must adhere to the requirements of Rule 11.

### **Local pricing rules: Rule for ambulance services**

#### **Rule 11**

**(a)** Providers and commissioners must use the four national currencies specified above as the basis for structuring payment for ambulance services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 4 in Section 6.4.2.

**(b)** Quality and outcome indicators must be agreed locally and included in the commissioning contracts covering the services in question.

**(c)** Once agreed, the local prices must be submitted to Monitor by providers in line with the requirements of Rule 3 set out in Section 6.4.2.

319. Providers and commissioners may wish to agree prices without using the four ambulance currencies, for example, to support the redesign of urgent care services or to incentivise alternatives to conveyance to hospital such as hear or see and treat/refer. These arrangements must comply with Rule 4 in Section 6.4.2 when departing from the currencies.

#### *Ambulance services without national currencies*

320. When agreeing prices for ambulance services not covered by the national currencies, providers and commissioners must adhere to the general rules set out in Section 6.4.1.

321. Activities not included within the national ambulance currencies are:

- a. other urgent care services such as: air ambulance; emergency bed services (EBS); GP out of hours; cross-border activity; and single point of access telephone services (e.g. 111)
- b. other patient care services such as: patient transport services, neonatal transfers and patient education
- c. other non-patient care services such as: emergency planning; clinical audit and research units (CARU); chemical biological radiological and nuclear (CBRN); decontamination units; hazardous area response teams (HART); and logistics or courier transport services.

#### **6.4.6. Primary care services**

322. Primary care is a core component of NHS care provision. It enables local populations to access advice, diagnosis and treatment. Primary care services cover a range of activities, including:

- a. providing coordinated care and support for general health problems
- b. helping people maintain good health
- c. referring patients on to more specialist services where necessary.

323. Primary care is also a key part of the provision of community-based health services, interacting with a number of other community-based health teams, such as community nurses, community mental health teams and local authority services.

*Primary care payments determined by, or in accordance with, the NHS Act 2006 framework*

324. The rules on local price-setting (as set out in Subsection 6.4) do not apply to the payments for primary care services which are determined by, or in accordance with, regulations or directions, and related instruments, made under the primary care provisions of the National Health Act 2006 (chapters 4 to 7). This includes, for example, core services provided by general practices under General Medical Services (GMS) contracts. For 2016/17, the national tariff will not apply to payments for these services.

*Primary care payments that are not determined by, or in accordance with, the NHS Act 2006 framework*

325. The national tariff covers all NHS services provided in a primary care setting where the price payable for those services is not determined by or in accordance with the regulations, directions and related instruments made under the NHS Act 2006. Therefore, where the price for services is determined by agreement between NHS England, or a CCG, and the primary care provider, the rules for local payment must be applied. This includes:

- a. services previously known as 'locally enhanced services' and now commissioned by CCGs through the NHS Standard Contract (eg where a GP practice is commissioned to look after patients living in a nursing or residential care home)

- b. other services commissioned by a CCG in a primary or community care setting using its power to commission services for its local population (eg walk-in or out-of-hours centre services for non-registered patients).<sup>106</sup>

326. The price paid to providers of NHS services in a primary care setting in most of these instances will be locally agreed, and providers and commissioners of these services must therefore adhere to the general rules set out in Section 6.4.1.

#### **6.4.7. Community services**

327. Community health services cover a range of services that are provided at or close to a patient's home. These include community nursing, physiotherapy, community dentistry, podiatry, children's wheelchair services and primary care mental health services. The services provided by community providers are a vital component in the provision of care to elderly patients and those with long-term conditions.

328. Community providers often work closely with other NHS and social care providers, such as GPs and local authority services, and are a key contributor to developing more integrated health and social care and new models of care.

329. Payment for community health services must adhere to the general rules set out in Section 6.4.1. This allows continued discretion at a local level to determine payment approaches that deliver quality care for patients on a sustainable basis.

330. Where providers and commissioners adopt alternative care pathway payment approaches that result in the bundling of services covered, at least in part, by national prices, the rules for local variations must be followed (see Section 6.2).

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<sup>106</sup> These are arrangements made under the NHS Act 2006, Sections 3 or 3A.

## 7. Payment rules

331. The 2012 Act allows for the setting of rules relating to payments to providers where health services have been provided for the purposes of the NHS (in England).<sup>107</sup> In this section, we set out the rules for:

- a. billing and payment
- b. activity reporting.

