

2014/15 National Tariff Payment System



About NHS England

NHS England aims to improve the health outcomes for people in England by putting patients and the public at the heart of everything it does.

Open, evidence-based, inclusive and transparent about the decisions it makes, NHS England represents everything the NHS should be.

NHS England empowers and supports clinical leaders at every level of the NHS through clinical commissioning groups (CCGs), networks and senates, in NHS England itself and in providers, helping them to make genuinely informed decisions, spend the taxpayers' money wisely and provide high quality services for all, now and for future generations.

About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are run well, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Foreword

The clear challenge for the health sector is to improve what matters to patients while keeping within a fixed NHS budget. Our teams at NHS England and Monitor are working with partners to put in place a coherent national framework to enable this to happen. The payment system, for which our two organisations now have responsibility, is key to doing this successfully. Next spring we will publish our proposals for how we see the payment system developing over the longer term.

Our joint work on the payment system for the coming financial year is set out in this document, the *2014/15 National Tariff Payment System*. Our approach has been shaped by valuable contributions from people from many different organisations, as well as involving a formal consultation process.

The challenges faced by providers and commissioners are substantial and varied. For providers there is the need to improve productivity, and for commissioners the need to support system-wide productivity improvements through their commissioning decisions while staying within a fixed NHS budget. At the same time, both are seeking to listen to patients better and to improve the quality of care that patients receive. To allow providers and commissioners to focus on these overriding priorities, we have taken the significant step of limiting our changes to national prices for 2014/15.

Clearly, there is an urgent need for improved operational efficiency. But we must also see more rapid changes in patterns of care. Consequently, our national tariff rules are designed to give commissioners and providers clear principles and consistent incentives to innovate locally in areas such as delivering care for the frail and the elderly and others with long-term conditions.

These twin themes – operational improvement and creating new patterns of care – will be at the heart of our approach to the payment system in the coming years.

Our overriding aim is simple: we want health services to be clinically effective and safe, and to provide a positive experience for everyone who uses them. Where choices need to be made, we should all be guided by what is in the best interests of patients.



Sir David Nicholson
Chief Executive, NHS England



Dr David Bennett
Chair and Chief Executive, Monitor

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Executive summary

Both demand for health care and patients' expectations are increasing while the health budget remains flat in real terms. The main strategic challenge facing those responsible for commissioning and providing NHS care is therefore how to spend the £110 billion health budget so it delivers better value for patients. The emerging answer is a combination of operational improvement, in terms of both quality and cost, and developing new service models outside the acute hospital setting.

NHS England and Monitor have taken on responsibility for the NHS payment system from the Department of Health under the provisions of the Health and Social Care Act 2012 (the 2012 Act). Within our partnership, we have different responsibilities. For example, as the overall commissioner of health care services, NHS England takes the lead on specifying the units of purchase (currencies) for what commissioners buy on behalf of patients. Meanwhile, Monitor leads on pricing methodologies, which govern how the prices paid by commissioners to providers are calculated. But, in accordance with the 2012 Act, all elements of the 2014/2015 payment system are agreed by the two bodies. Our long-term aim is to make improvements to the payment system that will support the delivery of good quality care for patients in a sustainable way.

The system is designed to help commissioners and providers over the coming year to address the strategic challenges facing NHS care in their localities. It does this in three ways:

- by offering more freedom, to encourage the development of new service models;
- by providing greater financial certainty to underpin effective planning; and
- by maintaining incentives to provide care more efficiently.

We expect to see more widespread development of new services, particularly services which give better and more sustainable support to growing patient groups with multiple care needs, such as the frail and elderly and others with long-term conditions. Our policies give commissioners and providers greater freedom to experiment with new payment approaches to support the new models of care that they will develop.

We recognise that major structural changes to commissioning are still working through the health care sector. At the same time, providers are facing higher levels of public scrutiny. In these fast-changing circumstances, commissioners and providers need more predictable income and expenditure so they can plan and invest with confidence. We are therefore limiting uncertainty in the system by making few changes to the details of national prices for 2014/15. In particular, we are keeping existing currencies, national prices and nationally determined rules as stable as possible.

Concerning incentives, based on evidence, we are applying firm pressure on providers to make productivity improvements in 2014/15, because improving productivity allows commissioners to buy more and better services within the fixed health care budget. Our judgement is that further opportunities for improving care and safety and for using resources more efficiently still exist. However, we recognise that finding new opportunities for productivity improvements becomes more difficult each year.

Similarly, we continue to expect commissioners and providers to share the risks of growth in the volume of emergency admissions, tailoring their responses to local circumstances. The approach we are taking this year promotes collaboration between commissioners and providers on targeting resources to manage demand for urgent and emergency care in their localities outside the hospital setting – for example, by investing in preventative services or more effective options for discharging patients from acute beds.

Context of the 2014/15 National Tariff Payment System

This document, the *2014/15 National Tariff Payment System*, is the national tariff required by section 116 of the 2012 Act. It sets out the payment system for 2014/15.

Monitor was required by the 2012 Act to consult formally on our proposals for the 2014/15 national tariff. The consultation included an opportunity for clinical commissioning groups (CCGs) and relevant providers (as defined by section 118(14) of the 2012 Act), each NHS foundation trust and any other provider of NHS services in England for which there is a national price) to object to the proposed method for determining national prices. Had a sufficient volume of either CCGs or relevant providers objected, we would have needed either to modify the proposals and re-consult or to make a reference to the Competition Commission requiring it to make a determination on our proposed method for determining national prices.

The consultation period ended on 4 November 2013, and we did not receive a sufficient volume of objections to require us to take either of these courses of action.

In light of the above, and in accordance with Monitor's duty under section 116 of the 2012 Act, we have proceeded with publication of the *2014/15 National Tariff Payment System* (this document), and the methods, rules and policies are materially similar to those set out in the consultation notice.

However, as part of the consultation process, NHS England and Monitor considered responses from CCGs, relevant providers and other stakeholders in relation to the proposals published in the consultation notice (further details are provided in the supporting document [Consultation on the 2014/15 National Tariff Payment System](#)). Where appropriate, we have clarified the text, and in other cases we will provide a response through a series of [Frequently Asked Questions](#) on Monitor's website.

NHS England and Monitor continue to engage with the sector on our longer-term strategy for the payment system. Section 2 of this document sets out our approach to developing the prices and rules for the *2014/15 National Tariff Payment System* and beyond in collaboration with the sector.

Scope of the 2014/15 National Tariff Payment System

Under the 2012 Act, all payments for the provision of NHS health care services (which does not include public health services) can be included in the national tariff. However, the national tariff must also be consistent with current legislative requirements – in particular, the NHS regulations, directions and other instruments which govern remuneration for primary care services, such as general medical services (GMS). The *2014/15 National Tariff Payment System* therefore does not cover these separate payment systems. Over time, as new service models develop, particularly for delivering integrated care across primary and secondary settings, NHS England and Monitor will work together to ensure there is a coherent payment system for both those areas. This is an issue that we will continue to consider over the next few months as we develop our long-term strategy for the payment system.

In Section 3, we describe how the *2014/15 National Tariff Payment System* interacts with a number of different funding flows to providers.

National currencies, prices and rules

Our approach to the national currencies, prices and rules in the *2014/15 National Tariff Payment System* is to keep relative prices broadly stable. This is shaped by two factors:

- the NHS is already going through extensive organisational and other changes; and
- the new legislation transfers responsibility for the national tariff to new bodies and introduces new processes which require decisions to be made earlier in the year.

These changes create operational risks for many organisations. We have sought to avoid adding risks by limiting the number of detailed adjustments we are making to prices this year.

Currencies

The national tariff specifies the NHS health care services which are subject to national prices; the specification for each particular service is described as a 'currency'. While we are limiting changes to currencies, we need to ensure that the *2014/15 National Tariff Payment System* is still clinically relevant and sufficiently up-to-date. For this reason, we are making a limited number of changes, including:

- introducing new arrangements for laparoscopic operations, complex therapeutic endoscopy, complex bronchoscopy and dialysis for acute kidney injury;
- changing the design of some currencies, primarily to rectify identified anomalies;
- introducing a new best practice tariff for primary hip and knee replacements to promote improved outcomes for patients, and amending two other best practice tariffs to reflect the latest advice; and
- introducing a new mandatory price for health assessments of looked after children.

These changes are described in Section 4.

National prices

Consistent with our emphasis on stability, we are using 2013/14 national prices, rather than updated reference cost data, as the starting point for setting prices in the *2014/15 National Tariff Payment System*. This approach avoids year-on-year volatility in reference costs flowing through to prices.

For 2014/15, we are adjusting the 2013/14 national prices to reflect both:

- the expected aggregate change in providers' input costs during the year; and
- our expectations for providers to deliver services more efficiently (the 'efficiency requirement').

There are several factors which will affect providers' input costs, such as changes in pay rates, drug costs, new service development requirements, capital costs and the cost of the Clinical Negligence Scheme for Trusts (CNST). We have used an approach for each of these factors that is consistent with the Department of Health's approach from previous years.

For the efficiency requirement, we have considered the available evidence on achieved and achievable efficiencies, in conjunction with our impact assessment. Based on this, we will apply an **efficiency requirement of 4%** for 2014/15.

In addition to these changes, there are a number of new or amended currencies which require us to set prices for 2014/15.

Section 5 specifies the methods we have used to determine national prices for 2014/15. These methods have been subject to a formal statutory process. The 2012 Act provides an opportunity for CCGs and relevant providers to object formally to the methods for determining national prices in each national tariff. As the numbers of CCGs and relevant providers which objected did not exceed prescribed thresholds, our method for calculating national prices remains essentially the same as set out in the consultation notice.

National variations

Nationally determined variations to national prices are permitted under the 2012 Act, and we refer to these as 'national variations'. Each national variation aims to do one of the following:

- improve the extent to which prices paid reflect regional cost differences (the Market Forces Factor);

- improve the extent to which prices paid reflect patient complexity (top-up payments);
- share financial risk appropriately following (or during) a move to new payment approaches; or
- provide incentives for sharing responsibility for preventing avoidable unplanned hospital stays.

The national variations and our approach to each of them is described in Section 6. Consistent with our emphasis on stability, we are:

- retaining the Market Forces Factor values from the 2013/14 national tariff (except in cases where providers have undergone an organisational restructure since the last set of MFF values was calculated);
- not making any changes to the top-up services and provider lists; and
- retaining the majority of the variations designed to share financial risk during the transition to certain nationally determined payment approaches.

The variations to provide incentives for sharing responsibility for preventing avoidable unplanned hospital stays comprise the 30-day emergency readmissions penalty and the marginal rate rule. Both of these rules were introduced to encourage providers and commissioners to manage emergency admissions better through well-planned discharges, participation in preventative initiatives, and greater involvement of experienced clinicians earlier in the decision-making process.

When properly implemented, these policies should help to create appropriate incentives for whole-system responses to urgent and emergency care planning.

For the *2014/15 National Tariff Payment System*, NHS England and Monitor conducted a joint review of historical evidence on emergency care and the operation of the marginal rate rule. This review suggested the rule has gone some way to achieving its aims in that the growth rate of emergency admissions has slowed. We also received qualitative feedback that in some cases the rule has encouraged more coordinated management of both demand for emergency care and of discharges back into the community.

We have 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 insufficient progress has been made in developing appropriate demand management and better discharge management schemes. We are therefore updating the marginal rate rule:

- to require baseline adjustment where necessary to account for significant changes in the pattern of emergency admissions faced by providers in some localities; and
- to ensure retained funds from the application of the marginal rate rule are invested transparently and effectively in appropriate demand management and improved discharge schemes.

Local prices, variations and modifications

The previous payment system includes rules on agreeing local prices for services that do not have national prices, and 'flexibilities' that allow providers and commissioners to agree new payment approaches for new services or new bundles of services. We are introducing new rules for agreeing local prices and local variations (which supersede 'flexibilities', following the 2012 Act).

We are keen to encourage local innovation in service design, particularly in the direction of more integrated services, and we hope to see widespread use of this policy in the payment system to support the development of such services. The 2012 Act and our rules require publication and disclosure of how these freedoms are being used so that we can learn lessons from experience with alternative payment models.

In addition to local prices and local variations, the 2012 Act also allows for local modifications to nationally determined prices (that is, national prices after the application of all relevant national variations) in cases where the services in question are uneconomic at those prices. Providers and commissioners can agree a local modification, or, in limited circumstances, a provider can apply to Monitor for a local modification where the commissioner does not agree.

For the *2014/15 National Tariff Payment System*, we have developed a consistent, principles-based framework that applies to all local prices, variations and modifications. Within this framework, there are separate rules for agreeing local prices (where there are no national prices) and for local variations. The framework also includes the method that Monitor will use to consider agreements and applications for local modifications.

Our approaches to local prices, variations and modifications, and the relevant rules and method, are described in detail in Section 7. As some of these terms are new in the 2012 Act, we have set out an overview of some of the key concepts below.

Principles

Our framework applies to agreeing all local payment approaches, whether these are local prices, local variations or local modifications. The framework requires commissioners and providers to apply three principles throughout the process of agreeing a local payment approach:

- **Local agreements must be in the best interests of patients.** They must maintain the quality of health care now and in the future, support innovation where appropriate, and make care more cost effective and allocate risk effectively.
- **Local agreements must promote transparency and accountability.** They should make commissioners and providers accountable to each other and to patients, and facilitate the sharing of best practice.
- **Providers and commissioners must engage constructively with each other when trying to reach local agreements.** This should involve agreeing a framework for negotiations, sharing relevant information, engaging clinicians and other stakeholders where appropriate, and agreeing appropriate objectives.

These principles apply in addition to all other legal obligations on providers and commissioners. This includes other rules set out in the national tariff, and the requirements of competition law, regulations under section 75 of the 2012 Act and Monitor's provider licence.

Under the 2012 Act, commissioners must also maintain and publish a written statement for each agreed local variation, and Monitor will publish key information on all local modifications that are approved.

Local prices

Across the NHS in England, the value of locally negotiated contracts was around £40 billion in 2012/13, significantly larger than the aggregate value of services purchased using national prices (around £30 billion).

Although many services do not have national prices, some of these services do have national currencies. Under our rules, providers and commissioners will continue to be required to use a number of national currencies when setting prices locally (this includes currencies for adult mental health services, ambulance services and some specialist services), unless alternative currency designs or service delivery models are agreed in accordance with those rules. To improve transparency and build an evidence base, we also require submission of information on local prices.

The rules allow commissioners and providers to depart from the national currencies (but only where they comply with certain requirements). This flexibility may be used to commission services in innovative ways (for example, to support the delivery of integrated mental health and social care).

Local variations

Local variations can be used to agree adjustments to prices or currencies where it is in the interests of patients to support a different service mix or delivery model. This includes cases where services (at least one of which has a national price) are bundled. Local variations must be agreed by both commissioners and providers. They are intended to allow both parties to innovate, redesign services or incentivise a different service mix in a way that delivers better value for patients.

Local modifications

Local modifications are intended to ensure that services are delivered where patients require them, even if the cost is higher than the nationally determined price.

Local modifications can be used by commissioners and providers to agree increases to nationally determined prices (without changing the currencies) in cases where the provider faces unavoidable, structurally higher costs that make the provision of specific services uneconomic at those prices. If agreement is not possible, in limited circumstances a provider may apply to Monitor for a local modification, without the agreement of its commissioner(s).

Impact assessment

The 2012 Act requires Monitor to publish an impact assessment of proposals for the national tariff. Monitor published this impact assessment on 7 October 2013.

In respect of our overall approach to national prices, the impact assessment supported our conclusions as to the appropriate level of efficiency requirement for 2014/15. This analysis tested the likely impacts of the efficiency requirement to make sure that it promoted patients' interests:

- For **commissioners**, nominal prices will marginally decrease. Therefore, all else being equal, commissioners will have more room to accommodate increased demand in their local health economies, which may arise in the form of higher volumes, more complex care needs, higher quality expectations, or through a combination of these pressures.
- For **providers**, Monitor examined a range of financial metrics under two scenarios: one in which providers achieve efficiency gains of 4%, and one in which providers achieve lower efficiency gains of 3%. On balance, and with particular consideration to providers' cash positions, our analysis suggested that the majority of providers would remain financially viable under both scenarios (although we acknowledge a number of providers may move from a small surplus to a small deficit if they achieve efficiency gains of 3%).

This analysis reassured us that 4% is a reasonable efficiency requirement for the *2014/15 National Tariff Payment System*. This balances the need for providers to remain stable, while allowing commissioners to meet rising demand.

We also reviewed other changes such as currency updates to reflect clinical developments, and local and national variations. We considered these changes could improve patient outcomes without adversely affecting providers.

As explained in Section 5, we have updated our cost uplift figures from the consultation notice to reflect the latest estimates. The new cost uplift figures do not change the overall conclusions of our impact assessment.

To inform our pricing decisions and to ensure that the prices we set will be in the best interests of patients, we plan to collect more data and extend our impact assessment analysis for future national tariffs.

Enforcement of the national tariff

Monitor, the NHS Trust Development Authority and NHS England each have different powers to take action when there is a failure to comply with the national tariff:

- Monitor is responsible for ensuring licensed providers comply with the national tariff, and has powers for ensuring commissioners comply with the national tariff.
- The NHS Trust Development Authority is responsible for ensuring NHS trusts comply with the national tariff.
- NHS England has no specific powers regarding enforcement of the national tariff but it does have powers to take action where a CCG is failing to discharge its duties properly.

Monitor intends to be predictable and transparent in carrying out enforcement activity, and will give support to providers and commissioners to help them comply with the national tariff. We are mindful that commissioners and providers in many areas have found it difficult to comply with NHS payment rules in the past (even when there has been no local innovation), and that those rules have not been strictly enforced. We are also aware that payment rules have been seen as a barrier to innovation in the past.

With this in mind, our aim in designing the national tariff and our enforcement approach has been to make the rules governing price negotiation clearer and more flexible, and the system more transparent, so that commissioners and providers can negotiate the best available services for patients with appropriate payment while remaining compliant with the national tariff.

Future priorities and options

To support the changes needed to the payment system over the longer term, NHS England and Monitor are developing a joint research and development programme. This will include national research, reviews of existing payment approaches, and collaborative working with local health economies.

In spring 2014, we will publish our priorities for improved payment incentive design in 2015/16. This will give the sector early indication of areas of policy development and enable us to gather feedback on our initial proposals.

In the future, all payment approaches, national or local, will rely on better information regarding service costs, patient outcomes, and patient experiences, to enable better decisions to be made for the benefit of patients.

1 Introduction

Many of the changes set out in the Health and Social Care Act 2012 (which we refer to as the '2012 Act') have now been implemented by the health care sector, and the new arrangements are operating. These include the new commissioning organisations (such as clinical commissioning groups, or CCGs, and Health and Wellbeing Boards) and the new role for Monitor as the sector regulator for health care.

The 2012 Act gives Monitor and NHS England (formerly known as the NHS Commissioning Board) responsibility for designing and implementing the payment system for NHS health care services for the financial year 2014/15 onwards. This includes setting the national prices for certain health care services as well as setting the rules for local pricing negotiations between providers of health care services and commissioners. This role was previously performed by the Department of Health.

For the first time, the 2012 Act also provides a statutory regulatory structure for the national tariff. Although NHS England and Monitor are given joint responsibility for the payment system, Monitor alone has responsibility for:

- publishing a consultation notice setting out proposals for the national tariff as agreed by NHS England and Monitor¹; and
- publishing the national tariff itself².

This document is the latter of the two. Monitor published the consultation notice on 3 October 2013.

In this introductory section, we:

- describe the context of this document, including the formal consultation process that has preceded this document;
- provide an overview of this document;
- state the period for which the *2014/15 National Tariff Payment System* will have effect;
- summarise the structure of this document; and finally

¹ 2012 Act, sections 118(1) and (2).

² 2012 Act, section 116(1).

- summarise the supporting documents.

1.1 Formal consultation on the national tariff

As required by the 2012 Act, this document is published by Monitor, but the content has been agreed jointly between NHS England and Monitor³. We engaged with the sector to test our proposals in the summer of 2013, following publication of the *National Tariff 2014/15: An Engagement Document* (referred to as the *Tariff Engagement Document*).

Following this engagement process, on 3 October 2013, Monitor published the *2014/15 National Tariff Payment System: A Consultation Notice* (referred to as the 'consultation notice'). Unlike the *Tariff Engagement Document*, this document was subject to a statutory consultation process as required by section 69(7) and section 118 of the 2012 Act. The consultation process provided an opportunity for certain stakeholders (specifically, CCGs and relevant providers (as defined by section 118(14) of the 2012 Act)) to challenge the method we had proposed for determining the national prices of specified health care services.

If the proportion of CCGs or the proportion of relevant providers (measured by number or share of supply) objecting to the method was equal to or greater than certain thresholds, we would have needed to either modify the proposals and re-consult or make a reference to the Competition Commission requiring it to make a determination on our proposed approach.

The consultation period ended on 4 November 2013. We received objections from 0.5% of CCGs (one CCG) and from 16.1% of all relevant providers (44 providers). These are below the thresholds (of 51%) that would have required us to re-consult or make a reference to the Competition Commission.

As part of the consultation process, NHS England and Monitor have also considered the responses from CCGs, relevant providers and other stakeholders in relation to the proposals published in the consultation notice. Having assessed these responses, we have not considered it necessary to make any substantial amendments to the national tariff proposals set out in our consultation notice.

³ Throughout the document the terms 'we' and 'our' are used to refer to both NHS England and Monitor; where a specific role or responsibility falls to either Monitor or NHS England this is clearly stated. This applies mostly to enforcement, applications and disclosure requirements, where Monitor is the operative entity.

In light of the above, we have proceeded with publication of the *2014/15 National Tariff Payment System* (this document) in accordance with Monitor's duty under section 116 of the 2012 Act, and the methods, rules and policies are materially similar to those of the consultation notice. Where appropriate, we have amended the text for clarity and in some cases we will provide a response through a series of *Frequently Asked Questions* on Monitor's website.

The supporting document *Consultation on the 2014/15 National Tariff Payment System* contains further details of the consultation process and our response to the key issues raised by stakeholders.

1.2 Overview of this document

The 2012 Act sets out the respective roles and responsibilities of NHS England and Monitor. It also states what content must be included in the national tariff and what additionally may be included.

The provisions of the 2012 Act on the national tariff encompass a comprehensive payment system, including not only a set of specified currencies and associated prices, but a suite of rules and variations that apply both nationally and locally. For this reason, we have given the national tariff for 2014/15 the title: *2014/15 National Tariff Payment System*.

Consistent with the 2012 Act, the *2014/15 National Tariff Payment System*:

- specifies a set of **specified health care services** provided for the purposes of the NHS (which we refer to as 'currencies')⁴;
- specifies the **method** used for determining the **national prices** of those specified services⁵;
- specifies the **national price** of each of those specified services (whether as an individual service or as a bundle or group of services)⁶;

⁴ 2012 Act, section 116(1)(a)

⁵ 2012 Act, section 116(1)(b).

⁶ 2012 Act, section 116(1)(c).

- specifies variations to the national price for a service by reference to factors relevant to the provision of that service⁷. We refer to such variations as **national variations**;
- specifies the method for **approving** an agreement between a provider and a commissioner to modify a national price and the method for determining a provider's application to modify a national price⁸. We refer to such modifications as **local modifications**;
- provides for **the rules** under which providers and commissioners may agree to vary the **specification** or the **national price** of services⁹. We refer to these variations as **local variations**;
- provides for the **rules** for determining the price payable for the provision of services that do not have a specified national price¹⁰. We refer to this process of establishing prices as **local price-setting**;
- provides for the rules for determining which currency applies in cases where a service is specified in more than one currency¹¹; and
- provides for the **rules** relating to the **making of payments** for the provision of health care services¹².