### 7.1. Billing and payment

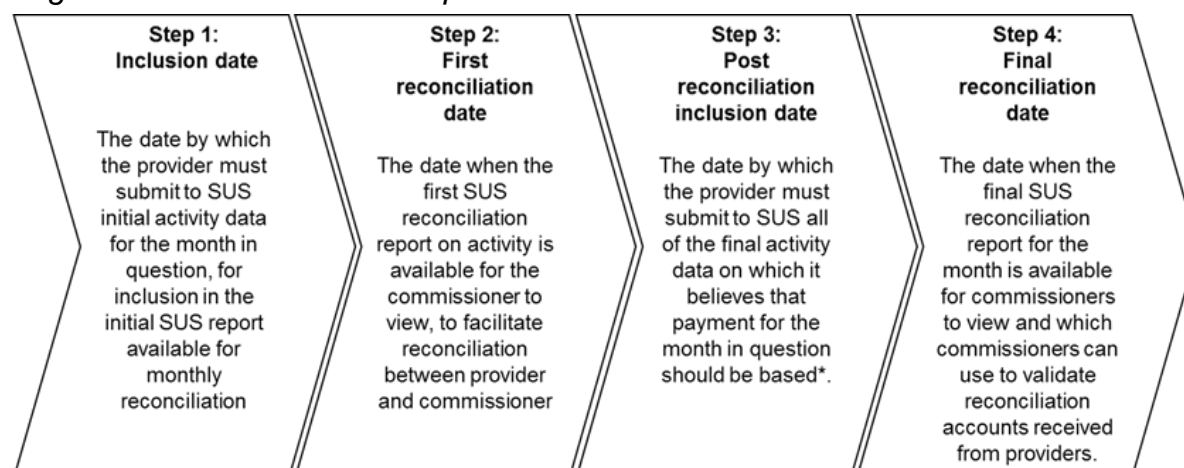
332. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS Standard Contract. Payments to providers may be reduced or withheld in accordance with provisions for contractual sanctions set out in the NHS Standard Contract (eg sanctions for breach of the 18-week referral to treatment standard).

### 7.2. Activity reporting

333. For NHS activity where there is no national price, providers must adhere to any reporting requirements agreed in the NHS Standard Contract.

334. For services with national prices, providers must submit data monthly to the Secondary Uses Service (SUS) system and comply with the two inclusion dates for each month, as set out in Figure 9.1.

Figure 9: SUS submission steps



*Note to Step 3: This submission may include amendments to take account of corrections identified by the provider's internal processes or through reconciliation feedback from commissioners. The provider must rely on this submission for the purposes of generating reconciliation accounts for commissioners, as set out in the NHS Standard Contract. Any subsequent amendments or corrections to the data on SUS, after the post-reconciliation inclusion date, should not affect payments*

<sup>107</sup> 2012 Act, section 116(4)(c).

*to be made by the commissioner.*

335. The 2016/17 dates for reporting monthly activity and making the reports available will be published on the Health and Social Care Information Centre (HSCIC) website.<sup>108</sup> HSCIC will automatically notify subscribers to its e-bulletin when these dates are announced.
336. NHS England has approval from the Secretary of State to allow CCGs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online<sup>109</sup> about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

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<sup>108</sup> <http://www.hscic.gov.uk/sus/pbrguidance>

<sup>109</sup> See: 'Who pays? Information Governance Advice for Invoice Validation' at <http://www.england.nhs.uk/wp-content/uploads/2013/12/who-pays-advice.pdf>



## Glossary

Term	Description
2012 Act	The Health and Social Care Act 2012
Admitted Patient Care (APC)	A hospital's activity (patient treatment) after a patient has been admitted.
Allied Health Professionals (AHP)	A group of statutory-registered healthcare practitioners who deliver diagnostic, therapies and other types of care.
Average length of stay (AvLos)	Length of stay refers to the number of days a patient is in hospital, from admission to discharge. Average length of stay describes the average stay for a group of patients at a provider or for all patients within an HRG.
Best practice tariffs (BPTs)	Tariffs designed to encourage providers to deliver best practice care and to reduce variation in the quality of care. Different best practice tariffs, with different types of incentives, cover a range of treatments and types of care.
British Association of Day Surgery (BADs)	An organisation that promotes the provision of quality care in day surgery and encourages providers to manage the majority of their elective patients with stays of under 72 hours.
Care clusters	National currencies that group patients of mental health services according to common characteristics, such as level of need and resources required.
Casemix	A way of describing and classifying healthcare activity. Patients are grouped according to their diagnoses and the interventions carried out.
Catch-up efficiency	The saving that could be gained from an averagely efficient provider becoming as efficient as a more efficient comparable provider (when accounting for differences in casemix, demographics, quality and input costs).
Choose and Book	The national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
Classification	Clinical classification systems are used to describe information from patient records using standardised definitions and naming conventions. This is required for creating clinical data in a format suitable for statistical and other analytical purposes such as epidemiology, benchmarking and costing.
Clinical Negligence Scheme for Trusts (CNST)	The scheme, administered by the NHS Litigation Authority, provides an indemnity to members and their employees in respect of clinical negligence claims. It is funded by contributions paid by member trusts. In the tariff calculation, cost increases associated with CNST payments are targeted at certain prices to take account of cost pressures arising from these contributions.
Commissioning data set (CDS)	Information on care provided for all NHS patients by providers, including independent providers.
Commissioning for Quality and Innovation (CQUIN)	A national framework for locally agreed quality improvement schemes. It allows commissioners to reward excellence by linking a proportion of payment for services provided to the achievement of quality improvement goals.
Cost improvement plans (CIPs)	CIPs are specific to each NHS provider and set out the savings that the provider plans to achieve over a period of time.

Term	Description
Cost uplift factor	An adjustment to prices that reflects expectations of the cost pressures providers will face, on average, in a given year.
Currency	A unit of healthcare activity such as spell, episode or attendance. A currency is the unit of measurement for which a price is paid.
Default tariff rollover	The 2014/15 national tariff. It is described this way because it continues to be the tariff in force until a new tariff is implemented.
Enhanced Tariff Option (ETO)	The ETO is a package of local variations to the national prices in the 2014/15 national tariff. It was offered by commissioners to providers for the 2015/16 financial year.
Excess bed day payment	Additional reimbursement for patients who for clinical reasons remain in hospital beyond an expected length of stay: this is known as an excess bed day payment (it is also sometimes referred to as a long-stay payment).
Finished consultant episode (FCE)	An FCE or consultant episode is a completed period of care for a patient requiring a hospital bed, under the care of one consultant within one provider. If a patient is transferred from one consultant to another, even within the same provider, the episode ends and another begins.
Frontier shift efficiency	The savings that could be gained from all providers by adopting technological advances and optimising service delivery.
Grouper	Software created by the Health and Social Care Information Centre, which classifies diagnosis and procedure information from patient records into clinically meaningful groups. The outputs from the grouper are used as activity currencies for costing and pricing.
Healthcare Resource Groups (HRGs)	Groupings of clinically similar treatments that use similar levels of healthcare resource. HRG4 is the current version of the system in use for payment. HRGs are used as the basis for many of the currencies in the National Tariff Payment System.
Hospital Episode Statistics (HES)	HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. This data is collected during a patient's treatment at a hospital to enable hospitals to be paid for the care they deliver. HES data are designed to enable secondary use for non-clinical purposes.
Improved Access to Psychological Therapies (IAPT)	The IAPT programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence guidelines for people suffering from depression and anxiety disorders.
Indexation	In the context of setting national prices using a model based on reference costs, indexation refers to adjustments made to modelled prices to reflect increases or achievable reductions in efficient costs of providing NHS healthcare services for the years between when the relevant reference costs were collected and the tariff year.
Integrated care	Defined by the World Health Organization as bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.