The national tariff may also include additional **guidance** for the above provisions and specifications, and commissioners must **have regard to** such guidance¹³.

Each of the above has been **agreed between NHS England and Monitor**.

⁷ 2012 Act, section 116(4)(a).

⁸ 2012 Act, section 116(1)(d).

⁹ 2012 Act, section 116(2).

¹⁰ 2012 Act, section 116(4)(b).

¹¹ 2012 Act, section 116(6).

¹² 2012 Act, section 116(4)(c).

¹³ 2012 Act, section 116(7).

The *2014/15 National Tariff Payment System* and supporting documentation together will replace the existing Payment by Results (PbR) documentation. While we recognise that the existing PbR documentation is familiar to users of the payment system, the new regulatory structure means there has been a need to change how the national tariff is presented and what information is provided. Where information is presented differently, this does not necessarily reflect a change in policy for 2014/15.

1.3 Period for which this national tariff has effect

This national tariff has effect for the period beginning on 1 April 2014 and ending on the later of:

- 31 March 2015; or
- the day before the next national tariff issued under section 116 of the 2012 Act has effect.

The national tariff presented in this document will therefore have effect for the financial year 2014/15, but if necessary would continue to have effect after the end of that year pending any new national tariff being put in place.

1.4 Structure of this document

In the following paragraphs we describe each of the core sections (together with annexes) of this document.

Some of the annexes are in the form of Microsoft Excel workbooks.

In **Section 1**, this introductory section, we describe the statutory consultation process that we undertook to produce this national tariff document. We also outline the structure of this document and supporting documents. Section 1 includes:

- [Annex 1A](#), a glossary.

In **Section 2**, we provide the wider strategic context in which the national tariff has been developed and will operate, and summarise our strategy. We also indicate some of the research and development projects that are under way or will start shortly.

In **Section 3**, we clarify the scope of the payments covered by the *2014/15 National Tariff Payment System* and how this might evolve.

In **Section 4**, we explain the system of currencies in the payment system, and specify the currencies which will have mandatory national prices¹⁴ (including 'best practice tariffs'¹⁵). We also outline changes to the currencies for 2014/15. Section 4 includes two annexes:

- [Annex 4A](#) provides further detail on currency descriptions (e.g. BPTs). A significant amount of guidance that used to be published under the PbR system has been revised and is now set out in this annex.
- [Annex 4B](#) sets out maternity data requirements and definitions.

Section 4, in combination with the full list of currencies in Annex 5A, specifies the NHS health care services subject to national prices¹⁶.

In **Section 5**, we specify our methods for determining the national prices of specified health care services. Section 5 includes one annex:

- [Annex 5A](#) is a spreadsheet which lists the currencies that have national prices and the prices themselves, as determined using the methods set out in Section 5.

In **Section 6**, we specify the nationally determined variations to national prices under section 116(4)(a) of the 2012 Act (for example, the marginal rate rule, top-up payments for specialised services, and the Market Forces Factor (MFF)). Section 6 includes two annexes:

- [Annex 6A](#) is a spreadsheet of MFF values.
- [Annex 6B](#) lists the specialist services and providers eligible for top-up payments.

¹⁴ [Annex 5A](#) contains a complete list of all currencies with national prices in the *2014/15 National Tariff Payment System*.

¹⁵ Best practice tariffs are paid to providers in place of normal tariffs, if best practice guidelines for treatment are followed. 'Best practice' is defined as care that is both clinically and cost effective, and is different for each procedure.

¹⁶ Pursuant to section 116(1)(a) of the 2012 Act.

In **Section 7**, we specify the rules that will apply to local prices and local variations to nationally determined prices, and the method that will be used by Monitor for considering local modifications. As part of the rules on local prices, we specify currencies for services which do not have national prices (such as mental health currencies) which should be used as the basis for local price-setting¹⁷. Section 7 includes three annexes:

- [Annex 7A](#) lists the acute currencies specified for local pricing.
- [Annex 7B](#) lists the high costs drugs, devices and procedures.
- [Annex 7C](#) is the mental health clustering tool booklet.

It should also be noted that Section 7 includes explanatory material on locally determined prices as well as the rules themselves.

Supporting documents also provide accompanying guidance for commissioners and providers to assist with the implementation of the rules and set out any established good practice.

In **Section 8**, we set out our rules for the making of payments (including billing and monthly reporting of activity).

1.5 Supporting documents

In the following paragraphs we describe the supporting documents published alongside this document. Supporting documents should not be considered part of the *2014/15 National Tariff Payment System*. Some of these contain further explanatory information which is best placed outside the *2014/15 National Tariff Payment System* because we may update this more or less frequently than the national tariff cycle, which is currently annual.

The supporting documents vary in status. Some are published jointly by NHS England and Monitor, and some are published by Monitor alone.

1.5.1 Contextual documents

There are eight supporting documents that we consider provide important context to this document.

¹⁷ See 2012 Act, section 116(5).

Discussion paper

In May 2013, NHS England and Monitor published a discussion paper, *How can the NHS payment system do more for patients?*¹⁸. This set out various approaches to designing a comprehensive payment system for NHS services for the long term. The paper presents our early thoughts on objectives for the NHS payment system, sets out the tools for payment regulation and explores some possible design options

Call to Action

In June 2013, NHS England published *The NHS belongs to the people: A Call to Action*. This set out the case for change in the NHS, stressing that a reshaping of services will be vital if the health service is to survive the challenges it faces.

Local contracting research paper

In September 2013, Monitor published a research paper, *Local price setting and contracting practices for NHS services without a nationally mandated price*. This work assessed how effective local contracts have been in delivering more for patients.

Impact assessment

Impact assessment analyses are an important part of policy development, and the 2012 Act mandates that Monitor carries out such an analysis for any proposals which are likely to have a significant impact on providers, patients or the general public¹⁹.

Monitor published the *Impact assessment* of our proposals on 7 October 2013. This covered the changes in the national tariff as set out in the consultation notice. In addition, it includes an explanation of how the discharge of Monitor's general duties²⁰ would be secured by implementation of the proposals; and, where appropriate, how Monitor has complied with those duties when developing its proposals.

¹⁸ Publications Gateway Reference Number: 00078.

¹⁹ 2012 Act, section 69.

²⁰ Monitor's general duties are its duties under sections 62 and 66 of the 2012 Act.

Guide to the Market Forces Factor

A guide to the Market Forces Factor explains the rationale, calculation and implementation of the Market Forces Factor. Monitor is re-publishing this document alongside the *2014/15 National Tariff Payment System* (although it remains unchanged from the version published alongside the consultation notice on 3 October 2013).

Review of marginal rate rule

Monitor and NHS England's review of the marginal rate rule is a joint review of the marginal rate rule, following our call for evidence earlier in the year. Monitor is re-publishing this document alongside the *2014/15 National Tariff Payment System* (although it remains unchanged from the version published alongside the consultation notice on 3 October 2013).

Explanatory leaflet

An explanatory leaflet called *Towards an NHS payment system that does more for patients* provides an overview of the payment system that is suitable for non-specialists. Monitor is re-publishing this document alongside the *2014/15 National Tariff Payment System* (although it remains largely unchanged from the version published alongside the consultation notice on 3 October 2013).

Consultation summary

Consultation on the 2014/15 National Tariff Payment System summarises our formal consultation process, and outlines the key issues raised by stakeholders and how we have responded to them.

1.5.2 Supporting guidance

Previously, the guidance provided to stakeholders in the PbR system has included both 'mandatory' and 'non-mandatory' guidance. To align better with the 2012 Act, we consider these two concepts are better characterised as 'rules' and 'guidance'.

Non-mandatory supporting guidance for the payment system has previously been set out alongside PbR rules within the *Payment by Results Guidance for 2013/14* and other associated documents. The 2012 Act allows Monitor to include supporting guidance within the national tariff and commissioners must have regard to such guidance if it is included²¹.

²¹ 2012 Act, section 116(7).

However, we generally believe it is best to place this guidance outside the national tariff itself. Our view is that non-statutory guidance outside the national tariff gives us the flexibility to update guidance as required rather than be restricted to the (currently annual) national tariff publication cycle.

The supporting documents characterised as such non-statutory guidance are:

- *Guidance on locally determined prices.* This sets out further information on the method for local modifications and guidance (including illustrative examples) on the templates for local prices, variations and modifications.
- *Guidance on mental health currencies and payment.* This guidance describes how providers can use the adult mental health currencies, and how they can be used by commissioners and providers as the basis for setting local prices.
- *National Tariff Information Workbook (including non-mandatory prices).* This contains additional information on:
 - non-mandatory prices;
 - clarification of services covered by national prices and guidance on processing;
 - processing adjustments and zero tariffs;
 - HRGs with no national price;
 - TFCs with no national price;
 - unbundled HRG list; and
 - changes to the grouper.

1.5.3 Enforcement of the national tariff

Enforcement of the national tariff sets out Monitor's enforcement policy, its relationship with the licence conditions and how it will be applied in practice. This document explains the enforcement approach as applied to commissioners, licensed providers, NHS trusts and exempt providers.

2 Context and strategy

NHS England and Monitor are taking on new responsibilities for the NHS payment system at a time when the health care sector faces major challenges. These are likely to persist for the foreseeable future. The payment system is one of a number of levers for influencing how commissioners and providers respond. Understanding the wider context of the payment system, including national health care quality objectives and fiscal challenges, is therefore critical to its design.

This section describes the context in which the *2014/15 National Tariff Payment System* has been developed. The section is structured as follows:

- first, we introduce the policy environment informing the design of the payment incentives in the *2014/15 National Tariff Payment System*;
- second, we examine how the payment system can do more for patients over the long term, supported by a programme of research and development; and finally
- we summarise our strategy for the *2014/15 National Tariff Payment System*, and how this represents a first step towards helping the sector meet the challenges of the future.

2.1 Policy environment

The basic function of a payment system for publicly-funded NHS care is to regulate the flow of funds from commissioners to health care providers. However, a well-designed payment system, supported by accurate information on the costs and quality of care, can do much more. The role of the payment system as a tool for effecting change rests on the power of payment approaches and price signals to influence behaviour. By a payment approach, we mean a way of defining and paying for a particular 'unit' of care, which is known as a 'currency'. Different payment approaches may be appropriate for different types of care: the approach that incentivises the best and most efficient care for, say, elective surgery will not be the same as the payment approach that incentivises the best outcome for a patient with multiple, long-term conditions.

Determining which behaviours we incentivise through the payment system is a function of legislative requirements, fiscal challenges and clinical priorities for quality improvement. However, the payment system is only one lever for meeting these often countervailing forces. It must work effectively alongside other levers such as transparency about performance and clinical guidelines.

Currently, the sector faces significant quality and fiscal challenges. Demographic pressures and growing expectations combined with restricted funding mean that the NHS must deliver health care more efficiently for the foreseeable future. But, in the absence of efficiency savings, NHS England has projected that by 2021/22 there will be a £30 billion gap between available funding and anticipated demand²².

To ensure that the NHS remains sustainable overall, services need to be redesigned to offer improved patient outcomes at lower cost. We expect to see more widespread development of new services, particularly services giving better and more sustainable support to patient groups with multiple care needs, such as the frail and the elderly and people with long-term conditions. Health care services need to be better coordinated and delivered with social care and other public services, such as housing and transport. Such changes would enable patients to have both better experiences and outcomes from NHS care.

Similarly, commissioners need to know which patterns of care and which providers serve patients best, in terms of both outcomes and value. This will allow them to make more informed purchasing choices that ensure the delivery of high quality and sustainable care on behalf of the local – and national – health economy.

Earlier in the year, NHS England published *A Call to Action*, explaining why we need to think differently about how health care services will be provided in future. NHS England is developing a strategy looking over two time horizons – five years and ten years, taking into consideration how future patients will access and use health services. NHS England's Medical Director, Professor Sir Bruce Keogh, is also leading reviews of the provision of seven-day services and urgent and emergency care, while the Secretary of State will be publishing a plan that addresses the care needs of vulnerable and older people. This work, drawing on feedback from patients and commissioners, will be incorporated in strategic business plans for future services.

²² Source: [NHS England news](#)

Integrated care, particularly integrated health and social care, is critical to ensuring that the quality of services improves in a context of constrained resources. Providing coordinated, person-centred services should address widespread concerns about fragmentation of care, resulting in delays, duplications, or obstacles to recovery.

However, the recent Future Forum report on integrated care²³ highlighted a number of barriers to its development, including the existing activity-based payment system. It called for Monitor and NHS England to develop new payment models to incentivise the delivery of coordinated, person-centred care. This finding was explored in more detail in Monitor's own 2012 research described in *Enablers and Barriers to Integrated Care*²⁴.

Since then, our research on international health care payment systems has investigated a number of alternative payment approaches designed to incentivise the delivery of integrated care. These include new ideas on currencies: for example, purchasing a whole pathway of care – from referral to re-ablement – or purchasing a person's care over a given time period, such as a year. We are working with the sector, for example the integrated care pioneers, to support them to identify the new shape of services and scope of outcomes they want provided for patients. We will be considering design options for payment approaches that promote integrated care for all patients. We are focusing, in particular, on those patient groups likely to benefit most from more integrated services, such as the vulnerable and the elderly. In the meantime, local health economies can experiment with their own payment approaches, using the rules for local variations (Section 7).

2.2 An emerging long-term strategy for the payment system

The main function of prices in the payment system is to provide signals to guide the decisions of providers and commissioners. Whether determined nationally or locally, prices informed by accurate information on the cost and quality of services will:

- help commissioners identify which services are best value for patients and best suited to the local health economy; and
- help providers to identify which activities to invest in.

²³ Future Forum *Integration Report*, 2012.

²⁴ Monitor, *Enablers and Barriers to Integrated Care*, 2012.

Ideally, the combined effect of all the price signals in the payment system should be to allocate scarce resources efficiently and for the benefit of patients, today and tomorrow.

These properties of a payment system make it a powerful lever for meeting the challenges outlined above. However, we are conscious that the payment system is only one lever among many for promoting value for patients and enabling change in the NHS. We are therefore aligning our strategy for the payment system in 2014/15 and beyond with other financial and non-financial levers that operate within the system, including clinical guidelines, National Institute for Health and Care Excellence (NICE) quality standards, reputational levers and patient choice and competition.

2.2.1 Payment system in the longer run

In 2003 the DH introduced the Payment by Results (PbR) system, an activity-based payment system, for a small number of common elective care procedures. This approach to setting prices for specified treatments or services underpins much of the NHS payment system for acute care today. Over the past decade the scope of services covered by an activity-based payment approach has expanded, and now represents almost £30 billion of NHS expenditure. However, our research on the PbR system and feedback we have received from the sector have identified emerging difficulties.

Our evaluation of the payment system found that the cost information underpinning national prices was not always accurate, that some incentives were no longer suitable for the NHS context, and that national prices were increasingly disregarded²⁵. Our subsequent research on local price-setting practice²⁶ has also identified that those using the payment system need better information, contracting skills and incentives to ensure that the payment system as a whole promotes value for patients.

The transfer of responsibility for design and oversight of the NHS payment system to NHS England and Monitor has offered a timely opportunity to stand back and assess how the system may develop in future. The PbR system has played a part in delivering key priorities, including reducing waiting times, but the sector now faces new and different challenges.

²⁵ Monitor, *Evaluation of the Reimbursement System for NHS funded care*, 2012.

²⁶ Monitor, *Local price setting and contracting practices for NHS services without a nationally mandated price*, 2013.

Our work on the detailed design of the payment system is still at a preliminary stage. In May, we published a discussion document which set out some early considerations, including some proposed objectives for the design of the NHS payment system.

We proposed that the payment system should:

- strive as far as possible to pay for outcomes for patients rather than treatments or inputs;
- aim to promote the long-term, sustainable well-being of the whole person;
- allow different payment approaches in different care contexts and leave room for local flexibility, based on a clear structure of rules; and
- create clear and credible signals to foster choices that promote sustainably better outcomes for patients.

2.2.2 What we've heard

Over the course of our engagement with the sector, we have received helpful feedback about the objectives listed above and the wider benefits of a rules-based payment system. Overall, the sector reported that, although the activity-based payment approach remained suitable for some services, it was not suitable for all. In particular, many stakeholders reported that alternative payment models may be more suitable for the provision of sustainable emergency services and for the co-ordination of care for long-term conditions or for the frail and elderly.

Nevertheless, the sector generally sees the benefits of the rigour imposed by a national system of rules and prices. In addition, the sector generally supported our four proposed objectives. We identified three major themes from the sector's feedback:

- *Patient outcomes:* The sector welcomed the concept of linking payment more closely to patient outcomes but recognised that these can be hard to define and measure objectively, particularly at the level of an individual patient. Indeed, there may be tension between outcomes appropriate to an individual patient and the needs of the local health economy as a whole. This means linking payment to input and output measures is likely to continue in some form, particularly where there is evidence which connects these inputs or outputs to better patient outcomes. We need to do further work to develop payment approaches that can reward patient outcomes, balancing the needs of patients and those of the local health economy.

- *Longer-term planning:* As a priority, the payment system should seek to support longer-term planning. Aligning the financial incentives that apply to different types of care – including primary, secondary, community, social and mental health services – will be a critical step. This would enable investments that depend on some certainty over future income or rewards for coming years. For example, investments in preventative care for patients with long-term conditions can be a means of both improving their care and managing acute care demand, but it takes time for benefits to be realised. Similarly, designing a local ‘whole-system’ response to managing emergency and urgent care demand which might require reconfiguration of local services, will need a careful transition.
- *Co-operation that improves care:* Finally the sector generally recognised that through the payment system, NHS England and Monitor must promote appropriate collaborative working and constructive engagement across all providers and among commissioners, including local authorities.

We will take this feedback into account as we finalise proposals for the longer-term design of the payment system over the coming months. We believe that the design of the NHS payment system can support both commissioners and providers in making the changes needed to respond to the challenges the sector faces. NHS England and Monitor will be working with the sector to develop a vision for the NHS, and the design of the payment system must help to realise this vision, and support the sector so that NHS services can continue to meet patient needs without spending beyond its means.

2.2.3 Research and development pipeline

To inform the design of the payment system over the longer term, NHS England and Monitor are developing a joint programme of research and development (R&D). These projects will include national research, reviews of existing payment approaches as well as collaborative working with local health economies. Pilot testing and evaluation will help to ensure that the payment system promotes value for patients continuously.

Our R&D work will incorporate the oversight of a number of currency models already at the pilot stage or in development:

- Long-term conditions year of care – the early implementers have entered into the second year of using this model, and they aim to have designed new contracting models for use in 2014/15²⁷.
- Palliative and end of life care – the aim of the pilot, which was initiated in May 2012 and runs until 2014, is to form an understanding of resources used in palliative care and the associated costs. Ultimately, the evidence gathered will be used to develop a payment approach for palliative and end of life care that incentivises good quality care and experiences for patients, irrespective of both time and setting.
- Mental health – pilot work continues on developing currencies for aspects of mental health services not covered by the working age adult cluster currencies. These include improving access to psychological therapies (IAPT), children’s and adolescent mental health, forensic mental health, learning disabilities and liaison psychiatry.
- Prescribed services – NHS England has launched a public consultation on specialised services commissioning policies and specifications²⁸.

In addition to work that is already underway, NHS England and Monitor are developing a work plan to support our priorities for 2015/16. This includes:

- work to improve our understanding of current financial flows in the payment system and the interaction between financial and non-financial incentives;
- efforts to design and collect core data flows related to provider costs that underpin all payment approaches; and
- designing new payment approaches that provide incentives for effective redesign of services, particularly for areas of clinical priority.

²⁷ NHS, Improving Quality, [Integrated Care and Support Pioneers programme](#)

²⁸ NHS England, [specialised commissioning resources](#)

2.2.4 Planning for 2015/16

While NHS expenditure is protected in real terms until 2015/16, the overall budget will, of course, continue to need to be carefully spent and closely monitored. In this regard, the current QIPP (Quality, Innovation, Productivity and Prevention) agenda remains highly relevant. In addition, the comprehensive spending review for 2015/16 sets aside £3.8 billion from the overall NHS funding for integrated health and social care, in the form of an integration transformation fund²⁹. This, alongside existing financial challenges, means that the NHS will be required to find new efficiencies in 2015/16, for example from better procurement, making savings through improved use of technology, and reducing pressures on A&E by providing good alternatives and more support to older people and people with multiple, long-term conditions.

In response, local health economies will be starting to make detailed two-year plans that span 2014/15 and 2015/16 as well as developing their five-year strategic visions. To assist this, we plan to publish our proposed priorities for improving the design of payment incentives in 2015/16 in spring 2014. This will give the sector early indication of future policies and enable us to gather feedback on our initial proposals.

2.3 Our strategy for the 2014/15 national tariff

While we develop options for the future payment system, the *2014/15 National Tariff Payment System* presents an opportunity to take our first steps towards ensuring the system promotes value for patients:

- Firstly, we wish to **encourage local experimentation** in payment approaches to support service redesign. Our rules for varying national prices and currencies are permissive in order to allow immediate changes to the payment system at a local level.
- Secondly, we have sought to **reduce volatility** in currencies, national prices and nationally determined rules. This will make incomes and expenditure across the sector more predictable, enabling sustainable provision and good investment decisions. The (limited) changes are designed to ensure that the national tariff remains clinically relevant and sufficiently up-to-date.

²⁹ NHS England *Statement on the health and social care integration transformation fund*.

In line with this, our core aims for the *2014/15 National Tariff Payment System* are:

- to establish a regulatory environment to help commissioners' and providers' planning;
- to progress the development of payment approaches for mental health (but not introduce major changes at this point);
- to introduce the first national price linked to reported patient outcomes;
- to strengthen incentives for coordinated whole system responses to managing demand for emergency care; and
- to introduce freedoms to allow commissioners and providers to vary local payment approaches to suit local circumstances (subject to their adherence to a number of core principles).

We briefly discuss each of these below.

2.3.1 A regulatory environment to help planning

Our regulation of the payment system will only be effective if we send signals sufficiently early for providers and commissioners to react to. The sector has told us that the publication of national prices, variations and rules needs to be as early as possible in the planning cycle to inform commissioning and investment decisions.

To give commissioners and providers greater certainty about their income and expenditure in 2014/15, we are keeping national prices largely unchanged in relative terms from 2013/14 and are not applying a reference cost update or making substantial changes to the way in which services are specified. For the large majority of services, we are updating 2013/14 prices only in line with expected cost pressures and efficiency gains. By including efficiency, we assume providers should make continuous improvements to the way they provide services, for example by organising their productive resources and controlling their costs.

2.3.2 Consolidating progress on mental health

We are maintaining current rules for setting local prices for mental health, to provide an opportunity for providers and commissioners to make progress on quality reporting and developing local cluster prices.

2.3.3 First outcomes-based national price

We are introducing the first currency based on patient outcomes: a best practice tariff for hip and knee replacements linked to measures of outcomes reported by patients receiving the treatment. This best practice tariff has been designed through wide consultation with orthopaedic clinicians and aims to reduce the variation in outcomes reported by patients following their hip or knee replacement. Providers will be paid the best practice tariff price only if their patient outcome scores are above a certain threshold.

2.3.4 Strengthen whole system incentives to manage demand for emergency care

While demand for emergency care appears to have stabilised over the past three to four years at a national level, continuing growth in demand at particular providers in some local health economies can present a significant challenge to local commissioners and providers. There is an emerging consensus that the best operational response to this growth is one that co-ordinates the provision of urgent and emergency care across providers, including hospitals, GPs, ambulances, community and social care.

For this reason, we are maintaining the 30-day emergency re-admission rule and 30% marginal rate rule for emergency admissions. We think these rules create helpful incentives for health economies to work together to manage demand for emergency bed days through avoidance of admissions, earlier discharge and better post discharge support.

However, our review of the marginal rate rule³⁰ has highlighted some significant operational problems with the way this rule operates. While we can find no universal evidence of unsustainable financial impact or direct consequences for patient care, we have identified that in some localities, change is needed to ensure provision of care remains sustainable. Some stakeholders told us that the 2008/9 baseline which is used to set the point at which the marginal rate will apply was not always appropriate and that plans for re-investing the money were not always transparent.

³⁰ This review was launched in May with a 'call for evidence' and also included three stakeholder events, comprehensive data analysis and testing with experts. We have published our full evidence base and findings.

Therefore, while we are maintaining the 30% marginal rate rule, we are updating its application in two respects:

- First, we require that the baseline value above which the 30% marginal rate applies be adjusted where evidence suggests there have been material changes in patient flows.
- Second, we are placing additional requirements on commissioners to demonstrate how the retained funds are used and to ensure plans are evidence-based, transparent and effective.

2.3.5 Freedom to vary national prices transparently

Our rules for varying national prices and currencies are permissive, but require contracting parties to adhere to three core principles (see Section 7). Where contracting parties in local health economies want to depart from national prices to support service redesign, they can do so, as long as they comply with the principles and other rules, publish the agreed variation and notify Monitor. Monitor will also publish the variations on-line, accessible to the public.

We expect that contracting parties in many local health economies may wish to use local payment variations to invest in, for example, seven-day services, co-ordination of urgent and emergency care provision, or integrated health and social care. We are providing scenarios to illustrate to commissioners and providers in local health economies how local payment variations might be used and to explain how they differ from local modifications and local price-setting.

Requiring transparent reporting of local payment approaches as well as monitoring and evaluating their impact will promote the sharing of good practice across the sector. We will also use this evidence to inform our longer-term reform of the payment system. What we learn from local innovations in payment approaches will complement our national programme of research and development.

3 Scope of the 2014/15 National Tariff Payment System

The 2012 Act provides a new statutory regulatory structure for the NHS payment system. As well as introducing a new consultation process, this regulatory structure is significantly greater in scope than the PbR system – it encompasses the policies and rules for determining the prices of ‘*NHS health care services*’³¹, rather than only planned hospital care.

Since the flows of funding between commissioners and providers that support the purchase of health care services are complex and differently regulated, our approach for 2014/15 is to maintain existing arrangements, of which there are many.

In this section, we set out how the *2014/15 National Tariff Payment System* will interact with a number of different funding flows to providers. These are:

- Public health services
- Primary care services
- Personal health budgets
- Devolved administrations
- Integrated health and social care
- Contractual incentives and sanctions

This is not an exhaustive list of funding to providers that supports the delivery of health care services. Over time, we will be reviewing how the national tariff interacts with all of the various funding flows, including those listed above. NHS England and Monitor are working together to map the various funding flows and agree the scope of the national tariff for future years, based on a shared understanding of where it makes sense for financial incentives to be brought together in a single coherent payment system.

³¹ This does not include public health.

3.1 Public health services

The national tariff will not apply to public health services provided or commissioned by local authorities or Public Health England, or to public health services commissioned by NHS England under its 'section 7A agreement' to exercise certain Secretary of State public health functions³².

3.2 Primary care services

For many NHS primary care services provided by general practices, community pharmacies, dental practices and community optometry practices, 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 2006³³. To ensure a consistent framework, the *2014/15 National Tariff Payment System* will not apply to payment for such services.

In other cases, 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 NHS Act 2006, and payment is agreed between the commissioner and provider. In such circumstances, the *2014/15 National Tariff Payment System* rules on local price setting will apply.

As NHS services become more integrated, with the provision of some NHS services spanning multiple settings – including primary care – it will be important to ensure the *2014/15 National Tariff Payment System* and other legal provisions for the payment of NHS services are consistent and supportive.

³² See the meaning of 'health care service for the purposes of the NHS' given in section 64 of the 2012 Act; and the exclusion of public health services in section 116(11).

³³ 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.

Some GPs also conduct simple procedures, which they have been commissioned to do by CCGs in order to bring care closer to patients' homes. For the avoidance of doubt, these procedures are not covered by the nationally specified currencies and prices set out in Sections 4 and 5. Instead, for the *2014/15 National Tariff Payment System*, the commissioning of these procedures are covered by the rules for local price-setting, set out in Section 7.

3.3 Personal health budgets

A personal health budget (PHB) is an amount of NHS money allocated to an individual patient with long term or chronic health needs to enable them to manage their health care and wellbeing needs, working in partnership with health professionals to set goals, and plan how to achieve these. The purpose of a personal health budget is to maximise patient choice and control, giving them the flexibility to meet their needs in ways that work for them. This can include traditional services, equipment and non-traditional services such as complementary and alternative therapies.

From April 2014, everyone entitled to NHS [continuing health care](#) will have the right to request a PHB from commissioners. The offer of PHBs to others who might benefit will remain at the discretion of commissioners. Given that this is a new initiative, PHBs are at an early stage in development and there is no single way to calculate the size of budgets, which will vary greatly depending on the individual patient's needs and agreed health goals. Learning from the pilot programme on setting personal health budgets is available in the [personal health budget toolkit](#).

Currently, PHBs can be managed in three ways:

- direct payments for health care (the money is given to individuals);
- third party budgets (a third party holds the budget); or
- notional budgets (the NHS continues to hold the budget).

When a PHB is managed through **direct payments** for health care the payment may be viewed as money in lieu of NHS services. The [direct payment for health care regulations](#) set out the rules around direct payments. For clarity, the following are not covered by the *2014/15 National Tariff Payment System*, as they do not involve paying for the provision of health care services:

- Payment for assessment of patient needs in respect of determining a personal health budget.

- Payment for advocacy – advice to patients and carers on how to use their personal health budget.

Payment to providers of NHS services from a **notional personal health budget** (when the budget is held by a commissioner on behalf of a patient) or a **third party budget** are within the scope of the *2014/15 National Tariff Payment System* and will either be governed by a national price as set out in [Annex 5A](#) (including national variations set out in Section 6) where applicable, or a local price. Payment for services where a local price is set would have to adhere to the general rules for local pricing in Subsection 7.4.1.

NHS England and Monitor will consider further guidance on the application of the national tariff to direct payments and would welcome any feedback on this issue.

More information around the implementation of PHBs can be found on the PHB [website](#).

3.4 Devolved administrations

The Devolved Administrations (DAs) (the governments in Scotland, Wales and Northern Ireland) are responsible for the NHS in Scotland, Wales and Northern Ireland. The provisions of the 2012 Act cover health care services provided for the purposes of the NHS in England only. However, there are often instances where a patient from Scotland, Wales or Northern Ireland is treated in England or where a patient from England is treated in one of those countries. The *2014/15 National Tariff Payment System* will apply in some but not all circumstances of cross border provision of NHS health care services.

Table 3-1 below summarises how the *2014/15 National Tariff Payment System* applies to various cross-border scenarios. 'DA patient' refers to a patient from Wales, Scotland or Northern Ireland. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in those countries (e.g. a Local Health Board in Wales (commissioner), or an NHS trust in Scotland (provider)).

Table 3-1: Devolved administrations

Scenario	National tariff applies to provider	National tariff 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	✗	✗	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 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

In the final scenario above, while the commissioner in England is bound to follow the prices and rules in the *2014/15 National Tariff Payment System*, there is no such requirement on DA providers. 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 locally determined prices (see Section 7). If there is a national price for the service, a local variation would be required in order to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the rules for local prices should be followed.

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's ['Who Pays?' Guidance](#) also provides comprehensive guidelines around payment responsibility in England. The scope of the *2014/15 National Tariff Payment System* does not cover payment responsibility rules as set out in these documents. These rules should therefore be applied in parallel with the provisions of the *2014/15 National Tariff Payment System*.

3.5 Integrated health and social care

The existing legislative flexibilities that enable joint working between NHS bodies and local authorities in respect of their health and social care functions remain in place following the 2012 Act. These include provisions in the NHS Act 2006, which itself consolidated those in the NHS Act 1977 and the Health Act 1999. The NHS Act 2006 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. There are several provisions for joint financing, including pooled funds, transfer payments and lead commissioning³⁴. Using such provisions can be an enabler of integrated care and can help reduce gaps and overlaps in health and social care to the benefit of patients.

Where NHS health care services are commissioned under these arrangements ('joint commissioning'), they remain within scope of the *2014/15 National Tariff Payment System* even if commissioned by a local authority. Payment to providers of NHS services that are jointly commissioned are governed either by a national price as set out in [Annex 5A](#) (including national variations set out in Section 6) where applicable, or by a local price (including a local variation in Subsection 7.2). Payment for services where a local price is set must adhere to the general rules for local pricing in Subsection 7.4.1. Local authority social care or public health services which are commissioned under joint commissioning arrangements are outside of the scope of the *2014/15 National Tariff Payment System*.

3.6 Contractual incentives and sanctions

Financial incentives and sanctions are important tools, which can contribute to improved outcomes through targeting improvements in the quality of health services. Contract sanctions can also ensure basic standards of quality are maintained.

After a process of engagement with stakeholders, NHS England has now concluded its review of incentives, rewards and sanctions, and will be publishing revised arrangements for 2014/15 for the national Commissioning for Quality and Innovation (CQUIN) scheme and for the sanctions within the NHS Standard Contract.

³⁴ *Our Shared Commitment: Integrated Care & Support* (2013).

CQUIN payments and contractual sanctions are applied based on provider performance, after a provider's income has been determined in accordance with the *2014/15 National Tariff Payment System*. To the extent that any sanction changes the price paid for the provision of an NHS service, the sanction is permissible under the rules relating to the making of payments to a provider under Section 8 of the *2014/15 National Tariff Payment System*.

As part of the development of a long-term strategy for the payment system, Monitor and NHS England will be considering the design of the payment system alongside contractual incentives and sanctions.

4 Currencies with national prices

For the purposes of paying for or getting paid for the provision of NHS care, there are a number of ‘building blocks’ which underpin the operation of the payment system. These include clinical classification systems and currencies for which there will be mandatory national prices in 2014/15.

Under the 2012 Act, the national tariff must specify certain NHS health care services, for which a national price specified in the national tariff is to be payable³⁵. The health care services to be specified (i.e. the currencies) must be agreed between NHS England and Monitor³⁶. In addition, the 2012 Act provides that the national tariff may include rules for determining, where a services is specified in more than one way, which specification applies in any particular case. This section, supported by [Annex 4A](#) (and in combination with the full list of currencies in [Annex 5A](#)), describes the services which we specify in the *2014/15 National Tariff Payment System*, and includes such rules.

In this section, we also explain the main concepts commissioners and providers need to understand for commissioning, recording and paying for or getting paid for NHS care in 2014/15, and explain the concept of ‘grouping’ using software provided by the Health and Social Care Information Centre (HSCIC).

This section is structured as follows:

- Subsection 4.1 defines the concepts of classification, grouping and currency;
- Subsection 4.2 introduces our policy approach for determining which services have mandated national currencies in the *2014/15 National Tariff Payment System*;
- Subsection 4.3 presents the currencies that remain unchanged from 2013/14; and

³⁵ 2012 Act, section 116(1)(a).

³⁶ 2012 Act, section 118(7).

- Subsection 4.4 describes the changes to a small number of currencies in 2014/15. (For these currencies, the detailed methods for determining their prices in the *2014/15 National Tariff Payment System* are set out in Section 5).

Information to support the implementation of the 2014/15 mandated national currencies for national pricing is provided in the following documents:

- [Annex 4A](#) (additional information on currencies with national prices);
- [Annex 4B](#) (maternity data requirements and definitions); and
- the *National Tariff Information Workbook (including non-mandatory prices)*, which is a supporting guidance document in Microsoft Excel format.

Much of the detail of this section, together with the accompanying annexes and information workbook, replaces and revises some of the guidance published by the Department of Health in previous years under the PbR system. We may publish further supporting documentation in due course, depending on the requirements of users.

4.1 Introducing the concepts of classification, grouping and currency

The NHS payment system is a data-driven system that has its foundation in patient-level data. To operate effectively, the payment system needs:

- a clinical classification system – this enables information about patient diagnoses and health care interventions to be captured in a standard format; and
- a currency – the codes in the primary classification system referred to above are too numerous to form a practical basis for payment. They are therefore ‘grouped’ into currencies, which are the specified units of health care for which payment is made.

In this section, we define each of the following concepts and their function in the process for recording and classifying care for the purposes of payment:

- classification;
- grouping; and
- currency.

4.1.1 Classification

Clinical classification systems are used to describe information from patient records using standardised definitions and nomenclature. This is necessary for creating clinical data in a format suitable for statistical and other analytical purposes such as epidemiology, benchmarking and costing. The *2014/15 National Tariff Payment System* relies largely on two standard classifications to process clinical data on acute care. These are:

- International Classification of Diseases tenth revision (ICD-10) for diagnoses; and
- Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions³⁷.

Clinical coders translate patient notes into OPCS-4 and ICD-10 codes. They are health care professionals who require knowledge of medical science and terminology, and the ability to make decisions about the appropriate codes to assign, based on the clinical documentation.

There are also other classifications which underpin some areas of the national tariff. For example, the acute renal dialysis currencies use data items available from the national renal dataset (NRD), and the antenatal and postnatal elements of the maternity pathway system use data items available from the maternity services' secondary uses (SUS)³⁸ data set.

4.1.2 Grouping

Grouping is the process by which 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) included in patient records are mapped to a currency. This is done by using [grouper software produced by the HSCIC](#). The HSCIC also publishes comprehensive documentation alongside the grouper, including a Code to Group workbook that enables users of the grouper to see how currencies (e.g. Healthcare Resource Groups (HRGs), which are described in the next subsection) are derived and to understand the logic used.

³⁷ The latest upgrade for OPCS-4, OPCS-4.6, was implemented in April 2011, and a further update is due for implementation in April 2014.

³⁸ The Secondary Uses Service (SUS) is the single, comprehensive repository for health care data in England which enables a range of reporting and analyses to support the NHS in the delivery of health care services. Further detail is [available here](#).

4.1.3 Currency

A currency is a unit of health care for which a payment is made. Under the 2012 Act, a health care service for which a national price is to be payable must be specified in the national tariff. Each service specification is a currency. A currency can take a variety of forms. For 2014/15, we use HRGs – groupings of clinically similar treatments which use common levels of health care resources – as the currencies to be used for admitted patient care, A&E, and some procedures performed in outpatients.

The latest version of the HRG currency system (known as HRG4³⁹) is arranged in 21 chapters each covering a body system. Some chapters also have ‘sub-chapters’.

HRG4 introduced the concept of ‘unbundled’ HRGs, making it possible to separately report, cost and remunerate the different components within a care pathway. This provides a mechanism for moving parts of a care pathway, for example diagnostic imaging or rehabilitation, away from the traditional hospital setting.

The currency used for outpatient attendances is based on attendance type and Treatment Function Code (TFC), which is explained in more detail at Subsection 4.3.4.

Some currencies describe defined ‘pathways’ of care, and in 2014/15 these currencies are used as the basis for setting prices for services such as maternity care and cystic fibrosis care.

4.2 Approach to currencies with national prices

As described in Section 2, our overall approach to the *2014/15 National Tariff Payment System* is to keep currencies and relative national prices broadly stable to reduce uncertainty and risk. Two factors have motivated this approach:

- first, the NHS overall is going through extensive change already. We want to provide some certainty for the sector in this year of transition. Therefore we will keep currency specifications broadly stable and publish prices earlier in the year, to help commissioners and providers plan for 2014/15; and

³⁹ HRG4 is available [here](#).

- second, this is the first year that Monitor and NHS England have been responsible for the national tariff. Inevitably, some risks arise from the handover of systems, data and processes. We are seeking to minimise these risks and ensure the transition is as smooth as possible, in the interests of all stakeholders, including, most importantly, patients.

We describe the currencies that are unchanged for 2014/15 in Subsection 4.3.

We are, however, conscious of the need to ensure that the *2014/15 National Tariff Payment System* is clinically relevant and sufficiently up-to-date. For this reason, we have made a small number of changes. These include introducing and/or amending national currencies for a limited number of services and amending a small number of existing prices. These changes are set out in Subsection 4.4. In addition, the grouper software provided by the HSCIC to support the payment process will include updates to the OPCS classification system.

Details of the methods which we have used to determine the national prices of the currencies described in this section are provided in Section 5. The list of the resulting national prices can be found in [Annex 5A](#).

In this section, we describe the currencies for which there are national prices in 2014/15. The arrangements for the local pricing of services with mandatory currencies but no national prices, such as adult mental health and ambulance services, are covered in Section 7.

Our approach sometimes includes different service specifications or currencies, and different prices, for individual HRGs. For example, the Best Practice Tariff alternative currencies, and the different specifications and prices for different cases such as outpatient procedures, day case-electives, long stay cases and short stay emergency cases. As well as specifying the currencies, this section (in combination with [Annex 4A](#) and [Annex 5A](#)) provides the rules for determining the particular cases in which the different currencies/prices should be used⁴⁰.

⁴⁰ Such rules are made under section 116(6) of the 2012 Act.

4.3 Currencies unchanged from 2013/14

In this subsection, we look at the national currencies that will continue to underpin national prices in the NHS payment system in 2014/15. There are no changes to the structure of these currencies and no changes to their corresponding prices (other than changes made to all prices to reflect cost pressures and efficiency gains). The areas of care for which some national currencies will remain unchanged from 2013/14 are summarised in Table 4-1 below.

Table 4-1: Currencies unchanged from 2013/14

Currency type	Subsection
Admitted patient care	4.3.1
Chemotherapy and radiotherapy	4.3.2
Post discharge rehabilitation	4.3.3
Outpatient care	4.3.4
Direct access	4.3.5
Urgent and emergency care	4.3.6
Best practice tariffs	4.3.7
Pathway payments	4.3.8

4.3.1 Admitted patient care

In this subsection, we consider in detail the structure of currencies used for admitted patient care.

HRG4 is the currency for admitted patient care. There are different national prices depending upon the patient's admission type (e.g. elective or non-elective), although any given HRG may not necessarily have a national price for each admission type. For admitted patient care, there will continue to be separate prices for non-elective care, and for elective care and day cases combined.

While admitted, a patient may see more than one consultant during a spell⁴¹ of care. These are called finished consultant episodes (FCEs). The vast majority of patient spells have only one FCE in them, some have two and there are a small number with three or more.

HRG4 is spell based, unlike its predecessors which were FCE based. Prices are therefore based on spells of care. It is possible to group each individual FCE to a HRG, but a feature of HRG4 is that the overall spell groups to a HRG based on the coding in all the FCEs within the spell.

Admitted patient care national prices also cover all related tests including the costs of diagnostic imaging. The appropriate national price to be applied is determined by date of discharge, regardless of date of admission.

To promote the move to day case settings where appropriate, the majority of elective prices are determined as an average of costs of day cases and the costs of ordinary elective cases, weighted according to the proportion of activity in each.

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 there is significant outpatient activity, cost differences are relatively low, and where the approach is clinically appropriate.

Where a patient has more than one distinct admission on the same day (e.g. the patient is admitted in the morning, discharged, then re-admitted in the afternoon), then each of these admissions is counted as the beginning of a separate spell. Alternatively, these admissions may attract a separate price as part of a pathway payment approach agreed with commissioners.

Short stay emergency adjustments⁴² and long stay payments⁴³ will remain in place for admitted patient care. These are explained in detail below.

⁴¹ A spell is a period from admission to discharge or death. A spell starts when a consultant, nurse or midwife assumes responsibility for care following the decision to admit the patient.

⁴² 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.

⁴³ For patients that remain in hospital beyond an expected length of stay for clinical reasons, we allow an additional re-imbusement 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.

Short stay emergency adjustment

The short stay emergency adjustment is a mechanism for ensuring appropriate reimbursement for lengths of stay of less than two days, where the average HRG length of stay is longer.

The short stay emergency prices are published in [Annex 5A](#), based on the percentages in Table 4-2. The level of reduction depends on the national average length of stay of the HRG. For example, the payment is 70% of tariff for a HRG with an average length of stay of 2 days.

Table 4-2: Short stay emergency adjustment percentages

Band	HRG with national average length of stay	% of full tariff
1	0-1 days	100%
2	2 days	70%
3	3-4 days	45%
4	5 or more days	25%

In 2012/13, a new best practice tariff was introduced to promote same day emergency care.

The short stay emergency adjustment applies when all of the following criteria are met:

- the HRG is not within the scope of a best practice tariff;
- the patient's adjusted length of stay is either zero or one bed day;
- the patient is not a child, defined as aged under 19 years on the date of admission;
- 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);
- the average length of non-elective stay for the HRG is two or more days; and
- the assignment of the HRG has the potential to be based on a diagnosis code, rather than on a procedure code alone, irrespective of whether a diagnosis or procedure is actually dominant in the HRG derivation.

If all of these criteria are met, then the short stay emergency tariff and *not* the non-elective tariff applies, regardless of whether the patient is admitted under a medical or a surgical specialty. Any adjustments to the tariff, such as specialised service top-ups⁴⁴, are applied to the reduced tariff. [Annex 5A](#) shows which HRGs the reduced short stay emergency tariff is applicable to.

Long stay payment

A long stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a trim point specific to the HRG.

The HRG costs reported in the published 2010/11 reference costs do not include the cost of stays beyond a defined trim point (these are reported separately in reference costs as excess bed days). 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 payment will operate after a patient's length of stay exceeds the trim point, when a daily rate will apply.

In 2014/15 we are continuing with the approach first adopted in 2011/12, whereby there is a trim point floor of five days⁴⁵. For 2014/15, there will be two long stay payment rates per chapter – one for children-specific HRGs and one for all other HRGs. This was first introduced in 2013/14.

If a patient is medically ready for discharge and delayed discharge payments have been imposed on local authorities under the provisions of the Community Care (Delayed Discharges etc) Act 2003, then commissioners should not be liable for any further long stay payment. SUS PbR will apply an adjustment for delayed discharge when the Discharge Ready Date field is submitted in the CDS, by removing the number of days between that and actual discharge from any long stay payment. This is the only circumstance in which long stay payments may be adjusted. Where the Discharge Ready Date field is submitted, providers will wish to satisfy themselves that local authorities are being appropriately charged.

4.3.2 Chemotherapy and radiotherapy

In this section, we describe the HRG sub-chapters that relate to chemotherapy and radiotherapy.

⁴⁴ Specialist top-ups are paid to reimburse providers for the higher costs of treating patients who require specialised care. Further information is provided in Section 6.

⁴⁵ 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.

Chemotherapy

Sub-chapter SB covers both the procurement and the delivery of chemotherapy regimens for patients of all ages. The HRGs in this sub-chapter are unbundled and include activity undertaken in inpatient, day case and non-admitted care settings.

Chemotherapy payment is split into three parts:

- a core HRG (covering the primary diagnosis or procedure) – this has a national price;
- unbundled HRGs for chemotherapy drug procurement – these have local currencies and prices; and
- unbundled HRGs for chemotherapy delivery – these have national prices.

Radiotherapy

Sub-chapter SC covers both the preparation and the delivery of radiotherapy for patients of all ages. The HRGs in this sub-chapter are for the most part unbundled and include activity undertaken in inpatient, day case and non-admitted care settings.

HRG4 groups for radiotherapy include one set for pre-treatment (planning) processes and one set for treatment delivered, with a separate HRG being allocated for each fraction delivered. These groups are therefore:

- radiotherapy planning; and
- radiotherapy treatment (delivery per fraction).

The planning HRGs are intended to cover all attendances required for completion of the planning process. It is not intended that individual attendances for parts of this process will be recorded separately.

The planning HRGs do not include the consultation at which the patient consents to radiotherapy, nor do they cover any medical review required by any change in status of the patient.