Term	Description
International Classification of Disease (ICD10)	The ICD is a medical classification list produced by the World Health Organisation. It codes for diseases, signs and symptoms and is regularly updated.
Joint Advisory Group (JAG)	A clinical organisation whose core objectives are: to agree and set acceptable standards for competence in endoscopic procedures; to quality assure endoscopy units; to quality assure endoscopy training; and to quality assure endoscopy services.
Local modifications	A modification to the price for a service where provision of the service at the nationally determined price is uneconomic (as provided for in sections 124 to 126 of the 2012 Act). The modification is intended to ensure that healthcare services can be delivered where required by commissioners, even if the cost of providing them is higher than nationally determined prices.
Local prices	For many NHS services, there are no national prices. Some of these services have nationally specified currencies, but others do not. In both instances commissioners and providers must work together to set prices for these services. The 2012 Act allows Monitor to set rules for local price setting where it believes this is appropriate.
Local variations	Local variations can be used by commissioners and providers to agree adjustments to national prices, or the currencies for national prices, particularly where it is in the best interests of patients to support a different mix of services or delivery model. This includes cases where services are bundled, care is delivered in new settings or where there is use of innovative clinical practices to change the allocation of financial risk.
Locally determined prices (also referred to as local payment arrangements)	Many prices, or variations to prices, for NHS healthcare services are agreed locally (ie between commissioner(s) and the provider(s) of a service) rather than determined nationally by the national tariff. We refer to arrangements for agreeing prices and service designs locally as 'local payment arrangements'. There are three types of local payment arrangements: local modifications to a national price; local variations to a national price or a currency for a service with a national price; and local prices (sometimes based on nationally specified currencies).
Market forces factor (MFF)	An index used in tariff payment and commissioner allocations to estimate the unavoidable regional cost differences of providing healthcare.
Mental Health Services Dataset (MHSDS)	MHSDS Information Standard is the specification of a patient-level data-extraction (output) standard intended for mental health service providers in England. This includes both NHS and independent providers.
National Heart Failure Audit	The National Heart Failure Audit was established in 2007 to monitor the care and treatment of patients in England and Wales with acute heart failure. The audit reports on all patients discharged from hospital with a primary diagnosis of heart failure, publishing analysis on patient outcomes and clinical practice.
National Joint Registry (NJR)	NJR collects information on all hip, knee, ankle, elbow and shoulder replacement operations and monitors the performance of joint replacement implants.

Term	Description
National Tariff Payment System (the national tariff)	The national tariff is provided for in the 2012 Act. It covers national prices, national variations, and rules, principles and methods for local payment arrangements. Where it is used in conjunction with a particular years national tariff the acronym NTPS will be used e.g. 2014/15 NTPS
NHS Litigation Authority	The NHS LA manage negligence and other claims against the NHS in England on behalf of their member organisations
NHS Mandate	The mandate to NHS England sets out the government's objectives for NHS England, as well as its budget.
NHS standard contract	The contract issued by NHS England for use when commissioning NHS healthcare services (other than those commissioned under primary care contracts). It is adaptable for use for a broad range of services and delivery models.
Pathway payments (eg maternity pathway payment)	Single payments that cover a bundle of services that may be provided by a number of providers covering a whole pathway of care for a patient.
Patient Level Information and Costing Systems (PLICS)	Systems that support the collection and recording of patient level costs.
Patient Reported Outcome Measures (PROMS)	These allow the NHS to measure and improve the quality of treatments and care that patients receive. Patients are asked about their health and quality of life before they have an operation, and about their health and effectiveness of the operation afterwards.
Payment by Results (PbR)	An approach to paying providers on the basis of activity undertaken, in accordance with national rules and a national tariff. The term is often used to refer to the tariff published by the Department of Health in the years before 2014/15.
Personal health budget (PHB)	An amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team.
Quality, Innovation, Productivity and Prevention (QIPP)	The QIPP programme is a large scale programme developed by the Department of Health to drive forward quality improvements in NHS care at the same time as making significant efficiency savings.
Reference costs	The detailed costs to the NHS of providing services in a given financial year which are collected in accordance with national guidance. NHS healthcare providers are required to submit reference costs data to the Department of Health. The costs are collected and published on an annual basis.
Reference cost design	The currencies according to which reference costs are reported.
Secondary Uses Service (SUS)	A single comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the delivery of NHS healthcare services.
Short stay emergency tariff (SSEM)	A mechanism for ensuring appropriate reimbursement for lengths of stay of less than two days, where the average HRG length of stay is longer.
Spell	The period from the date that a patient is admitted into hospital until the date they are discharged, which may contain one or more episodes of treatment.

Term	Description
Treatment Function Code (TFC)	Outpatient attendance national prices are based on TFCs. Main Specialty codes represent the specialty within which a consultant is recognised or contracted to the organisation. Outpatient activity is generally organised around clinics based on TFC specialties and they are used to report outpatient activity.
Trend efficiency	Trend efficiency is the average sector-wide efficiency gain we observe over time
Trim point	For each HRG, the trim point is calculated as the upper quartile length of stay for that HRG plus 1.5 times the inter-quartile range of length of stay. After the spell of treatment exceeds this number of days, a provider will receive payment for each additional day the patient remains in hospital. This is referred to as an excess bed day payment or a long stay payment.
UK specialist Rehabilitation Outcomes Collaborative (UKROC) database	The UK specialist Rehabilitation Outcomes Collaborative (UKROC) was set up through a Department of Health National Institute for Health Research Programme Grant to develop a national database for collating case episodes for inpatient rehabilitation.



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