The HRGs for radiotherapy cover the following elements of care:

- external beam radiotherapy preparation – has a national price;
- external beam radiotherapy delivery – has a national price; and
- brachytherapy and liquid radionuclide administration – has local currencies and prices.

Further information on the structure of the chemotherapy and radiotherapy HRGs and payment arrangements can be found in [Annex 4A](#).

National prices for the chemotherapy and radiotherapy currencies were introduced in 2013/14. Section 6 contains information on national variations to national prices that are designed to ensure that the risks associated with transition to new payment approaches are shared appropriately.

4.3.3 Post discharge rehabilitation

National prices for post discharge rehabilitation were first introduced in 2012/13 to encourage a shift of responsibility for patient care following discharge to the acute provider who treated the patient. This was in response to increasing emergency re-admission rates in which many patients were being re-admitted to providers following discharge.

Post discharge national currencies cover an entire pathway of treatment. Their use is designed to help reduce the number of avoidable emergency re-admissions and provide a service which has been nationally agreed by clinical experts to facilitate better post discharge rehabilitation and re-ablement for patients.

NHS staff helped develop post discharge currencies for four specific rehabilitation pathways:

- cardiac rehabilitation⁴⁶;
- pulmonary rehabilitation⁴⁷;
- hip replacement rehabilitation; and
- knee replacement rehabilitation.

For 2014/15, the national prices for these four post discharge currencies will continue to be mandatory for the care of patients where a single provider provides both acute and community services. Where services are not integrated, the national price would not apply; we would however encourage the use of these prices in local negotiations on commissioning of post discharge pathways of care.

⁴⁶ Based on the pathway of care outlined in the Department of Health's *Cardiac Rehabilitation Commissioning Pack*.

⁴⁷ Based on the pathway of care outlined in the Department of Health's *Chronic Obstructive Pulmonary Disease (COPD) Commissioning Pack*.

Degrees of service integration vary and so commissioners and providers will need to establish which health communities receive both acute and community services from a single provider in order to determine whether the post discharge national prices should be used.

The post discharge national prices must be paid on completion of a full rehabilitation pathway.

The post discharge activity and national price will not be identified by the grouper or by SUS so in deriving a contract for this service, local agreement between commissioners and providers will be required on the number of patients expected to complete rehabilitation packages. This forecast would then be reconciled to the actual numbers of packages completed at year end.

Further detail on all four post discharge currencies, their scope and their specific rules can be found in [Annex 4A](#).

4.3.4 Outpatient care

In this subsection, we consider in detail the structure of currencies used for outpatient care (this includes outpatient attendances and outpatient procedures).

Outpatient attendance national prices are based on TFCs. A TFC is based on the Main Specialty Code, which describes the speciality within which the consultant is recognised or contracted to the organisation. TFCs record the service within which the patient is treated and are, in effect, sub-specialisations⁴⁸.

The outpatient attendance national price remains applicable only to pre-booked, consultant-led attendances. The pre-booking requirement is not limited to Choose and Book⁴⁹, and may include local systems accepting 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.

⁴⁸ 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”.

⁴⁹ 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.

Where an attendance with a consultant from a different main specialty during a patient's admission replaces an attendance which would have taken place regardless of the admission then, provided it is pre-booked and consultant-led, it should attract a national price.

Where a patient has multiple distinct outpatient attendances on the same day (e.g. attendance in the morning and then a second separate attendance in the afternoon) then each of these attendances is counted separately and will attract a separate national price unless a pathway price has been agreed with commissioners.

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 to receive the national price. For these clinics, it is important to make sure the data flows into SUS PbR⁵⁰ in order 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.

For the avoidance of doubt, if a patient proceeds to separate attendances with an Allied Health Professional (AHP) (e.g. a physiotherapist) following an outpatient attendance, the costs of attendances with the AHP are not included in the national price for the original attendance.

Commissioners and providers should use the NHS Data Model and Dictionary to agree on the appropriate categorisation of outpatient attendance and day case activity⁵¹. Furthermore, providers must ensure that the way that they charge for activity is consistent with the way that they cost activity in reference costs, and consistent with any conditions for payment that commissioners include within contracts.

For some procedures that are undertaken in an outpatient setting, there are mandatory HRG prices. If more than one of these procedures is undertaken in a single outpatient attendance, only one price will be paid to the provider. The grouper software will determine the appropriate HRG, and the provider will receive payment based on the price for this HRG.

⁵⁰ An explanation of what SUS PbR is and does can be [found here](#).

⁵¹ The [NHS Data Model and Dictionary Service](#) is a source of information on this issue. It provides a reference point for assured information standards to support health care activities within the NHS in England. The Audit Commission also [carried out a review](#) on definitional issues in conjunction with the Department of Health, and the HSCIC.

Where patient data generates a procedure-driven HRG (i.e. not from HRG4 sub-chapter WF⁵²), SUS PbR determines whether the HRG has a mandatory HRG national price and, if so, applies it. Outpatient procedures for which there is no mandatory HRG price will be paid using the relevant outpatient attendance TFC national price.

Where patient data generates a non-admitted attendance HRG (i.e. from HRG4 sub-chapter WF), SUS PbR determines whether the relevant mandatory outpatient attendance national price, based on TFC, is applicable, and, if so, applies it. If the TFC does not have a mandatory national price, the price should be set through local negotiation between commissioners and providers. The national price for any diagnostic imaging associated with the attendances must be used in all cases.

Diagnostic imaging in outpatients

In 2013/14, separate national prices were set for diagnostic imaging from the outpatient attendance prices. This change was made to address concerns raised by the sector about under-payment of diagnostic imaging delivered for complex patients and under-provision of imaging services in some local areas. It was also felt that paying separately for outpatient diagnostic imaging may allow primary care to have more direct access to diagnostic imaging, supporting primary care clinicians to make diagnoses without a consultant referral.

The approach of setting separate national prices for diagnostic imaging in outpatients will continue in 2014/15. These national prices are mandatory, regardless of whether or not the core outpatient attendance activity has a mandatory national price. Section 6 contains information on national variations designed to assist with the transition to separate prices for diagnostic imaging.

4.3.5 Direct access

There are a number of national prices for activity accessed directly from primary care, for diagnostic imaging and also for airflow studies and flexible sigmoidoscopies. One example is where a GP sends a patient for a scan and results are sent to the GP for discussion with the patient. This is in contrast to such a service being requested during an outpatient consultation.

⁵² HRGs are divided into a number of categories, or 'chapters'. Sub-chapter WF is dedicated to non-admitted consultations.

A new (optional) field was added to the outpatient CDS version 6.2 which can be used to identify services that have been accessed directly⁵³.

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 and the separate diagnostic imaging should attract a payment.

Direct access diagnostic imaging

There are national prices for direct access diagnostic imaging. While the costs of reporting are included in the published prices, they are also shown separately so that they can be used in case an organisation provides a report but does not carry out the scan.

Other direct access prices

There are also national prices for:

- direct access simple airflow studies (HRG DZ44Z);
- simple bronchodilator studies (HRG DZ35Z); and
- diagnostic flexible sigmoidoscopy 19 years and over, with and without biopsy (HRGs FZ54Z and FZ55Z).

There is also a non-mandatory price for direct access plain film x-rays, for which information is provided in [Annex 4A](#).

4.3.6 Urgent and emergency care

For 2014/15, there will continue to be national prices mandated for A&E and minor injury units (MIUs), based on 11 HRGs (sub-chapter VB – Emergency Medicine). The A&E currency model has been designed with classifications based on investigation and treatment.

Where a patient is admitted following an A&E attendance, both the relevant A&E and non-elective prices would be payable. Patients who are dead on arrival (DOA) must always attract the price VB09Z.

⁵³ SUS PbR does not yet use this field, and will not distinguish between outpatient services and services accessed directly. For diagnostic imaging, this means that SUS PbR will assign a national price to any direct access diagnostic imaging activity that is submitted to the outpatient CDS, and providers must ensure that this activity is reported against TFC 812 (diagnostic imaging) so that an attendance national price is not paid in addition. Providers and commissioners can, however, use the information in this optional field locally to identify services accessed directly.

For 2014/15, Type 1 and Type 2 A&E departments continue to be eligible for the full range of A&E national currencies and corresponding national prices, and Type 3 A&E departments are eligible for the simplest currency only (VB11Z).

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 7.

There will continue to be short stay emergency prices (as explained at Subsection 4.3.1). These ensure that emergency stays of less than two days, where the average length of stay of the HRG is longer, are appropriately reimbursed.

4.3.7 Best practice tariffs

This subsection sets out information on the 2013/14 best practice tariffs (BPTs) that are structurally unchanged in 2014/15. Information on the one new BPT being introduced in 2014/15 and amendments to two existing BPTs can be found at Subsection 4.4.3.

The BPT prices can be found in [Annex 5A](#), and information to assist with implementation is provided in [Annex 4A](#).

A BPT is a national price that is designed to incentivise high quality and cost effective care. 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.

Where a BPT introduces an alternative currency, that currency should be used in the cases described here, and in [Annexes 4A](#) and [5A](#)⁵⁴.

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:

- avoiding unnecessary admissions;

⁵⁴ The provisions set out in this section 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 of cases).

- delivering care in appropriate settings;
- promoting provider quality accreditation; or
- improving quality of care.

The service areas covered by BPTs are all selected as being:

- high impact (i.e. high volumes, significant variation in practice, or significant impact on patient outcomes); and
- supported by a strong evidence base and clinical consensus as to what constitutes best practice.

The first BPTs were introduced in 2010/11 following Lord Darzi's review in 2008⁵⁵. In 2013/14, 17 mandatory best practice tariffs were included in the Department of Health's PbR guidance.

A summary of the full 2014/15 BPT package and its evolution is provided in Table 4-3 below.

Table 4-3: Summary of BPT package for 2014/15

BPT	Introduced	Additional changes since introduction	
Acute stroke	2010/11	2011/12 and 2012/13 2013/14	<ul style="list-style-type: none"> ○ Increased price differential ○ Currency split to differentiate by patient complexity
Cataracts	2010/11	2013/14	<ul style="list-style-type: none"> ○ Status changed from mandatory to non-mandatory
Fragility hip fracture	2010/11	2011/12 2012/13	<ul style="list-style-type: none"> ○ Increased price differential ○ Further increase in price differential + expansion of best practice characteristics

⁵⁵ *High Quality Care For All*, presented to Parliament in June 2008.

BPT	Introduced	Additional changes since introduction	
Day case procedures	2010/11 (gall bladder removal only)	2011/12 2012/13 2013/14	<ul style="list-style-type: none"> ○ 12 further procedures added ○ 2 further procedures added + breast surgery procedures amended and revisions to some day case rates ○ 1 further procedure added + hernia and breast surgery procedures amended
Adult renal dialysis	2011/12 (vascular access for haemodialysis)	2012/13	<ul style="list-style-type: none"> ○ Home therapies incentivised
Transient ischaemic attack	2011/12	2013/14	<ul style="list-style-type: none"> ○ MRI payment removed in line with guidance on unbundling
Interventional radiology	2011/12 (2 procedures introduced)	2012/13	<ul style="list-style-type: none"> ○ 5 further procedures introduced
Outpatient procedures	2012/13 (3 procedures introduced)	2013/14	<ul style="list-style-type: none"> ○ Flexibility to encourage see and treat hysteroscopy
Same-day emergency care	2012/13 (12 clinical scenarios introduced)	2013/14	<ul style="list-style-type: none"> ○ 7 new clinical scenarios introduced
Diabetic ketoacidosis and hypoglycaemia	2013/14		
Early inflammatory arthritis	2013/14		
Endoscopy procedures	2013/14		
Paediatric epilepsy	2013/14		

BPT	Introduced	Additional changes since introduction	
Parkinson's disease	2013/14		
Pleural effusions	2013/14		
Major trauma care	2012/13	2014/15	<ul style="list-style-type: none"> Best practice characteristics changed
Paediatric diabetes	2011/12 (activity based structure – non-mandatory)	2012/13 2014/15	<ul style="list-style-type: none"> Year of outpatient care structure (mandatory) Updated to include inpatient care
Primary hip and knee replacement outcomes	2014/15		

Further detail on the BPTs listed above can be found in [Annex 4A](#).

Some BPTs relate to specific HRGs while others are more granular and relate to a subset of activity within a HRG. The BPTs that are set at a more granular level are identified by BPT 'flags', which are listed in [Annex 5A](#). 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.

Specialist top-ups and long-stay payments would apply to all of the relevant BPTs. The short stay emergency adjustment would apply to all relevant BPTs except for acute stroke care, fragility hip fracture and same-day emergency care.

4.3.8 Pathway payments

This subsection sets out information on the 2013/14 pathway payments that remain structurally unchanged in 2014/15. Pathway payments are single payments that cover a bundle of services provided by a number of 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 health care providers. Improving the co-ordination of care, including across different settings of care (e.g. primary, secondary, community services and social care), has the potential to improve patient outcomes through reducing complications and readmissions. Pathway payments therefore aim to promote the greater clinical effectiveness and efficiency to be gained by organising the pathway of care as a whole.

There are two pathway-based payment systems. These relate to the provision of maternity health care services and to the provision of health care for patients with cystic fibrosis. We discuss each of these pathway payments in turn below.

Maternity pathway payment

The maternity pathway payment system was mandated in 2013/14. The new pathway payment approach was introduced to address two main issues arising from the previous episodic payment system. These were that:

- there were persistent problems with the way different providers described and recorded antenatal and postnatal non-delivery activity; and
- there was an unintended incentive to provide excess clinical interventions where some patients may have benefited from fewer interventions but more proactive care.

The new approach aimed to resolve these issues and to encourage providers to develop innovative and patient-centred approaches to the delivery of maternity care. In conjunction with patient choice and local contracts that focus on quality, this payment approach frees providers to develop services that focus on outcomes for patients rather than inputs.

The new payment approach also included some services that were previously part of local contracts and not covered by mandatory national prices, such as community antenatal and postnatal care. The cost of these services is now covered by the pathway payments.

The maternity pathway is split into three stages; antenatal, delivery and postnatal. The woman chooses her provider, and the commissioner makes a single payment to that provider (who is known as the lead provider) to cover the cost of all required care. The level of the payment that the provider receives depends on factors that will affect the level of care that the woman is expected to require.

Women may still receive some of their care from a different provider either through choice or clinical need, but this care is paid for by the lead provider who will have received the entire pathway payment from the commissioner. Women may have a different lead provider for each of the three stages of the maternity pathway.

Further information on the pathway payment approach can be found in Annexes 4A and 4B. Section 6 contains information on national variations that are designed to ensure that the risks associated with transition to new payment approaches are shared appropriately.

Cystic fibrosis pathway payment

The cystic fibrosis (CF) pathway currency is a complexity-adjusted yearly banding system with seven bands of increasing patient complexity. There is no distinction between adults and children.

The CF pathway currency was designed to support specialist CF multidisciplinary teams to provide care in a seamless, patient-centred manner, removing any incentives to hospitalise patients who 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.

4.4 Currency updates to support clinical development

As explained above, we are making a small number of changes to currencies and associated prices in 2014/15 to ensure that the national tariff is clinically relevant and sufficiently up-to-date. These changes are summarised in Table 4-4 below and include a limited number of new currencies with associated prices.

Table 4-4: Summary of currency updates

Description of change	Currency description	New/revised price for 2014/15?
New HRGs		
Kidney and ureter: reflect relative costs of laparoscopic and open procedures	4.4.1	Yes (Subsection 5.6.1)
Complex bronchoscopy: correct for under-reimbursement	4.4.1	Yes (Subsection 5.6.2)
Complex therapeutic endoscopy	4.4.1	No
Acute kidney injury: identify dialysis procedures	4.4.1	No
HRG design changes		
STARR ⁵⁶ : adjustment for under-reimbursement	4.4.2	No
Fractional flow reserve (FFR): correct for under-reimbursement	4.4.2	No
Orthopaedics: better reflect the costs of treatment for physical abuse	4.4.2	No
Spinal surgery ⁵⁷ : correct for under-reimbursement	4.4.2	No
Electroencephalograph telemetry: correct for under-reimbursement	4.4.2	No
Intravenous induction of labour: discourage incorrect coding	4.4.2	No
General coding: encourage coding of 'other' and 'unspecified' procedures using correct chapters	4.4.2	No

⁵⁶ Stapled transanal rectal resection for obstructed defecation syndrome.

⁵⁷ Specifically: spinal surgery for posterior instrumented spinal instrumentations and decompressions for tumour and deformity.

Description of change	Currency description	New/revised price for 2014/15?
New or amended best practice tariffs		
New best practice tariff: primary hip and knee replacements	4.4.3	Yes (Subsection 5.6.3)
Amended best practice tariff: paediatric diabetes	4.4.3	Yes (Subsection 5.6.4)
Amended best practice tariff: major trauma	4.4.3	No
New mandatory prices		
Health assessments for looked after children (out-of-area)	4.4.4	Yes ⁵⁸ (Subsection 5.6.5)
Corrected prices		
RC31Z (interventional radiology procedures – hepatobiliary – major)	4.4.5	Yes (Subsection 5.6.6)
Change from mandatory to non-mandatory price		
RA42Z (PET CT)	4.4.6	Yes (Subsection 5.6.7)

Further detail and explanation of these changes is provided in the rest of this subsection.

4.4.1 New HRGs

We are introducing new HRGs in four areas, two of which have associated national prices and two of which do not have national prices. We discuss each of these in turn below.

Laparoscopic kidney and ureter operations

Laparoscopic operations on the kidney and ureter are covered by a single HRG in the 2013/14 national tariff.

⁵⁸ The non-mandatory price made available in 2013/14 will be mandatory in 2014/15.

For the 2014/15 national tariff, we are introducing a new HRG design (with associated national prices) to allow more complex laparoscopic operations, such as nephrectomy (kidney removal), to be reimbursed at a more appropriate level. The new HRG design also takes better account of the presence or absence of complications or comorbidities. As a result, six HRGs have been deleted and eight new HRGs have been created. These HRGs and associated new prices are provided in [Annex 5A](#).

Complex bronchoscopy

We are introducing a new HRG design and national price for complex bronchoscopy, which is designed to reflect the resource use of this specialised procedure more accurately, and therefore support its implementation.

Complex therapeutic endoscopy

We are also introducing a new HRG design for complex therapeutic endoscopy, although we are not specifying a national price for this activity in 2014/15. The currency should be used for local price-setting, in accordance with the rules in Subsection 7.4.

Dialysis for acute kidney injury

Dialysis for acute kidney injury is not currently identified by HRGs, and will be associated with activity in many different HRGs. We have changed the design of HRGs to help providers and commissioners better identify and discuss dialysis for acute kidney injury.

As a result, four new HRGs⁵⁹ are being introduced for dialysis for acute kidney injury. Activity for these HRGs can be identified using combinations of procedure and diagnosis codes. These HRGs are unbundled HRGs, i.e. they are generated in addition to a HRG for the core activity for the patient. One HRG will be generated for each session of dialysis.

We are not specifying national prices for these new HRGs for 2014/15, but commissioners and providers should use these new currencies in accordance with the rules in Section 7.4.

⁵⁹ LE01A, LE01B, LE02A and LE02B.

4.4.2 Changes to the design of seven HRGs

We are changing the design (i.e. currency specification, but not pricing method) of seven HRGs. We discuss the change in design being made to each of the seven HRGs in turn below.

New HRG design for stapled transanal rectal resection for obstructed defecation syndrome (STARR)

STARR is a complex procedure that is not appropriately reimbursed under the HRG design used for 2013/14 national prices.

The new design ensures that STARR procedures group to HRGs FZ11A/B (large intestine – major procedures). The grouper will use a combination of procedure codes⁶⁰ to identify this activity.

New HRG design for fractional flow reserve (FFR)

FFR (a heart procedure) when used with arteriography is not appropriately reimbursed under the HRG design used for 2013/14 national prices.

For 2014/15, the FFR approach when used with arteriography will now group to HRG EA35Z (other percutaneous interventions). The grouper would identify the activity using a combination of procedure codes and reflects new coding guidance for coding FFR⁶¹.

New HRG design to recognise coding of physical abuse in orthopaedics

There is an anomaly in the way ICD-10 (diagnosis) codes for physical abuse are treated within the orthopaedic HRG chapter. We have corrected this for 2014/15 to ensure that the coded activity groups to the appropriate HRG. This affects a very small amount of activity and is not concentrated in any particular HRG.

New HRG design for spinal surgery for posterior instrumented spinal instrumentations and decompressions for tumour and deformity

This set of spinal surgery procedures are not appropriately reimbursed under the HRG design used for 2013/14 national prices.

⁶⁰ The majority of this activity previously mapped to HRG FZ50Z (intermediate large intestine procedures 19 years and over).

⁶¹ The majority of this activity previously mapped to HRGs EA36A/B (catheter).

For 2014/15, activity relating to posterior instrumented spinal instrumentations and decompressions for tumour and deformity will group to HRG HR02Z (reconstruction procedures category 5). The grouper will identify this activity using a combination of procedure codes⁶².

New HRG design for electroencephalograph telemetry

This complex procedure is not appropriately reimbursed for certain conditions under the HRG design used for 2013/14 national prices.

Activity for electroencephalograph telemetry will group to other HRGs in chapter AA (largely AA20A/B and AA21A/B), by reinstating the HRG design that was in place in 2012/13. In addition, HRGs AA34C/D (neurophysiological operations) have been renamed as AA34E/F (other neurophysiological operations) for 2014/15, to reflect the change in activity mapping to these HRGs.

New HRG design to discourage use of OPCS-4 code X351 (intravenous induction of labour)

We are introducing a new design to improve compliance with coding guidance for this procedure. According to [coding guidance](#), the procedure (OPCS-4) code X351 is not to be used.

This procedure code maps to a HRG which attracts a zero price – UZ01Z (data invalid for grouping). This will affect a very small amount of activity.

New HRG design to discourage use of .8 and .9 codes from OPCS-4 overflow chapters

Guidance on the use of procedure (OPCS-4) codes is issued by the Clinical Classifications Service at the HSCIC. There are instances in OPCS-4 where an existing full category needs extension. In such cases, and dependent on the chapter capacity, an extended category has been added within the chapter. These categories are referred to as principal and extended categories.

For example **C46 Plastic operations on cornea** is extended at **C44 Other plastic operations on cornea**. The .8 or .9 code should always be assigned from the principal category. The principal category can be distinguished from the extended category in the OPCS-4 Tabular List by reference to the note. The use of these codes, which is not in line with the guidance issued by the

⁶² The majority of this activity previously mapped to HRG HC02B/C (extradural spine major 1).

Clinical Classifications service, will map to HRG UZ01Z (data invalid for grouping), which has a zero price.

4.4.3 Changes in best practice tariffs

We are introducing one new BPT and amending two existing BPTs. These are discussed in turn below.

New BPT for primary hip and knee replacement outcomes

This BPT is our first step towards linking payment to outcomes achieved for patients. We believe that through linking payment more closely to what matters to patients, namely their outcomes and experiences of care, we can create incentives for a more consistent delivery of efficient and clinically effective care.

The aim of the BPT is to reduce the unexplained variation that exists between providers in terms of the outcomes of surgery as reported by patients.

The new BPT applies to all elective admissions that generate HRGs HB12B, HB12C, HB21B and HB21C. This BPT replaces the BPT for primary hip and knee replacements set out in previous 2013/14 guidance under the PbR system. Payment of the BPT is conditional on criteria linked to data collected through Patient Reported Outcome Measures (PROMs) and the National Joint Registry (NJR), set out below.

There are considerable differences between individual providers' levels of compliance with both the PROMs and NJR collections. Collecting data on quality of care through PROMs and clinical audits is important as these data underpin high quality care and can inform choices made by commissioners and patients, as well as the development of policy. By linking payment for the BPT to achieving minimum levels of compliance and consent rates, we aim to improve data collection, submission and response rates.

Payment of the new BPT is therefore conditional on two areas of best practice. The criteria for payment of the BPT are:

- the provider not having an average health gain significantly below the national average⁶³; and

⁶³ Defined as 3 standard deviations (99.8% significance) below the mean and termed an 'alarm' in the PROMs publication.

- the provider adhering to the following data submission standards:
 - a minimum PROMs participation rate of 50%;
 - a minimum NJR compliance rate of 75%; and
 - an NJR unknown consent rate below 25%.

Where these criteria are not met, providers will receive a price 10% below the best practice price.

Health gain will be measured by the condition-specific Oxford hip score and Oxford knee score after applying a casemix adjustment for primary joint replacement procedures only. The casemix adjustment controls for patient characteristics, including the patient's health status before the operation and the average health that would be expected.

Collections of these data are well established so we do not expect this new requirement to be burdensome to providers. These particular collections contain all of the information a commissioner would need to help identify whether a provider is achieving best practice. As data are regularly updated and published, commissioners will need to use the latest available data sets to assess whether or not providers have met the best practice payment criteria. These are to be found at:

- PROMs: www.hscic.gov.uk/proms
- NJR: www.njrcentre.org.uk

This is a new and innovative approach to BPTs and the payment criteria have been set accordingly. The minimum criteria required to receive the BPT have been set at a level thought achievable by most providers but below levels currently delivered by the highest achieving providers. The intention is that these rates will increase in future years in line with improvements. Therefore, all providers should strive to improve regardless of whether or not they meet the current standard.

The intention is that providers and commissioners will monitor their data and, where identified as outliers, improve their performance.

We recognise that there are circumstances where some providers will not be able to demonstrate that they meet all of the best practice criteria, but where it would be inappropriate for the full BPT not to be paid. These are explained in Section 6, which describes the arrangements for national variations to prices in 2014/15.

Amended BPT: Paediatric diabetes year of care

In a change from 2013/14, the price for this BPT now includes payment for all inpatient admissions (elective and non-elective) which are for diabetes⁶⁴.

The aim of this BPT is to enable access to consistent high quality management of diabetes. It is an annual payment that covers all diabetes care after the initial diagnosis of diabetes until the young person is transferred to adult services at the age of 19. The cost of insulin pumps and associated consumables are not covered by the BPT.

Providers will no longer be reimbursed separately for diabetes management admissions of children where they receive the BPT.

Providers not meeting the best practice standards will be paid on the basis of the existing outpatient attendance prices (first and follow-up) for TFC 263 and the two paediatric diabetes HRGs (with and without ketoacidosis).

Amended BPT: Major trauma

In 2014/15 we are amending and adding to the 2013/14 criteria for both Level 1 and Level 2 payments under the BPT for major trauma.

Although the criteria have changed, the 2013/14 price has not changed (except to reflect the cost uplifts and efficiency requirement).

The major trauma BPT was designed to drive improved standards of care while ensuring an appropriate level of re-imburement for Major Trauma Centres (MTCs). The BPT supports funding for enhanced specifications for MTCs which include immediate consultant input, immediate access to imaging and surgery, combined multispecialty input, and planned complex rehabilitation.

Changes for 2014/15 have been informed by a recommendation from the Major Trauma Clinical Reference Group (CRG) that we should amend the criteria for best practice in order to continually improve quality of care for patients.

⁶⁴ Admissions of paediatric diabetes patients which are not related to diabetes can still be invoiced separately.

The BPT is made up of two levels of payment differentiated by the [Injury Severity Score \(ISS\)](#) of the patient and conditional on achieving the criteria set out below.

A Level 1 BPT is payable for all patients with an ISS of more than 8, providing that the following criteria are met:

- the patient is treated in an MTC;
- Trauma Audit and Research Network (TARN) data is completed and submitted within 25 days of discharge;
- a rehabilitation prescription is completed for each patient and recorded on TARN;
- any coroners' cases are flagged within TARN as being subject to delay to allow later payment;
- tranexamic acid must be administered for those patients receiving blood products within three hours of injury; and
- if the patient is transferred as a non-emergency, they must be admitted to the MTC within two calendar days of referral from the Trauma Unit (TU)⁶⁵. **This is a new Level 1 criterion for 2014/15.**

A Level 2 BPT is payable for all patients with an ISS of 16 or more providing Level 1 criteria are met and that the following additional criteria are also met:

- if the patient is admitted directly to the MTC or transferred as an emergency, the patient must be received by a trauma team led by a consultant in the MTC. The consultant can be from any specialty, but must be present within five minutes (**this is new for 2014/15, the criteria for 2013/14 was 30 minutes**); or
- if the patient is transferred as a non-emergency they must be admitted to the major trauma centre within two calendar days of referral from the TU⁶⁶; and

⁶⁵ If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution.

⁶⁶ If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution.

- Patients directly admitted to an MTC with a head injury (AIS⁶⁷ 1+) and a GCS⁶⁸ <13 (or intubated pre-hospital), and who do not require emergency surgery or interventional radiology within one hour of admission, receive a head CT scan within 60 minutes of arrival. **This criterion is new for 2014/15.**

A patient cannot attract payments for both Level 1 and 2. For example, a patient with an ISS score of 17 would get a Level 2 payment.

We will continue to review these payment criteria in future years to ensure care is of the highest possible standard.

The BPT applies to adults and children.

The BPT will not be applied through SUS PbR and organisations will need to use the TARN database to support the payment. Further information to assist with the implementation of the major trauma BPT is provided in [Annex 4A](#).

4.4.4 New national prices for looked after children health assessments

Looked after children are one of the most vulnerable groups in society and data show that they have poorer health outcomes than other children with a corresponding adverse impact on their life opportunities and health in later life. 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.

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.

Usually, there are clear arrangements between commissioners and local providers for health assessments of looked after children placed 'in-area'. However, arrangements for children placed out-of-area are variable, resulting in concerns over the quality and scope of assessments. There are often no clear requirements and no established communication channels between remote local authorities and providers. Considerable delays can occur due to the individual negotiations between commissioners and providers.

⁶⁷ Abbreviated Injury Scale. See website of the [Trauma Audit & Research Network](#).

⁶⁸ Glasgow Coma Scale. See explanation on [NHS Choices](#) website.

To address this, a currency was devised and mandated for use in 2013/14, including a checklist for the components that must be included in the assessment. The aim was to promote consistency and also enable more timely assessments. Non-mandatory prices were also made available for use in 2013/14. For 2014/15 we are specifying mandated national prices as well as the currency itself. A checklist for implementing the currency is included in Annex 4A.

4.4.5 Corrections to 2013/14 national prices

For elective activity in RC31Z (interventional radiology (IR) procedures - hepatobiliary – major), there was an oversight in preparing the 2013/14 national tariff and so the price was incorrect. For 2014/15, we have corrected this (further detail is given in Section 5).

4.4.6 Change from mandatory to non-mandatory price

In 2014/15, there will no longer be a mandatory national price for RA42Z (PET CT scans). Further detail is provided in Section 5.

5 Method for determining national prices

One of the functions of the national tariff is to set the national prices for certain health care services (which we group as ‘currencies’ for pricing purposes). In this section, we explain our method for determining the national prices for the currencies described in Section 4.

Under our rules for locally determined prices (see Section 7), where local prices already exist for services without a national price, the cost uplift factors and efficiency requirements in the *2014/15 National Tariff Payment System* must be used as the basis for local negotiation.

This section is structured as follows:

- first, we explain the key principles that have informed our method for determining national prices;
- second, we describe our overall approach, which is to use the 2013/14 prices as the base. We refer to this as a ‘rollover’ approach;
- third, we discuss the method and data sources for uplifting 2013/14 prices to reflect inflation and other cost pressures on providers;
- fourth, we explain the efficiency requirement, which reflects our expectations for how much more efficient we expect providers, in aggregate, can be in 2014/15;
- fifth, we present the overall (nominal) changes to national prices for the currencies that are unchanged from 2013/14 (the vast majority), which reflects our rollover approach; and
- finally, we discuss our methods for determining the national prices of some new or altered currencies in the *2014/15 National Tariff Payment System*.

This section has one associated annex, [Annex 5A](#), which sets out the national prices for 2014/15, as determined using the methods described in this section.

5.1 Key principles

Under the 2012 Act, NHS England and Monitor have joint responsibility for the payment system, including setting national prices for particular services. This is the first time that we have set national prices, so we have not previously established the principles that guide our pricing decisions. Therefore, in this subsection, we explain the underlying principles that we have adopted for setting prices.

Our aim is to set unit prices that encourage better patient care within the budget available. We have developed two principles which support this overall aim, reflecting our statutory duties, best practice in pricing regulation and input from the sector.

Our two key principles are that:

- prices should reflect efficient costs; and
- prices should provide appropriate signals.

We explain each of these below.

5.1.1 Prices should reflect efficient costs

In other parts of the economy, prices for a product or service generally reflect the resource costs of providing that product or service. There are circumstances where this does not apply – for example, in non-competitive markets (where a single buyer or seller may be able to extract an unfair premium). In many cases, this leads to regulatory intervention.

Consistent with our duties, and in particular our duty to ensure that prices for providers are set at a fair level⁶⁹, we consider that prices, as in other parts of the economy, should reflect the efficient costs of provision.

This means that prices should reflect the costs that a reasonably efficient provider ought to incur in supplying health care services at the level of quality expected by commissioners. In turn, providers can recover their efficiently incurred costs (which will typically include provisions for the depreciation and financing of capital expenditure as well as for necessary operating expenditure). This can be particularly important in the long-term, as it can allow providers to expect to earn a reasonable return on their investments.

⁶⁹ See, in particular, the 2012 Act, section 119(1).

A significant caveat to our principle that prices should reflect efficient costs is that they should do so *only so far as is practicable*. In setting prices, and designing the pricing system more generally, there will be an inevitable tension between two competing factors:

- on the one hand, having a proliferation of prices for different types of services and different types of patients will tend to reflect more accurately the underlying efficient costs of providing those services relative to a pricing system with fewer prices; and
- on the other hand, a system with a proliferation of prices will tend to be more complicated, difficult to operate and costly to administer. This would affect both the central administrators of the system as well as the stakeholders operating in it.

Therefore, in setting prices, we balance the need for prices to reflect efficient costs and the need for the pricing system to be as simple and as transparent as possible.

A further caveat to note is that, relative to other sectors of the economy, the health care sector has some unusual features that are likely to affect the pricing system as a whole. For example, those benefiting from (and increasingly choosing) the service – patients - do not pay for that service. Also, there are often significant information asymmetries between patients, commissioners and providers. This means, for example, that it is sometimes difficult for patients to know what the most appropriate service is – particularly relative to the provider that is serving the patient.

Because of this, unit prices should only be considered as one feature of the overall payment system. Other common features for payment systems in health (often at a more aggregate level) include quality bonuses and sanctions, and measures for supply-side cost sharing to help limit total spend growth. It is not uncommon, for example, for payments in health to be subject to a payment cap to encourage appropriate provider behaviour.

5.1.2 Prices should provide appropriate signals

By reflecting efficient costs, one function prices play is to signal to buyers the resource costs of a product or service. In the NHS payment system, prices signal to commissioners the costs of each service.

Consistent with our duty to protect and promote the interests of people who use health care services⁷⁰, it is important that prices provide signals and incentives that enable delivery of unit cost reductions that, all else being equal, will allow better health care in the NHS for a given budget. This can happen in two main ways:

- with appropriate signals, commissioners can make the best decisions about which mix of services is likely to offer the highest value to patients, thereby encouraging the most effective use of available fixed budgets; and
- prices set appropriately give incentives for providers to reduce their unit costs by finding ways of working more efficiently.

We are mindful that, in aiming to serve patient needs better, we may have to balance short-term and long-term considerations. For example:

- Overall, setting prices **too high** may disadvantage patients, by reducing the volume of services that commissioners can purchase, within a fixed budget. Inappropriately high prices may also reduce the incentive for providers to find cost savings, which would have a negative impact on patients in the longer term.
- Setting prices **too low** can be just as detrimental to patient interests, particularly in the long term, as:
 - providers may not be adequately compensated for the services they provide, potentially leading to withdrawal of services, compromise on service quality, and/or under-investment in the future delivery of services; and
 - commissioners may 'over-purchase' those services, because they will perceive the resource costs of those services to be lower than they actually are.

We also recognise that the relationship between cost and quality is complex: some providers have shown that they can achieve both higher quality and lower costs.

⁷⁰ 2012 Act, section 62(1).

5.2 Overall approach

As described in Section 2, we have set national prices for 2014/15 in a way that emphasises stability relative to the 2013/14 national prices. 2014/15 national prices (for currencies that are unchanged) are calculated by using 2013/14 prices as the base and adjusting those prices generally for:

- cost pressures on providers (we set out this adjustment in Subsection 5.3); offset by
- our expectations for improved efficiency on the part of providers (we set out this adjustment in Subsection 5.4).

We refer to the above approach as a ‘rollover’ approach, to reflect the fact that we have adjusted the vast majority of prices by a common factor (rather than use updated reference costs at the currency level).

We consider on balance that a rollover approach for national prices is most appropriate for the *2014/15 National Tariff Payment System*. While we are applying this approach for 2014/15, for 2015/16 we may propose a different method for setting national prices, based on updated cost data (which is likely to include reference costs data as well as potentially PLICS⁷¹ data).

5.3 Cost uplifts

In this subsection, we discuss the adjustments made to 2013/14 national prices to reflect inflation and other cost pressures on providers. We refer to these as ‘cost uplifts’.

Each year, providers will typically tend to find that their input costs have increased, due to factors beyond their control. In other parts of the economy, when all providers of a product or service experience a general increase in input costs, this will typically feed through into the prices they charge for the product or service.

⁷¹ A Patient Level Information and Costing Systems (PLICS) pilot collection was conducted by Monitor in the summer of 2013.

Therefore, for changes in costs which providers have little control over, it is appropriate to make corresponding changes to the prices. In other regulated sectors, cost uplifts are sometimes covered by a single factor, usually the retail price index (RPI). But for the *2014/15 National Tariff Payment System*, we have used an approach consistent with that used by the Department of Health (the DH) under the Payment by Results (PbR) system, which is more tailored to the cost pressure facing the NHS.

We anticipate that adjusting prices for expected changes in costs will be an ongoing feature of the national tariff, regardless of the specific methods used to set prices in the future.

Our approach includes cost uplifts across four main categories. These are:

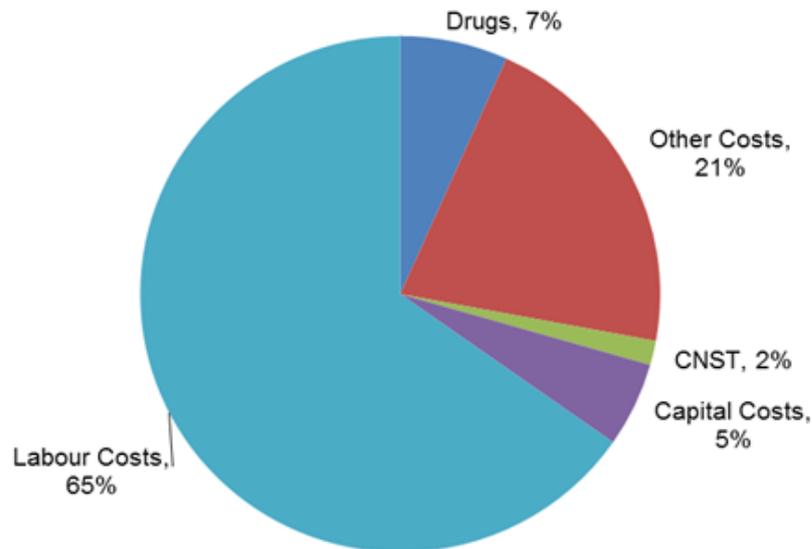
- inflation – which includes pay, drug costs and other operating costs;
- changes in the cost of the Clinical Negligence Scheme for Trusts (CNST);
- changes in capital costs (i.e. changes in costs associated with depreciation and PFI payments)⁷²; and
- additional costs as a result of changes to NHS England's *Mandate*. We call these changes 'service development'.

For each of these factors, we wish to reflect the additional expected cost pressures in 2014/15 for an average provider. The projected growth in each component is weighted by the relevant cost base of that component to calculate an aggregate price adjustment.

Figure 5-1 below shows the proportion of aggregate provider expenditure⁷³ each cost category represents. It is based on the DH's forecast of 2014/15 expenditure.

⁷² Depreciation and private finance initiative (PFI) payments (made by providers) are implicitly included in the tariff prices for 2013/14. In line with the DH's past approach, we have included an estimate of how these payments will change in aggregate for 2014/15 as part of our cost uplifts.

⁷³ Note: this excludes impairment costs.

Figure 5-1: Breakdown of provider input costs

Source: DH, with Monitor calculations.

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

5.3.1 Inflation in operating costs

This subsection sets out the data that we have used to reflect inflation in operating costs. The categories of operational costs are:

- pay;
- drugs; and
- other operating costs.

Pay

As shown in Figure 5-1 above, labour costs are a major component of providers' aggregate input costs, so it is important that we reflect these costs as accurately as possible when setting national prices.

Pay-related inflation has two elements. These are:

- pay settlements, which is the increase in the unit cost of labour reflected in pay awards for the NHS; and

- pay 'drift', which is the movement in the average unit cost of labour due to changes in the overall staff mix (e.g. 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 that providers pay to staff, and changes to the cost of pension provision or any other staff-related costs.

We have used the DH's best estimates for both pay settlements and pay drift, since the DH maintains the most accurate and detailed records of labour costs in the NHS, and is directly involved in pay negotiations.

For this year, we have not split the pay inflation estimate explicitly between pay settlements and pay drift. Pay negotiations for 2014/15 are ongoing, and both elements of pay inflation will be affected by the final agreement. The DH gave us its best estimate at the time of publishing this decision. Further, the DH has chosen to combine its estimate of the effects of pay settlements and pay drift into a single figure.

The DH projects pay inflation to be 1.5% in 2014/15. This translates to a 1.0% impact on national tariff prices. This is in line with the estimate set out in the consultation notice.

Drugs

Although drugs costs are a small component of total provider costs (7%), they have historically tended to grow faster than other costs. This can make drugs costs one of the largest cost uplift components in some years.

To reflect the expected increase in drugs costs, we have used the DH's estimate of the expected increase in drug prices. This estimate is based on long-term trends and the 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. The DH has provided us with its best estimate of the increase in drugs unit costs for providers in 2014/15. This figure is 7.2%, which translates to a 0.5% cost uplift.

Other operating costs

The final cost category aims to cover operational costs that are not related to pay or drugs. It includes general operational 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 figure is from the Chancellor's Autumn Statement of 5 December 2013: 2.1%, which translates to a 0.4% cost uplift.

5.3.2 Clinical Negligence Scheme for Trusts (CNST)

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 negligence⁷⁴. 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.

In line with the previous Department of Health (DH) approach, we have allocated the increase in CNST costs to core HRG sub-chapters in line with the average increase that will be paid by providers. This approach to the CNST uplift is different to other cost uplifts, because the estimate of cost increase is different for each HRG sub-chapter⁷⁵. Each relevant HRG has received an uplift based on the change in CNST cost per unit of activity in that sub-chapter. This means that our cost uplift reflects, on average, each provider's relative exposure to CNST cost growth, given the mix of services it provides⁷⁶.

On average for all services, CNST cost uplift represents a price adjustment of 0.3% (taking into account outpatient and other services), but there is significant variation in the effect for each HRG sub-chapter. CNST adjustments are based on modelling work by the DH. Table 5-1 below lists the percentage uplift that we have applied to each HRG sub-chapter to reflect the increase in CNST costs.

⁷⁴ CCGs and NHS England are also members of the CNST scheme.

⁷⁵ Sub-chapters are larger groupings of HRGs (for example, sub-chapter AA refers to Nervous System Procedures and Disorders and sub-chapter AB refers to Pain Management).

⁷⁶ For example, maternity services have been a major driver of CNST costs in recent years. For this reason, a provider where maternity services are 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 the DH.

Table 5-1: CNST tariff impact table by HRG sub-chapter

HRG sub-chapter	% uplift	HRG sub-chapter	% uplift	HRG sub-chapter	% uplift
AA	0.40%	AB	0.25%	BZ	0.23%
CZ	0.08%	DZ	0.00%	EA	0.09%
EB	0.07%	FZ	0.21%	GA	0.32%
GB	0.15%	GC	0.18%	HA	0.39%
HB	0.36%	HC	0.52%	HD	0.01%
HR	0.20%	JA	0.13%	JC	0.18%
JD	0.10%	KA	0.09%	KB	0.07%
KC	0.01%	LA	0.05%	LB	0.11%
MA	0.40%	MB	0.15%	PA	0.44%
PB	0.00%	QZ	0.31%	SA	-0.06%
VA	0.32%	WA	0.10%	Maternity*	2.81%
A&E	0.73%				

Source: The DH. Note: *Maternity is delivery element only.

The vast majority of the increases in CNST costs are allocated at HRG sub-chapter level, but a small residual amount (about £9 million) is unallocated. This unallocated figure is re-distributed as a general uplift across all prices, which makes all prices 0.01% higher in 2014/15.

We have applied a general uplift of 0.01% for all prices, in addition to the figures in Table 5-1 specific to each HRG sub-chapter.

5.3.3 Capital costs (changes in depreciation and PFI payments)

Providers' costs typically include depreciation charges and PFI payments. Like operating costs, providers should have an opportunity to recover these capital costs.

In previous years, the DH has reflected changes in these capital costs when calculating cost uplifts, and we have adopted the same approach for the *2014/15 National Tariff Payment System*. Specifically, we have applied the DH's projection of changes in overall depreciation charges and PFI payments.

In aggregate, the DH projects PFI and depreciation to grow by 3.8% in 2014/15. This translates to a 0.2% impact on tariff prices.

5.3.4 Service development

The service development uplift factor reflects the additional costs to providers of major initiatives that are in NHS England's *Mandate*⁷⁷.

The DH published its *Mandate for NHS England for 2014/15* in November 2013. NHS England has identified the new policies in the *Mandate* for 2014/15 and assessed whether they will result in additional costs to providers. NHS England has advised that there should be two components to the service development uplift for 2014/15:

- First, it estimates that the expansion of the *Friends and Family Test* to community and other acute services will add £46 million to provider costs in 2014/15. This initiative covers all of hospital and community health services, which had a total provider expenditure of £69.0 billion in 2013/14. This means that the additional £46 million spend translates to a 0.1% cost uplift.
- Second, it estimates that providers will spend an additional £150 million in 2014/15 to meet requirements linked to the recommendations of the *Francis and Keogh* reports. These initiatives are specific to acute health services, which had a total provider expenditure of around £47.6 billion in 2013/14⁷⁸. This means that the additional £150 million spend translates to a 0.3% cost uplift for services provided by the acute sector. As this additional cost is specific to the acute sector, this service development component be applied to national prices, but should not

⁷⁷ 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.

⁷⁸ We estimated this figure, based on 2012/13 data from the DH. The 2012/13 figure was £46.3 billion – see table 16 of the *DH Annual Report and Accounts*. We assumed that 'acute services' would be the sum of (i) Maternity, (ii) General and Acute, and (iii) A&E in this table. To convert this sum of £46.3 billion to a 2013/14 figure, we assumed that this figure would grow in line with general growth in hospital and community health services costs.

be taken into account when using the costs uplift in this section as the basis for local price negotiation for non-acute services (see Section 5.5)

NHS England advises that all other components of the *Mandate* are consistent with existing service requirements, or outside the scope of the national tariff for 2014/15 (e.g. most primary care services), and therefore will not impose additional costs on providers. Based on this advice, we do not expect NHS England to introduce further service development initiatives for 2014/15.

5.3.5 Summary of data for cost uplifts

Section 5.5 summarises the data points that we have included in the final *2014/15 National Tariff Payment System*, and how they apply to final prices.

5.4 The efficiency requirement

The cost uplift factors discussed in the previous section reflect expected changes in input costs over time, which in most markets would change the prices of services provided. However, over time, organisations would normally also expect 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. In this way, the efficiency requirement reflects 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 2014/15, compared with 2013/14.

This subsection describes the specific steps that led us to the efficiency requirement for the *2014/15 National Tariff Payment System*. We summarise:

- our approach to setting the efficiency factor; and
- how we have cross-checked our efficiency requirement with an impact assessment analysis.

5.4.1 Approach to setting the efficiency factor

We consider that the efficiency requirement this year should be set at the highest level that it is reasonable to expect providers to deliver, as this represents best value for patients. While we have looked to robust evidence, we acknowledge that, in this first year of a new regulatory regime, we will have to apply considerable judgement as the evidence base is built up over the coming years.

In the TED, we introduced analysis published by Monitor as *Improvement opportunities in the NHS: Quantification and Evidence Collection*, referred to as Monitor (2013). This is the most detailed forward-looking analysis of the potential for providers to make efficiency gains currently available.

The Monitor (2013) analysis suggests total sector efficiency savings of between 17% and 28% could be achieved over an 11-year period from 2010/11 to 2021/22⁷⁹. We do not expect all of these gains solely through provider efficiencies (rather, commissioners should also be expected to buy services more efficiently). However, the overall potential for providers to make efficiency gains is substantial.

Given this potential, the principal issue to address is what rate of improvement is practically achievable by providers. Necessarily, this involves some degree of judgement.

To make this judgement, we were guided by recent financial returns provided to us by NHS foundation trusts, which in our view provide the best assessment of efficiencies that have actually been delivered over the past financial year or are expected to be delivered in the coming financial year⁸⁰ (we do not have equivalent data for providers other than NHS foundation trusts, because they do not supply the same reports to Monitor).

This evidence suggests that most providers have recently delivered efficiency gains of 3.5% or above, and, looking forward, more than two thirds of NHS foundation trusts anticipate efficiency gains in their plans of 4% or more in 2014/15.

Taking this information into account, together with the overall potential suggested by the Monitor (2013) analysis, we believe that providers could reasonably be expected to deliver efficiency gains of 4% in 2014/15, and so set the efficiency requirement at this level.

We acknowledge that 4% is a stretching requirement, but we have cross-checked this with an impact assessment analysis, as described in the following subsection.

⁷⁹ This excludes the impact of wage freezes.

⁸⁰ This comes from Annual Plan Review (APR) data, the financial information Monitor collects from all NHS foundation trusts about their projections for the next three years. More information about APR data is available on the [Monitor website](#).

5.4.2 Cross-check with impact assessment

Monitor's *Impact assessment of proposals for the 2014/15 National Tariff Payment System*, published on 7 October 2013, supported our conclusions as to the appropriate level of efficiency requirement for 2014/15. This analysis tested the likely impacts of our proposals to make sure that they promote patients' interests:

- For commissioners, nominal prices will marginally decrease. Therefore, all else being equal, commissioners will have more room to accommodate increased demand in their local health economies, which may arise in the form of higher volumes, more complex care needs, higher quality expectations, or through a combination of these pressures
- For providers, Monitor examined a range of financial metrics under two scenarios: one in which providers achieve the efficiency gain of 4%, and one in which providers achieve a lower efficiency gain of only 3%.

On balance, and with particular consideration to providers' cash positions, our analysis suggested that the majority of providers would remain financially viable under both scenarios (although we acknowledge a number of providers may move from a small surplus to a small deficit if they achieve efficiency gains of 3%). We also examined a scenario in which providers achieved efficiency gains of 4.5%. Under this scenario we found (not unexpectedly) that provider surpluses increased.

This analysis reassured us that 4% is a reasonable, if stretching, efficiency requirement for the *2014/15 National Tariff Payment System*. This balances the need for providers to remain stable, while allowing commissioners to meet rising demand.

In Section 5.3 we noted that we now have the final estimates for inflation (pay, drugs and other operating costs) and service development. These changes mean that the general uplift for national tariff services is around 2.5%, not including CNST impacts. This is up from 2.1% in the national tariff consultation notice. We have re-run our impact assessment analysis to reflect this.

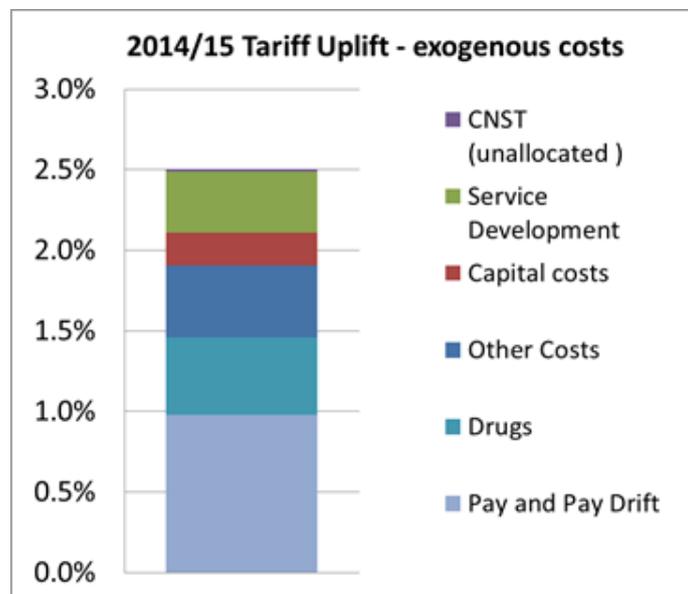
The new cost uplift figures do not change the overall conclusions of our impact assessment, in either the ‘expected case’ (where providers meet the 4% efficiency requirement that we have set) or the ‘sensitivity case’ (where providers miss their efficiency targets by 1 percentage point per annum). In both cases, the number of providers in surplus or deficit remains as before (with 19 providers in deficit in the ‘expected case’ and 111 providers in deficit in the ‘sensitivity case’ by 2014/15, assuming no change in volumes or casemix). It does not change our view that the efficiency target of 4% is a reasonable, if stretching, efficiency requirement for the *2014/15 National Tariff Payment System*.

To inform our pricing decisions and to ensure that the prices we set will be in the best interests of patients we plan to collect more data and extend our impact assessment analysis for future national tariffs.

5.5 Overall price adjustments

Figure 5-2 below shows our final estimate for each of the cost uplifts, as discussed in Section 5.3.

Figure 5-2: Aggregate 2014/15 tariff uplift



Note: Pay, Pay Drift and Drugs have been consolidated for the purposes of this document. The CNST component in this general uplift is only the small portion of CNST costs that are not allocated to specific sub-chapters. The majority of CNST costs are applied to prices in a subsequent step.

On *average*, and not taking account of the CNST costs that we allocate to specific groups of HRGs, prices for 2014/15 are around **1.5%** lower than their corresponding 2013/14 prices. This reflects both:

- cost uplifts which increase prices on average by around 2.5%; offset by
- the efficiency requirement, which reduces prices by 4.0%.

This adjustment also has direct implications for locally determined prices. Under our rules for locally determined prices (described in Section 7), where local prices already exist for services without a national price, commissioners and providers should have regard to the cost uplift factors and efficiency requirements in the *2014/15 National Tariff Payment System* when agreeing prices. These factors and requirements should therefore be used as the basis for local negotiation. Some costs uplifts however reflect costs which apply only in relation to certain parts of the sector (e.g. costs which apply to acute services but not community services).

For the avoidance of doubt, the nominal price adjustments that should be used as the basis for local negotiation are:

- **-1.5%** for **acute services**; and
- **-1.8%** for **non-acute services**.

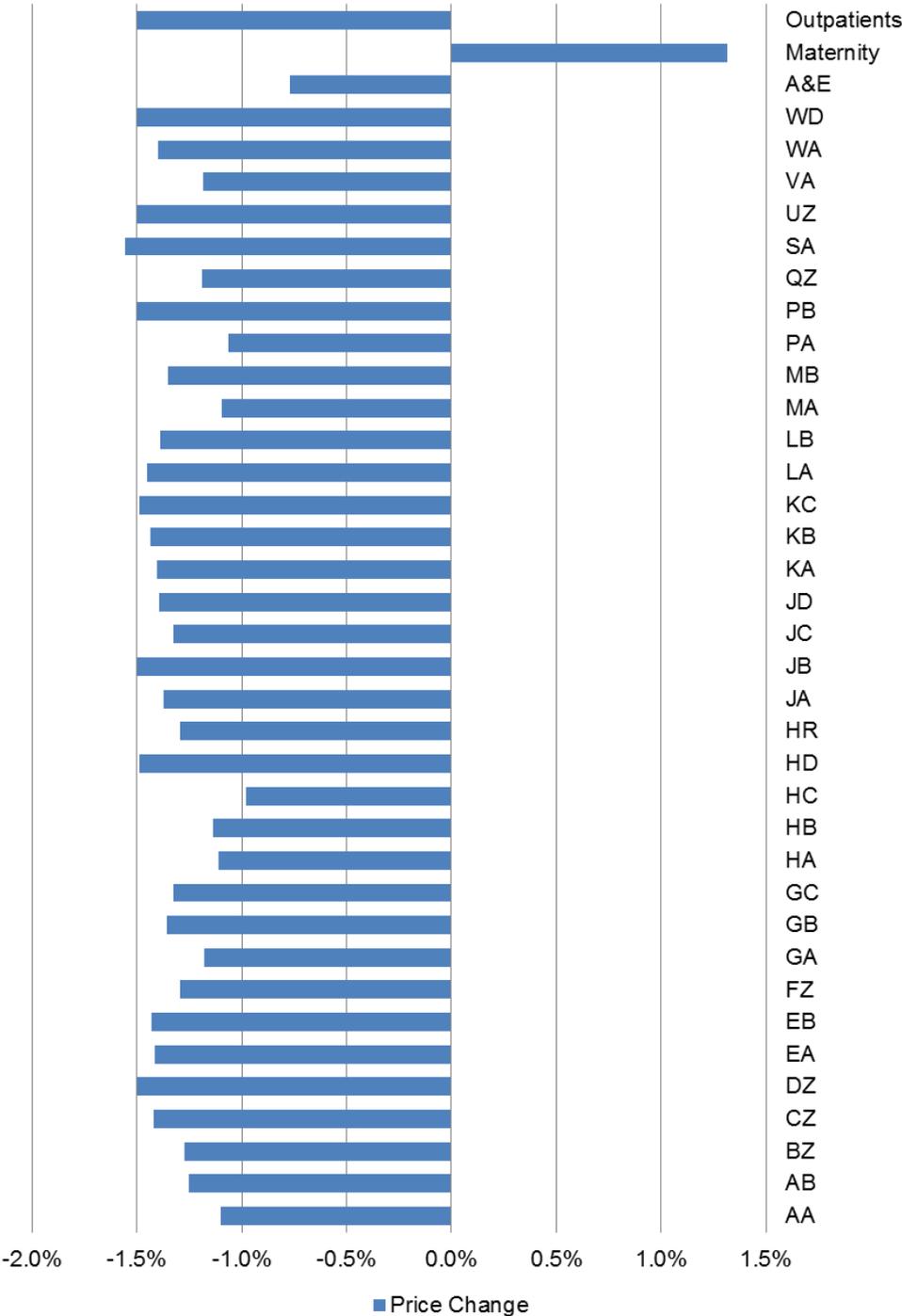
The nominal reduction for non-acute services is slightly larger than for acute services. This is because the £150 million service development estimate that relates to the recommendations of the Francis and Keogh reports does not apply to non-acute services (see Subsection 5.3.4 above).

For services subject to national prices, a further, and final, adjustment is made at a HRG sub-chapter level to reflect the impact of the costs of CNST. This has the impact of increasing prices on tariff services by an average of 0.3 percentage points. This means that tariff services will be, on average, 1.2% lower than in 2013/14.

Figure 5-3 below shows the national price change for each HRG sub-chapter from 2013/14 prices, after all adjustments (i.e. the general cost uplift including service development, the efficiency requirement, and the sub-chapter specific adjustments for CNST).

Figure 5-3: Total price change by sub-chapter

Total Price Change per Sub Chapter



5.6 National prices of new or altered currencies

As explained in Section 4, for the *2014/15 National Tariff Payment System* we are introducing a number of small changes to currencies, to support clinical development. These changes include introducing a limited number of new currencies with associated prices.

This section sets out our methods for determining national prices for these new or changed currencies for the *2014/15 National Tariff Payment System*. We present our calculations, where applicable, in 2013/14 terms (i.e. before application of the costs uplifts and efficiency requirement as described in Subsections 5.3 and 5.4 above).

We set new prices for:

- a new HRG design for laparoscopic kidney and ureter operations;
- a new HRG design for complex bronchoscopy;
- a new best practice tariff: primary hip and knee replacements;
- an amended best practice tariff for paediatric diabetes;
- health assessments for looked after children (out-of-area); and
- the HRG RC31Z (Interventional Radiology Procedures – Hepatobiliary – Major), where there was an error in the 2013/14 price list.

We discuss each below.

5.6.1 Laparoscopic kidney and ureter operations

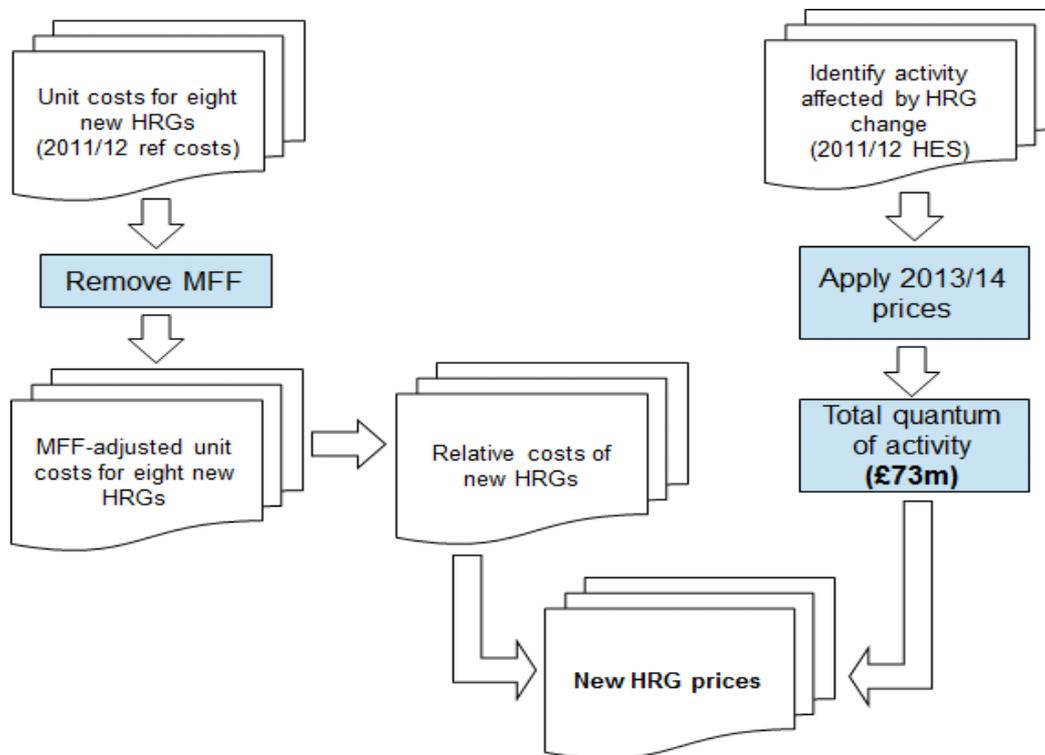
As explained in Subsection 4.4.1, we have adopted a new HRG design to allow the prices for more complex laparoscopic operations, such as nephrectomy (kidney removal), to be set at a more appropriate level. This new design involves removing six HRGs and creating eight new HRGs.

This change means that we need a method to calculate the prices for the eight new HRGs. Our method to calculate these prices is to:

- **Step 1:** estimate the total spend for the six removed HRGs in 2013/14.
- **Step 2:** calculate the unit cost weights of the eight new HRGs (i.e. the level of their unit costs relative to the lowest one).
- **Step 3:** allocate the total spend in Step 1 to the eight new HRGs according to their unit cost weight-adjusted volumes.

This method is summarised in Figure 5-4 below.

Figure 5-4: Illustration of approach to setting new HRG prices in laparoscopic procedures



In the paragraphs below, we explain the detail of each step.

Step 1 – estimate the total spend relating to the six removed HRGs

Our first step was to estimate the total spend on the old HRGs in total in 2013/14. We are setting national prices that apply to a typical length of stay⁸¹. We therefore need to project the aggregate ‘inlier’ spend⁸².

We estimated the total inlier spend by multiplying:

- the 2013/14 inlier price (i.e. not including excess bed day payments or other pricing adjustments such as MFF) for each of the old HRGs; by

⁸¹ These prices will be supplemented by ‘excess bed day’ payments for patients who stay significantly longer than average, as well as the Market Forces Factor (MFF).

⁸² ‘Inlier’ spend covers all admitted patient care activity where the length of stay of the patient does not trigger payment of extra money. It therefore excludes ‘excess bed day’ payments.

- the number of spells for each HRG in the HES⁸³ data for the 2011/12 financial year (this is the latest full year of activity data available).

There were different national prices for different HRGs, and for each HRG there were two national prices representing different admission methods (i.e. non-elective and day case/elective care).

The total affected activity is around 16,000 spells. The quantum of spend is around £73 million in 2013/14 prices.

Step 2 – calculate the relative costs of the eight new HRGs

We calculated the relative cost of each of the new HRGs based on inlier costs reported in the 2011/12 reference cost collection⁸⁴.

A logic check was then carried out on the relative costs to ensure that the reported costs for 'with complications and comorbidities' were not less than the costs for 'without complications and comorbidities'. Reference costs were consistent with this for most HRGs, but not for two HRGs (LB62A and LB62B, for non-elective care only). As a result, we calculated a weighted average unit cost across these two HRGs for use in subsequent calculations.

The relativities of each HRG (again, split by non-elective and day case/elective care) are shown in Table 5-2.

⁸³ Hospital Episode Statistics, as submitted by NHS organisations through their Patient Administration Systems (PAS).

⁸⁴ Reference costs are the average unit cost to the NHS of providing a defined service in a given financial year, as submitted by NHS organisations annually. The relative costs are calculated using 2011/12 reference cost data, as reference cost data for 2010/11 did not contain these HRGs.

Table 5-2: Relativities for the eight new HRGs

HRG	Day case/ elective	Non-elective
LB60A - Complex Open or Laparoscopic, Kidney or Ureter Procedures, with Major CC	2.0	2.0
LB60B - Complex Open or Laparoscopic, Kidney or Ureter Procedures, without Major CC	1.2	1.4
LB61A - Major Open Kidney or Ureter Procedures, 19 years and over with Major CC	1.5	1.5
LB61B - Major Open Kidney or Ureter Procedures, 19 years and over without Major CC	1.0	1.0
LB62A - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over with CC	1.2	1.6*
LB62B - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over without CC	1.1	1.6*
LB63A - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under with CC	1.4	2.3
LB63B - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under without CC	1.0	1.4

*Note: *the relativities for these HRGs are not consistent with Reference Costs, as a weighted tariff across LB62A and LB62B has been set.*

Step 3 – allocate the total spend to the eight new HRGs

To allocate the total spend to the new HRGs, we needed projections of what the volumes for the new HRGs would have been in 2013/14, had they been part of the HRG design for that year. To do this, we applied the latest reference cost 'grouper'⁸⁵ to 2011/12 HES data (i.e. the same service activity data set that we used in Step 1). This grouper uses a HRG design that includes the eight new HRGs, and so once it was applied to the raw data, we were able to count the number of spells that would have occurred for each HRG in 2013/14.

⁸⁵ The grouper is the software, produced by the Health and Social Care Information Centre, which groups diagnosis and procedure information from NHS organisations into the appropriate currency (HRG) for costing and payment.

Once we had estimates of service volumes for the new HRGs, we:

- divided the total affected quantum (£73 million) by the unit cost weight-adjusted volumes, to derive the unit cost for the lowest cost HRG; and then
- multiplied this figure by each HRG's unit cost weight to calculate the unit costs for each of the new HRGs. Within each HRG there is a separate price for each of:
 - elective and day case admissions (combined); and
 - non-elective admissions.

A final adjustment was made to ensure that the total spend (for a given total level of activity) for the new HRGs is the same as if the HRG design had not been introduced. This takes into account excess bed days as well as inlier spend. As a result of this final step, all tariffs for the eight HRGs were increased by 2.5%. The tables below set out the new HRG codes, their related cost relativities and the number of spells for each HRG that we estimated in Step 3.

Table 5-3: Day cases/elective care: relativities and estimated number of spells for the eight new HRGs

HRG	Relativity	Activity (spells)
LB60A - Complex Open or Laparoscopic, Kidney or Ureter Procedures, with Major CC	2.0	519
LB60B - Complex Open or Laparoscopic, Kidney or Ureter Procedures, without Major CC	1.2	1,953
LB61A - Major Open Kidney or Ureter Procedures, 19 years and over with Major CC	1.5	634
LB61B - Major Open Kidney or Ureter Procedures, 19 years and over without Major CC	1.0	4,283
LB62A - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over with CC	1.2	2,125
LB62B - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over without CC	1.1	1,685
LB63A - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under with CC	1.4	206
LB63B - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under without CC	1.0	673

Table 5-4: Non-elective care: relativities and estimated number of spells for the eight new HRGs

HRG	Relativity	Activity (spells)
LB60A - Complex Open or Laparoscopic, Kidney or Ureter Procedures, with Major CC	2.0	1,684
LB60B - Complex Open or Laparoscopic, Kidney or Ureter Procedures, without Major CC	1.4	947
LB61A - Major Open Kidney or Ureter Procedures, 19 years and over with Major CC	1.5	590
LB61B - Major Open Kidney or Ureter Procedures, 19 years and over without Major CC	1.0	701
LB62A - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over with CC	1.6*	47
LB62B - Major Laparoscopic Kidney or Ureter Procedures, 19 years and over without CC	1.6*	20
LB63A - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under with CC	2.3	55
LB63B - Major Open or Laparoscopic, Kidney or Ureter Procedures, 18 years and under without CC	1.4	24

*Note: *the relativities for these HRGs are not consistent with Reference Costs, as a weighted tariff across LB62A and LB62B has been set.*

5.6.2 Complex bronchoscopy

In Subsection 4.4.1, we explained that we have adopted a new HRG design and price for complex bronchoscopy designed to reflect the resource use of this specialised procedure more accurately.

The price for this HRG in 2014/15 is based on both reference costs for 2012/13⁸⁶ and other expert advice on the appropriate cost of this procedure.

First, we calculated the average cost of this procedure in 2012/13, based on 2012/13 reference costs, for both:

- non-elective procedures; and
- day case and elective procedures combined.

⁸⁶ 2011/12 reference cost collection did not collect these cost data.

We then applied the [2013/14 cost uplift factors and efficiency requirement](#), to convert these costs to 2013/14 prices.

We cross-checked the results of this calculation with expert advisors, to make sure that it reflected the appropriate cost of this procedure.

5.6.3 New best practice tariff: primary hip and knee replacements

In Subsection 4.4.3, we explained that we have introduced a new best practice tariff (BPT) for primary hip and knee replacements for 2014/15. Payment will be linked to submission of clinical data and achievement of improved patient reported outcomes.

This BPT has been set at the same price level as for the now-superseded primary hip and knee replacements BPT. This is a 2013/14 price, which we have adjusted for cost uplifts and efficiency requirement (summarised in Section 5.5) in order to determine a price for 2014/15.

5.6.4 Amended best practice tariff: paediatric diabetes year of care

We have revised the price of this BPT to cover the additional cost associated with inpatient admissions.

We calculated the additional cost of a year of care associated with inpatient admissions by multiplying:

- the annual rate of admissions for this patient group (i.e. children with diabetes); by
- the average cost per admission for these patients.

To estimate the benchmark rate of admissions, we used data from 31 best practice sites on the number of unavoidable non-elective admissions for children registered⁸⁷ as having diabetes.

We used these data to calculate an average annual non-elective admission rate of 14% for this cohort of children. As part of good clinical management, however, some additional elective admissions can be considered to be unavoidable. Following discussions with stakeholders, we have based the tariff price on an assumed overall admission rate of 20%, rather than 14%, to reflect these potentially unavoidable admissions, both elective and non-elective.

⁸⁷ To receive this year of care tariff, providers must comply with requirements for registering relevant patients.

The weighted average price (in 2013/14 prices) of elective and non-elective admissions is £1,120 per patient. Based on our assumed admission rate of 20%, we decided that the 2013/14 BPT for paediatric diabetes (£2,764) should be increased by £224 (i.e. 20% of £1,120).

On this basis, the price for this BPT has been amended to £2,988 (in 2013/14 prices), which we have rolled over to a 2014/15 price based on the cost uplifts and efficiency requirement set out earlier in this section.

5.6.5 Health assessments for looked after children (out-of-area)

As set out in Subsection 4.4.4, we have introduced national prices for health assessments for looked after children in out-of-area placements.

The new national prices have been set at the same level as the 2013/14 non-mandatory prices (before adjustment for cost uplifts and efficiency requirement as summarised in Section 5.5).

5.6.6 Correction to RC31Z

For elective activity in RC31Z (Interventional Radiology Procedures – Hepatobiliary – Major), there was an oversight in preparing the 2013/14 national tariff so that the price was incorrect. We have corrected this by setting the price for elective activity at the same level as the price for non-elective activity.

5.6.7 Change from mandatory to non-mandatory price for PET-CT scans

In Subsection 4.4.6, we noted that there will no longer be a national price for RA42Z (PET CT scans). This change has been made in response to feedback that the 2013/14 price is inappropriate as the cost data on which it was based does not properly reflect the costs of providing the service.

6 National variations to national prices

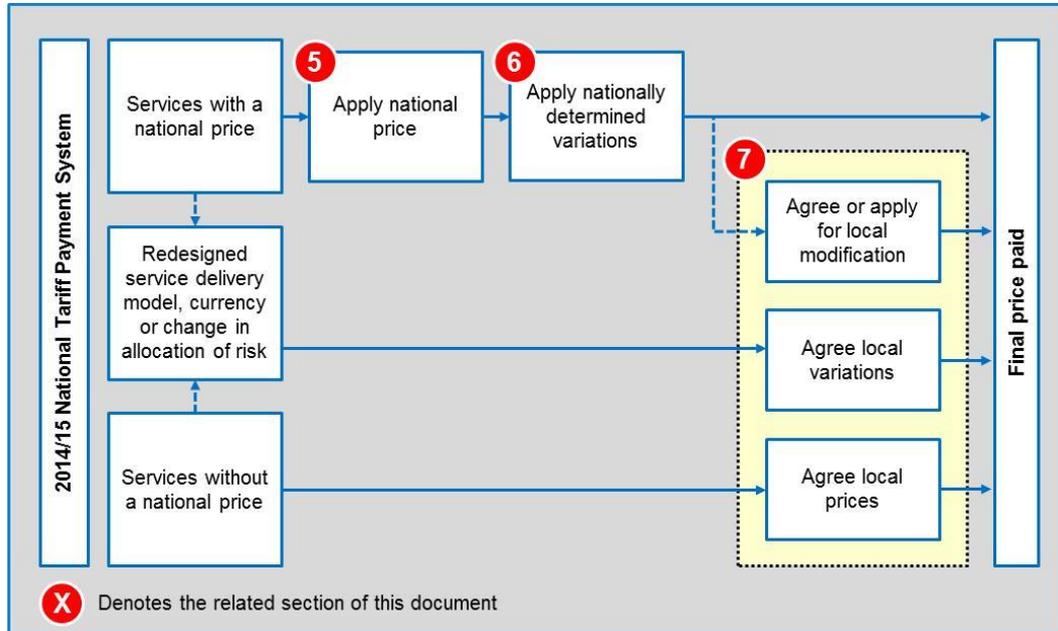
In some circumstances, it may be appropriate to make national adjustments to national prices, for example, to reflect certain features of cost that the formulation of national prices has not taken into account or to share risk more appropriately among parties. We refer to these nationally determined adjustments as 'national variations' to national prices, and we refer to the price, after application of national variations, as the nationally determined price. Specifically, each national variation aims to do one of the following:

- improve the extent to which actual prices paid reflect location-specific costs;
- improve the extent to which actual prices paid reflect patient complexity;
- provide incentives for sharing responsibility for preventing avoidable unplanned hospital stays; or
- share financial risk appropriately following (or during) a move to new payment approaches.

This section sets out the national variations specified in the *2014/15 National Tariff Payment System*, under section 116(4)(a) of the 2012 Act. The section is relevant to providers and commissioners. Both groups will need to understand national variations as they prepare to implement the 2014/15 national tariff.

National variations form one important part of an overarching framework. Figure 6-1 below illustrates the framework of the 2014/15 national tariff and shows how national variations sit alongside local variations and local modifications.

Figure 6-1: Framework for national tariff rules and variations



Providers and commissioners should note in particular that:

- national variations only apply to services with a national price (the focus of this section);
- if a commissioner and provider choose to bundle services that have a mix of national prices and locally determined prices, then national variations need not be applied. Instead the rules for local variations apply (see Subsection 7.2);
- in the case of an application or agreement for a local modification (see Subsection 7.3), the analysis must reflect all national variations that may alter the price payable for a service (i.e. it is the price *after* any national variations have been applied that should be compared with a provider's costs); and
- where a new service is commissioned that does not have a national price, then rules for local price-setting apply (see Subsection 7.4).

The rest of this section covers the four types of national variation that may be applied to national prices.

6.1 Variations to reflect regional cost differences – the Market Forces Factor

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 for the cost differences of providing health care in different parts of the country. Much 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.

The MFF takes the form of an index. This allows for a comparison of each provider's location-specific costs relative to 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 Leeds Teaching Hospitals NHS Trust for a pain management first outpatient attendance, which has a national price of £168;
- Leeds Teaching Hospitals 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).

In the past, MFF values have been calculated by the Department of Health based on the recommendations of the Advisory Committee on Resource Allocation. Further information on the calculation and application of the MFF is provided in the supporting guidance document [A guide to the Market Forces Factor](#).

The 2013/14 MFF indices will remain unchanged for 2014/15, except in cases where organisations are merging or are undergoing some other organisational restructuring (e.g. dissolution) during 2013/14. The cases where the MFF values have changed from the consultation notice are set out below.

As a result of the financial failure of South London NHS Healthcare Trust (SLHT), its assets will be acquired by the following trusts:

- King's College Hospital NHS Foundation Trust;
- Lewisham Healthcare NHS Trust;

- Dartford and Gravesham NHS Trust; and
- Guy's and St Thomas' NHS Foundation Trust.

SLHT has a different MFF from the trusts that are acquiring its assets. As a result of the acquisition of these assets, we have recalculated a new MFF for each of the acquiring trusts. We have done this using the standard approach for calculating MFFs across all providers, taking into account the new mix of services for the providers affected. We expect that the results will be broadly cost neutral for each of the providers and commissioners involved in the redistribution of SLHT assets. Consequently, we believe the new MFFs will not lead to financial distress at any of these organisations.

The 2014/15 MFF index values for each NHS provider can be found in [Annex 6A](#).

Organisations merging or undergoing other organisational restructuring during 2014/15 will not have a new MFF set in-year; we propose that any MFF change would be calculated and confirmed by Monitor from 1 April 2015. Organisations should notify Monitor of any planned changes that may impact on the MFF index by [email](#).

6.2 Variations to reflect patient complexity – top-up payments

National prices in this national tariff are calculated on the basis of average costs. They therefore do not take into account cost differences between providers that arise because some providers systematically serve more complex patients with specialised services. The purpose of top-up payments for specialised services is to recognise these cost differences and to improve the extent to which prices paid reflect the actual costs of providing health care to patients requiring different levels of care.

Specialised service top-ups have been part of the payment system since 2005/06. Where complex patients require specialised activity which is systematically more costly than non-specialised activity, and where this specialised activity is not sufficiently differentiated in the HRG design, national prices may under-reimburse providers serving these patients. In these cases, specialised top-ups are paid to reimburse providers for the higher costs of treating patients who require specialised care. Only a small number of providers tend to provide such care.

The list of services for which specialised and non-specialised activity is insufficiently differentiated within the HRG, and the design and calculation of specialised top-ups for these services, is informed by work undertaken by the Centre for Health Economics (CHE) at the University of York⁸⁸. The Department of Health published an [explanatory note](#) in 2011 to accompany the CHE publication.

The levels and coverage of top-up payments for 2014/15 are the same as in 2013/14, and are set out in Table 6-1 below along with the relevant specialised service code (SSC) flag. With the exception of specialised orthopaedic services, eligibility for top-up payments is limited to specified providers.

Table 6-1: Specialised service top-ups

	Top-up	Codes with SSC flags ⁸⁹	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

[Annex 6B](#) lists those providers eligible for specific specialised top-ups. This list was determined in 2010 by a panel of Specialist Services Commissioners, NHS Specialised Services and other NHS organisations. [Annex 6B](#) also lists the top-up trigger codes.

⁸⁸ Estimating the costs of specialised care (CHE, 2011); Estimating the Costs of Specialised Care: Updated Analysis Using Data for 2009/10 (CHE, 2011).

⁸⁹ To determine which spells are eligible for specialised service top-ups, the grouper generates an SSC flag where the patient record contains an ICD-10 or OPCS-4 code which appears in the list of trigger codes provided in [Annex 6B](#). These codes are taken from the third edition of the Specialised Services National Definition Set (SSNDS) published in 2009 by the National Commissioning Group (NCG). OPCS-4 codes can be present in any position, but ICD-10 codes must be in the primary position.

6.3 Variations to support prevention of avoidable hospital stays

There are two national variations that are designed to incentivise both a) the sharing of responsibility for managing the care of patients in the most appropriate setting; and b) the prevention of avoidable unplanned hospital stays. These are:

- the marginal rate emergency rule; and
- reimbursement arrangements for emergency readmissions within 30 days.

We retain both variations in the 2014/15 national tariff and discuss each in turn below.

6.3.1 Marginal rate emergency rule

The marginal rate emergency rule was introduced in 2010/11 in response to a growth in emergency admissions in England which exceeded that which could be explained by population growth and A&E attendance growth alone⁹⁰. This growth in emergency admissions was made up primarily of emergency spells lasting less than 48 hours.

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

- firstly, to incentivise lower rates of emergency admissions; and
- secondly, to stimulate acute providers to work with other parties in the local health economy to reduce the demand for emergency care.

The marginal rate rule sets a baseline value (specified in £s)⁹¹ for emergency admissions at a provider⁹². A provider is then paid 30% of the national price for any increases in the value of emergency admissions above this baseline. Overall, commissioners must set aside sufficient budget to pay for 100% of emergency admissions. Commissioners are then required to spend the retained 70% on managing the demand for emergency care.

⁹⁰ Over 70% of emergency admissions are patients who are admitted following an attendance at A&E.

⁹¹ The baseline value of emergency admissions is specified as a monetary value (i.e. in '£' terms).

⁹² 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).

As part of the development of the proposals for the *2014/15 National Tariff Payment System*, NHS England and Monitor conducted a joint review of historical evidence relating to emergency care and the operation of the marginal rate rule⁹³. Evidence suggests the rule has gone some way to achieving its aims in that the growth rate of emergency admissions has slowed. We also received qualitative feedback that in some cases the rule has encouraged more coordinated management of both demand for emergency care and of discharges back into the community. We received some feedback to the statutory consultation in relation to the marginal rate rule and have provided a response where helpful in our supporting document *Consultation on the 2014/15 National Tariff Payment System*. We are reviewing the entire payment system for urgent and emergency care as a priority to support the findings of Sir Bruce Keogh's review of Urgent and Emergency Care.

We have 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 insufficient progress has been made in developing appropriate demand management and better discharge management schemes. We are updating the marginal rate rule:

- to require baseline adjustment where necessary to account for significant changes in the pattern of emergency admissions faced by providers in some localities; and
- to ensure retained funds from the application of the rule are invested transparently and effectively in appropriate demand management and improved discharge schemes.

We discuss each in turn before explaining how the rule should be applied in practice. These changes go significantly further than the changes made for 2013/14, which made NHS England's Area Teams, working in partnership with CCGs, responsible for administering the 70% retained funds.

⁹³ Information is provided in the supporting document *Monitor and NHS England's review of the marginal rate rule*.

Setting and adjusting the baseline

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 2014/15 national tariff prices⁹⁴. A contract baseline value must be calculated for each contractual relationship.

We recognise that changes to HRGs since 2008/09 and the introduction of best practice tariffs (BPTs)⁹⁵ 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.

Our review of the evidence in emergency care found that changes in the volume and value of emergency admissions have varied locally. Some providers may have seen material changes in admissions which are a result of changes in the local health economy, for example:

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

In these cases, it is necessary to make adjustments to the baseline value to ensure an appropriate balance between maintaining the positive incentives to manage demand and ensuring providers receive sufficient income to provide safe and sustainable emergency care.

⁹⁴ See below for emergency activity which is excluded from the marginal rate rule and should not be included in the calculation of baseline values.

⁹⁵ Activity reimbursed by best practice tariffs is not subject to the marginal rate, with the exception of the best practice tariff for same day 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 2014/15. 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.

When assessing supply and demand drivers for emergency admissions, commissioners should consider the factors set out in Table 6-2 below.

Table 6-2: 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 this reflects a change in commissioning patterns ⁹⁶
	Change in total demand in the locality due to demographics	Yes, if exceptional and demonstrable
Changes in the provision of emergency services at a provider	Changes in clinical threshold for admissions for certain procedures, for example due to increased risk-aversion in clinical assessment in A&E ⁹⁷	No, unless this reflects a change in commissioning patterns
	Changes in the emergency services commissioned by CCGs (e.g. designation as trauma centre or hyper acute stroke unit, or (HASU))	Yes, if material
	Changes in the method for coding or counting emergency admissions	Yes, re-calculate 2008/09 activity according to new method

When calculating baseline values, both increases and decreases in the value of activity should be considered equally according to the criteria in Table 6-2.

⁹⁶ We expect commissioning patterns to reflect best clinical practice, including where this results in the decommissioning of any out-of-hospital activity (e.g. closure of a walk-in-centre) or a change in the arrangements of emergency after-care for post-discharge complications by tertiary providers (e.g. of cancer patients).

⁹⁷ We recognise that establishing a definitive change to clinical practice may be hard to achieve. We would 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 (e.g. use of locums, consultant cover for A&E). Clinical audit or insight from the local Urgent Care Working Group may also facilitate agreement.

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 of these two providers should be adjusted symmetrically so that, as far as possible, the sum of their baseline values remains constant all other things being equal.

The agreed baseline value (specified in £s) must be explicitly stated in 2014/15 standard contracts and in the plans which 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 Urgent Care Working Group.

Where acute providers or other parties in the local health economy have concerns about the investment plans, they should raise these with NHS England, through its Area Teams. Where local consensus cannot be reached, NHS England, through its Area Teams will provide mediation, in the context of its 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 the use of their enforcement powers. Where the Area Team is the commissioner, the NHS England Regional Team will provide mediation. In all cases, Monitor must be notified where concerns have been raised, and whether (and how) plans were changed as a result to enable us to keep the operation of the rule under review.

Investing the retained funds

The 70% of the value of emergency admissions above a provider's baseline that is retained by commissioners must be spent on managing the demand for admitted emergency care. To comply with the variation, these investment decisions must be:

- Properly prepared, with plans:
 - based on clear evidence that they can relieve pressure on emergency care;
 - coordinated with other commissioning decisions on demand management; and
 - developed through constructive engagement and with input from Urgent Care Working Groups;
- Communicated to all relevant stakeholders, with plans:

- published on their website;
- sent to the chief executives of relevant affected acute providers, and shared with Monitor, the NHS TDA (where relevant) and NHS England; and
- subject to oversight by NHS England, through its Area Teams;
- Reviewed for effectiveness

We discuss each requirement in turn.

Preparation of demand management plans

Commissioners should invest the retained funds, on the basis of clear evidence⁹⁸, at the point in the system where investment will have greatest effect locally. As well as funding initiatives to reduce the number of emergency admissions⁹⁹, this investment might aim to improve a patient's recovery through earlier discharge, enhanced community-based rehabilitation and re-ablement to prevent inappropriate readmissions.

For planning purposes, this investment decision must be coordinated with other decisions made by commissioners on demand management, including the investment of funding retained due to 30-day readmission penalties.

Our review of the marginal rate rule found that the use of the retained funds was most effective when stakeholders engaged constructively to forecast demand and formulate demand management plans. To be effective, this constructive engagement needs to involve all relevant parties, including emergency care clinicians and the local authority, and must take place early in the commissioning cycle.

Commissioners must therefore prepare plans for managing demand early in the year with input from their local Urgent Care Working Group, through consultation with NHS England through its Area or Regional Teams, and input from all relevant providers and advisory groups (e.g. stroke networks).

⁹⁸ This includes, for example: Interventions to reduce unplanned hospital admission: a series of systematic reviews, ECIST, June 2012; Urgent and emergency care – A review for NHS South of England, King's Fund, March 2013; NHS England: Improving A&E performance, NHS England, May 2013.

⁹⁹ Our review heard several examples of such initiatives, including case management for long term conditions and enhanced geriatric assessment in A&E departments.

Where acute providers or other parties in the local health economy have concerns about the investment plans, they should raise these with NHS England, through its Area Teams. Where local consensus cannot be reached, NHS England, through its Area Teams, will provide mediation, in the context of its 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 the use of their enforcement powers. Where the Area Team is the commissioner, the NHS England Regional Team will provide mediation. In all cases, Monitor must be notified where concerns have been raised, and whether (and how) plans were changed as a result to enable us to keep the operation of the rule under review.

Communication of demand management plans

Under these requirements, commissioners must publish before the start of the financial year, on their website, details of their plans for investment of the retained funds. CCGs must also send these details to the relevant acute providers' chief executives. Monitor and NHS England should also be sent a copy¹⁰⁰.

The communication of the plans should include:

- details of targeted service redesign initiatives for managing demand for emergency admissions;
- details of evidence used in consideration of investment proposals;
- the amount invested as a result of the marginal rate rule;
- the expected change in demand patterns as a result of the investment; and
- how progress of targeted initiatives will be measured.

Additionally, CCGs must explain how these demand management plans are coordinated with other investment decisions.

Review of demand management implementation

Once agreed, the implementation of demand management investment initiatives will form part of the commissioner quarterly assurance process¹⁰¹.

¹⁰⁰ Correspondence should be sent to pricing@monitor.gov.uk and england.paymentsystem@nhs.net

¹⁰¹ CCG Assurance Framework 2013/14

In order to further ensure transparency of the outcomes of the investment process, commissioners will be expected to feedback on the impact of their plans. Therefore, at the end of the financial year, when they publish their accounts, commissioners must publish a summary giving the final value of funds retained due to the marginal rate rule in each contract they commission. This summary should also include an assessment of the outcomes of the investment of these retained funds against the targets set out in the plan published before the start of the year.

Application of the rule

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.

Some providers may have seen an overall reduction in their emergency admissions against their baseline value, which reflects a reduction in admissions in some contracts which 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 less control. Therefore, small contracts¹⁰² 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.

The marginal rate should be applied to the value of a provider's emergency admissions after any other national adjustments for MFF, short stay emergency spells, long-stay payments, or specialised service top-ups have been applied. 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.

The marginal rate does not apply to:

- activity which does not have a national price;
- non-contract activity;

¹⁰² Based on stakeholder advice, the definition of a "small" contract is one where the baseline value is less than 5% of the provider's total baseline value across all contracts.

- activity covered by best practice tariffs, with the exception of the best practice tariff that promotes same day emergency care¹⁰³;
- A&E attendances;
- outpatient appointments; or
- contracts with commissioners falling within responsibility of Devolved Administrations.

6.3.2 Emergency readmissions within 30 days

To provide the most appropriate care for patients when they leave hospital, providers need to plan their discharge from admitted care. Planning may include coordinating with the patient's family and GP regarding medication or arranging post-discharge equipment, rehabilitation or re-ablement with a community or social care provider.

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 readmission by investing in, for example, better discharge planning, more collaborative working and better coordination of clinical intervention with community and social care providers.

We are retaining this national variation for 2014/15. The rest of this section provides a definition of an emergency readmission for the purpose of the readmission rule, explains how savings made from application of the rule should be reinvested and sets out how the rule should be applied.

¹⁰³ The marginal rate policy will apply to activity covered by the Best Practice Tariff 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.

Definition of an emergency readmission

The definition of an emergency readmission is any readmission¹⁰⁴:

- where the time between discharge from the initial admission and the readmission is equal to or less than 30 days;
- that has an emergency admission method code¹⁰⁵; and
- that has a national price.

For 2014/15 there will continue to be a number of 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:

- any readmission which does not have a national price;
- maternity and childbirth¹⁰⁶;
- cancer, chemotherapy and radiotherapy¹⁰⁷;
- patients receiving renal dialysis;
- patients readmitted subsequent to an organ transplant;
- young children – where the patient is under four years old at the time of readmission;
- patients who are readmitted having self-discharged against clinical advice¹⁰⁸;

¹⁰⁴ 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.

¹⁰⁵ As defined in the NHS Data Model and Dictionary.

¹⁰⁶ Where the initial admission or readmission is in HRG sub-chapter NZ (obstetric medicine).

¹⁰⁷ 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 sub-chapter SB (chemotherapy) or SC (radiotherapy).

¹⁰⁸ Included in discharge method code 2 in the initial admission.

- emergency transfers of an admitted patient from another provider, where the admission at the transferring provider was an initial admission¹⁰⁹; and
- cross border activity – where the initial admission or readmission is in Northern Ireland, Scotland or Wales.

Investing the savings

Commissioners must reinvest money they retain from not paying for emergency readmissions in post discharge services that support rehabilitation and re-ablement and, in turn, may help to prevent avoidable readmissions. Clinical reviews may highlight particular types of patients who would most benefit from these services. To ensure transparency and effectiveness, commissioners must discuss with providers where this money will be reinvested. Reinvestment proposals must be coordinated with other commissioning decisions on demand management for emergency care, for example initiatives funded by the retained funds from the marginal rate rule.

Application of the rule

In order to implement the 30 day emergency readmission rule, providers and commissioners must:

- first, undertake a clinical review of a sample of readmissions;
- second, set an agreed threshold (informed by the clinical review), above which readmissions will not be reimbursed; and
- third, determine the amount that will not be paid for each readmission above the threshold.

We explain each of these steps in detail below.

¹⁰⁹ 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.

Step 1 – the clinical review

Acute providers and commissioners must work together to undertake clinical reviews of 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 readmissions¹¹⁰.

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.

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 organisations¹¹¹.

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

The clinical reviews (step 1 above) 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.

As in 2013/14, providers and commissioners are not required to undertake a clinical review in 2014/15 where there continues to be local agreement on the readmissions threshold.

¹¹⁰ For example, following an operation, a patient may be discharged from hospital and, with appropriate care e.g. in the community setting and provision of information, this may be the best course of care for that patient even while acknowledging that there is a possibility of an emergency readmission occurring within 30 days of discharge.

¹¹¹ 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.

Step 3 – determining the amount not to be paid

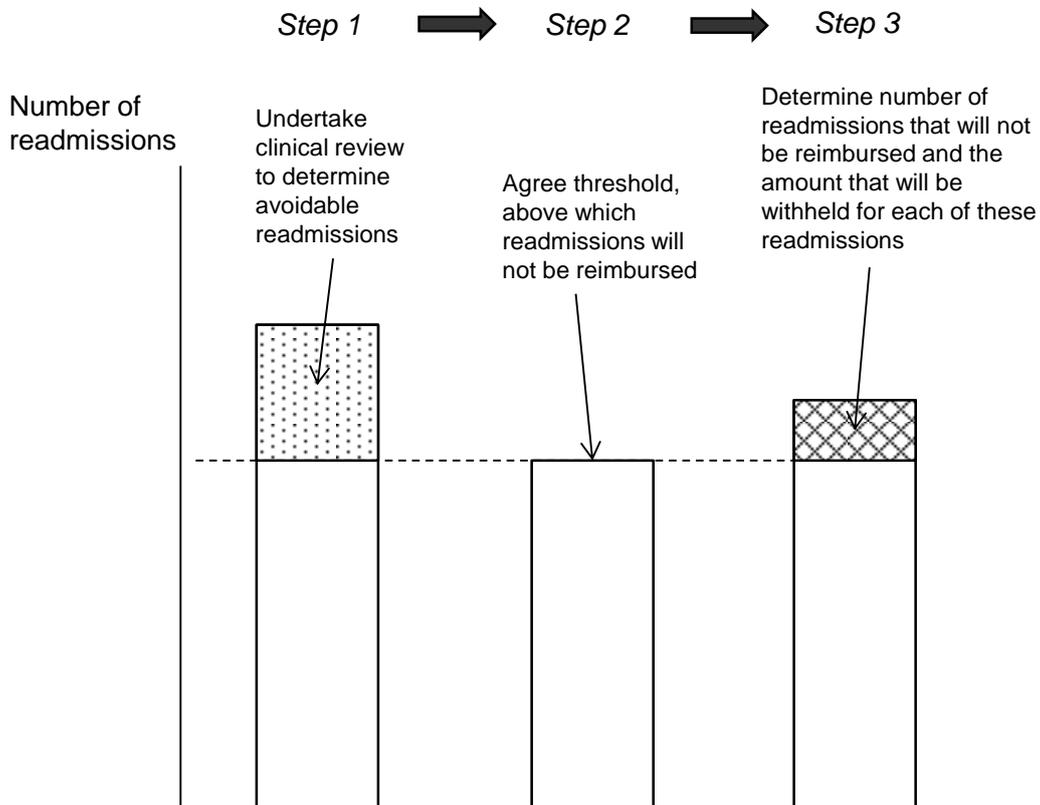
The amount that will not be paid for any given readmission above the agreed threshold is the total price associated with the continuous inpatient readmission spell¹¹², including any associated unbundled costs, for example critical care or high cost drugs.

Where a patient is readmitted to a different provider from the one where the initial admission occurred, the second provider must be reimbursed. However, the commissioner will deduct an amount¹¹³ from the first provider.

The three steps for implementing the readmission rule are summarised in Figure 6-2 below. This illustrates how the clinical reviews inform the proportion of readmissions that could have been avoided which, in turn, 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.

¹¹² The spell in this context includes all care between admission and discharge, regardless of any transfers which may take place.

¹¹³ 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 second provider's MFF applied. This also applies where the readmission includes an emergency transfer.

Figure 6-2: Implementing the emergency readmissions rule

6.4 Variations to support transition to new payment approaches

Introducing new or changed payment approaches can change provider income or commissioner expenditure in 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 help mitigate the risk of a potentially destabilising change in income or expenditure caused by new payment approaches. These proposed variations are designed to ensure that this risk is shared appropriately.

These national variations will apply to the payment approaches for:

- the maternity pathway currency;
- diagnostic imaging in outpatients;

- chemotherapy delivery and external beam radiotherapy; and
- the new BPT for primary hip and knee replacements.

We discuss each of these in turn below.

6.4.1 Maternity pathway

In 2013/14, the maternity pathway currency and national prices were mandated for use. To mitigate the financial impact of the new pathway payment approach, providers and commissioners were asked to share any resulting estimated financial gain or loss in 2013/14. These provisions for sharing financial risk will continue in 2014/15. We are not specifying in detail how these risk-sharing arrangements should operate, recognising that providers and commissioners will wish to agree an approach that suits their local situation.

To inform local negotiations for risk sharing, providers and commissioners should estimate income from maternity activity in 2013/14 and compare this with estimated income from using the pathway prices in 2014/15.

Information on data requirements and definitions can be found in [Annex 4B](#) and the maternity pathway prices for 2014/15 can be found in [Annex 5A](#).

6.4.2 Diagnostic imaging in outpatients

Separate national prices for diagnostic imaging undertaken in the course of an outpatient attendance were introduced in 2013/14. This change was made in order to address concerns about underpayment for diagnostic imaging provided for complex patients, and in response to concerns about under provision of imaging services in some local areas.

We recognise that this change has introduced a financial risk for commissioners and providers. This risk arises because commissioners have moved from paying providers for an average level of diagnostic imaging activity 'bundled' into the outpatient attendance prices (as was the case in 2012/13) to paying for actual diagnostic imaging activity, which could be higher or lower than the average.

For 2014/15, commissioners and providers will continue to be able to manage the resulting financial risk through the following measures:

- as in 2013/14, sharing the expected financial gain or loss resulting from the change to reimbursement for imaging on the basis of actual activity levels¹¹⁴; and
- applying a marginal rate of 50% of the national price to any activity above a 2014/15 baseline¹¹⁵. This measure is designed to mitigate the financial risks to commissioners associated with a sudden increase in diagnostic imaging or the accurate reporting of imaging activity where it has historically been under-reported.

We are not specifying in detail how these risk-sharing arrangements should operate, recognising that providers and commissioners will wish to agree an approach that suits their local situation.

Outpatient diagnostic imaging prices for 2014/15 can be found in [Annex 5A](#).

6.4.3 Chemotherapy delivery and external beam radiotherapy

Following the introduction of mandatory currencies for chemotherapy delivery and external beam radiotherapy in 2012/13, national prices were introduced in 2013/14. Recognising the potential challenges of moving from local to national prices for some organisations, the 2013/14 PbR system provided for a staged transition. Commissioners and providers were expected to move at least 50% of the way from local prices to national prices during 2013/14.

For 2014/15, providers and commissioners must use the national prices unless doing so would have an unmanageable financial impact on either provider or commissioner. Our analysis has identified a very small number of health economies where a move to national prices in 2014/15 could have an unmanageable financial impact. For 2014/15, these health economies are not required to use the full national prices but they must move further towards the national prices.

¹¹⁴ The risk of financial gains or losses occurs as under the previous 'bundling' arrangements, some providers will have undertaken less imaging than the average level assumed in the price (and so may be worse off under the new arrangements) whereas some providers would have undertaken more imaging activity, or more complex imaging, than the average level assumed in the price (and so may be better off under the new arrangements).

¹¹⁵ To establish a baseline, providers and commissioners must agree an estimate of outpatient diagnostic imaging activity in 2014/15. We expect that to do this they will want to refer to current and historic activity data. The agreed baseline will need to be adjusted to reflect trends in growth appropriately.

6.4.4 New BPT for primary hip and knee replacements

Section 4 sets out details of a new BPT for 2014/15 for primary hip and knee replacements to promote improved outcomes for patients.

We recognise that there are circumstances where 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:

- where recent improvements in patient outcomes are not yet reflected in the nationally available data;
- where 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; or
- where a provider has a particularly complex casemix that is not yet appropriately taken into account in the casemix adjustment in PROMs.

We are therefore proposing a variation whereby commissioners must pay the full BPT, if the provider can demonstrate that any of the above circumstances apply. The rationale for using a variation in these three circumstances is explained below.

Recent improvements

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

To mitigate the risk of deteriorating outcomes among those providers not meeting the payment criteria, commissioners must continue to pay the full BPT if providers have identified shortcomings with their service and can show evidence of a credible improvement plan.

In both situations, the variation would be a time-limited agreement. Improvements would need to show in the published data for reimbursement at the BPT level to continue.

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

- 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, questions relating to pain management.
- Individual patient outcomes might also be compared against patient records to check for complications in surgery or comorbidities which 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.
- Reviewing the surgical techniques and prosthesis used against clinical guidelines and NJR recommendations is another way providers might try to address poor outcomes. As well as improving the surgical procedure itself, scrutinising the whole of the care pathway can also improve patient outcomes by ensuring that weakness in another area is not affecting the patient outcomes after surgery.
- Providers may also choose to collaborate with those providers with 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

Providers that have a particularly complex casemix and who cannot demonstrate that 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 will likely 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.

7 Locally determined prices

The previous sections of this document have considered health care services with nationally determined prices. However, there are a range of circumstances in which prices for health care services are determined locally rather than nationally. This section considers the two broad categories where this is the case:

- Where services have a national price but prices are determined locally. These arrangements are classified as either:
 - i. a local variation; or
 - ii. a local modification.
- Where services do not have national prices and prices are set locally.

We use the term 'locally determined prices' to refer to all three types of payment arrangement stated above. We explain the distinction between the three types below.

When services have a national price, it may be that, for a variety of possible reasons, the national currency or price is not appropriate for local circumstances. For example, commissioners and providers may be trying to implement a new service delivery model based on an integrated pathway of care. In this case, a pathway-based payment approach might be more appropriate than using national prices for individual components of the pathway. Under the 2012 Act, commissioners and providers may agree local variations to nationally determined prices and related currencies but, in doing so, they must follow the rules set by NHS England and Monitor¹¹⁶. This section therefore sets out those rules.

¹¹⁶ The rules are made under section 116(2) of the 2012 Act.

The 2012 Act also provides for local modifications to be made to nationally determined prices when it would otherwise be uneconomic for a provider to provide the service at the national tariff price. NHS England and Monitor have responsibility for agreeing the method to be used by Monitor to determine local modifications to national prices. This method is also described in this section. (Note that the method for determining local modifications is distinct from the rules relating to local variations¹¹⁷).

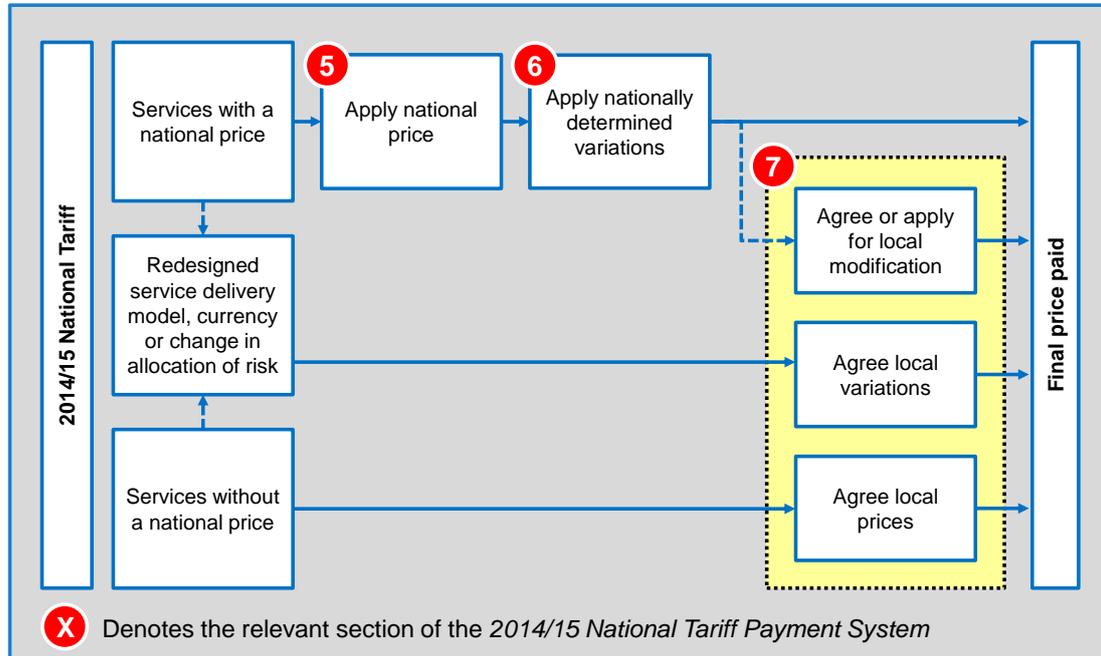
Finally, many of the health care services that are provided by the NHS in England do not have national prices. These include some acute services, as well as all mental health, ambulance, primary care, and community care services. NHS England and Monitor are responsible for setting the rules which commissioners and providers must follow to agree prices for services without national prices, including rules specifying which of those services have national currencies. This section therefore also sets out those rules¹¹⁸.

The figure below illustrates how the scope of this section fits within the national tariff.

¹¹⁷ 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.

¹¹⁸ 2012 Act, sections 115(2) and 116(4)(b) and (5).

Figure 7-1: Scope of Section 7 of the national tariff



Section 7 is divided into the following four subsections:

- 7.1 **Principles for local variations, modifications and prices.** NHS England and Monitor have developed an overarching principles-based framework that applies to all local variations, modifications and prices. This subsection explains the principles that providers and commissioners must apply throughout the process of agreeing locally determined prices.
- 7.2 **Rules for local variations.** This subsection sets out the rules that providers and commissioners must follow when agreeing local variations to national prices or the currencies for national prices.
- 7.3 **Method for local modifications.** This subsection sets out the method for determining local modifications to national prices.
- 7.4 **Rules for local prices.** This subsection sets out the rules that providers and commissioners must follow when agreeing prices for services without national prices, including rules about the use of national currencies for those services.

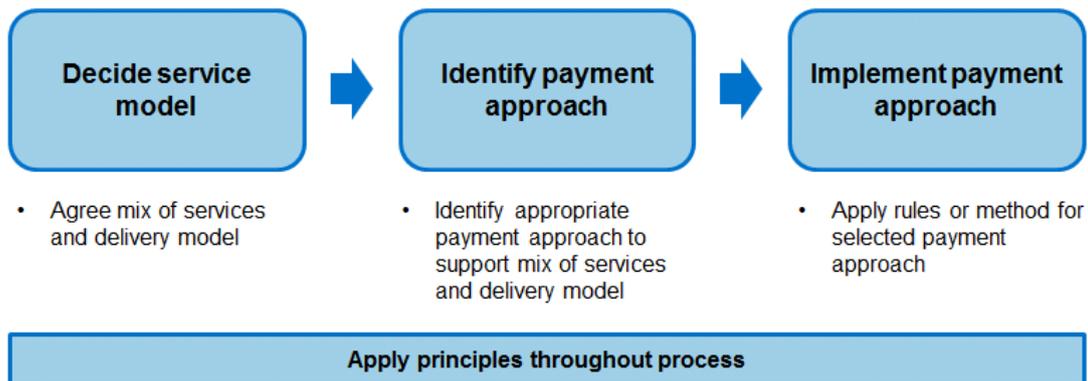
7.1 Principles for local variations, modifications and prices

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

- local payment approaches must be in the **best interests of patients**;
- local payment approaches must **promote transparency** to improve accountability and encourage the sharing of best practice; and
- providers and commissioners must **engage constructively** with each other when trying to agree local payment approaches.

These principles should be applied throughout the process of agreeing all local variations, modifications or prices. Figure 7-2 below summarises this process.

Figure 7-2: Process for agreeing local variations, modifications and prices



These principles are explained in more detail in Subsections 7.1.1 to 7.1.3 below and apply in addition to all other legal obligations on commissioners and providers. This includes other rules set out in the national tariff, and the requirements of competition law, regulations under section 75 of the 2012 Act¹¹⁹ and Monitor's provider licence.

¹¹⁹ See the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (S.I. 2013/500).

7.1.1 Best interests of patients

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:

- **Quality** – Will the agreement maintain or improve the outcomes, patient experience and safety of health care today and in the future?
- **Cost effectiveness** – 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?
- **Innovation** – 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?
- **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?

7.1.2 Transparency

Local variations, modifications and prices should be transparent where possible and appropriate. 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. Providers and commissioners should therefore consider:

- **Accountability** – Is relevant information shared in a way that allows commissioners and providers to be held to account by one another, patients, the general public and other stakeholders?
- **Sharing best practice** – Are innovations in service delivery or payment approaches shared in a way that spreads best practice?

7.1.3 Constructive engagement

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 relevant stakeholders where possible. 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:

- **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 Contract¹²⁰?
- **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?
- **Involvement of relevant clinicians and other stakeholders** – Are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?
- **Short- and long-term objectives** – Are clearly defined short- and long-term strategic objectives for service improvement and delivery agreed before starting price negotiations?

Guidance on constructive engagement is set out in the supporting document *Guidance on locally determined prices*.

¹²⁰ 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.

7.2 Local variations

Commissioners and providers can use local variations to agree adjustments to national prices or the currencies for those prices¹²¹. As such, local variations are the main mechanism through which commissioners and providers can design alternative payment approaches that better support the services required by patients. This may be desirable in a variety of situations, for example:

- Commissioners and providers may want to offer innovative clinical treatments, deliver integrated care pathways or deliver care in new settings, and may need to change the payment system to support these changes.
- Commissioners and providers may consider that it is in the best interests of patients to bundle or unbundle existing national currencies, or create a new integrated currency which combines services with a national currency together with services without a national currency.
- A local variation could be used to support wide scale reconfiguration that integrates primary, secondary and social care with payment aligned to patient outcomes.
- Commissioners and providers may wish to amend nationally specified currencies or prices to reflect significant differences in casemix compared to the national average.
- A local variation could also be used to adjust the way risk and gains are shared to incentivise better care for patients or changes in the mix of services provided.

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.

Local variations are distinct from local modifications, which allow providers and commissioners to increase prices for specific services under certain circumstances and must be approved by Monitor. Local modifications are explained in Subsection 7.3.

¹²¹ Local variations are covered by sections 116(2), 116(3) and 118(4) of the 2012 Act.

The following subsections are structured as follows:

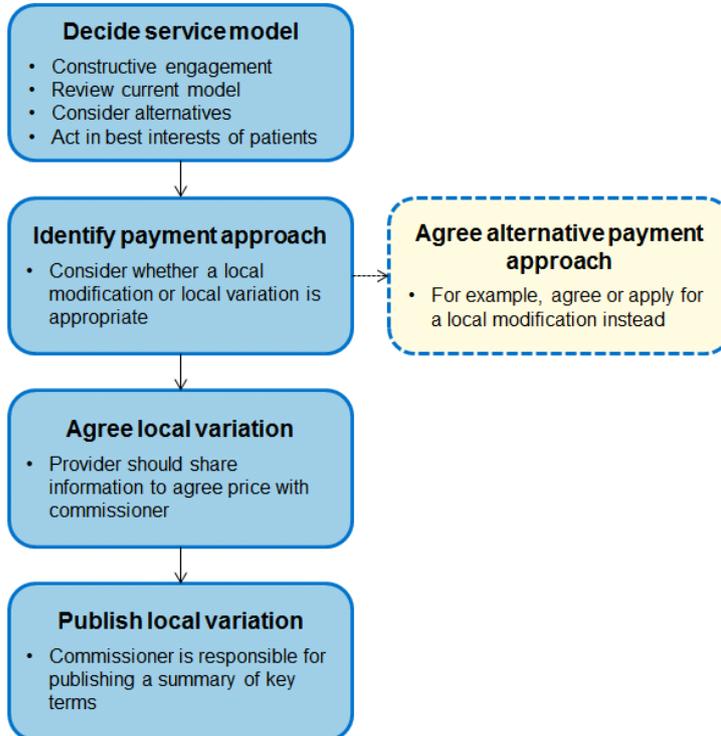
- Firstly, we describe the process for agreeing a local variation (Subsection 7.2.1).
- Secondly, we set out the rules that commissioners and providers must follow (Subsection 7.2.2).
- Thirdly, we outline the publication guidance that commissioners must have regard to when publishing their written statement of a local variation (as required by the 2012 Act) (Subsection 7.2.3).
- Finally, we discuss evaluation of local payment approaches and the sharing of best practice (Subsection 7.2.4).

7.2.1 Required process for local variations

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 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.

To agree a local variation, commissioners and providers must apply the principles set out in Subsection 7.1 when deciding an appropriate service model and payment approach. The process for agreeing a local variation is summarised in Figure 7-3 below.

Figure 7-3: Overview of process for agreeing local variations



This process requires providers and commissioners to engage constructively to review the current model, consider alternatives, and decide on a delivery model that is in the best interests of patients. After the service model has been decided, the provider and commissioner must identify the appropriate payment approach and, in the case of a local variation, agree a local variation to national prices and/or currencies. Under the 2012 Act, all agreed local variations must be recorded and published by the relevant commissioner to be compliant. Local variations do not require approval from Monitor to have effect.

7.2.2 Rules for local variations

For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules¹²²:

- 1) The commissioner and provider must apply the principles for local variations, modifications and prices set out in Subsection 7.1 when agreeing a local variation.
- 2) The agreed local variation must be documented in the commissioning contract between the commissioner and provider which covers the service to which the variation relates¹²³.
- 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 Act¹²⁴.
- 4) The commissioner must also submit the written statement of the local variation to Monitor.

Monitor may take enforcement action in cases of non-compliance with these rules¹²⁵. Monitor may also request further information about any local variation that has been agreed by commissioners and providers at any time. Such information can be requested under Monitor's statutory powers, and must be provided within a reasonable time¹²⁶.

¹²² The rules in this subsection are made pursuant to the 2012 Act, section 116(2).

¹²³ 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.

¹²⁴ As required the 2012 Act, section 116(3).

¹²⁵ See Monitor's *Enforcement of the national tariff*.

¹²⁶ 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.

7.2.3 Publication guidance for local variations

Promoting transparency is one of the three principles that apply to all local variations, modifications and prices.

Under the 2012 Act, commissioners must maintain and publish a written statement of an agreed local variation¹²⁷. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services¹²⁸. Monitor, with the agreement of NHS England, may include guidance in the national tariff on how commissioners should maintain and publish a written statement, to which commissioners must have regard¹²⁹. For the 2014/15 national tariff, Monitor's guidance is as follows:

- A local variation applies to an individual service for which there is a national price (e.g., a HRG). In practice, commissioners and providers are likely to agree the same or similar local variations to a range of related services. Commissioners may comply with their statutory duty to publish a written statement by publishing a single statement covering a number of related local variations.
- Commissioners should use the template provided by Monitor to prepare the written statement. Information on how to use this template is set out in Annex 1 of the *Guidance on locally determined prices*. The completed template should be included in the commissioning contract (Schedule 3 of the NHS *Standard Contract*).
- All written statements of agreed local variations should be published within 30 days of the commissioning contract being signed or, in the case of a variation agreed during the term of an existing contract, the date of the agreement. Commissioners should refer to instructions on [Monitor's website](#) for information on how to submit completed templates for publication, and may take additional steps to publish the details of their agreed local variations on their own websites¹³⁰.

¹²⁷ 2012 Act, section 116(3).

¹²⁸ 2012 Act, section 116(3)(b).

¹²⁹ Commissioners have a duty to have regard to guidance in the national tariff on the information that should be included in the written statement. See the 2012 Act, section 116(7).

¹³⁰ Where Monitor publishes a completed local variation template, it will do so on behalf of the commissioner for the purposes of section 116(3) of the 2012 Act (the commissioner's duty to publish a written statement).

- The 2012 Act requires that the statement is maintained as well as published. Commissioners must therefore update the statement if they agree changes to the variations covered by the statement. If they agree any new local variations, a new statement should be published, which incorporates details of previous local variations.

7.2.4 Evaluation and sharing of best practice

We encourage commissioners and providers to use the rules set out in this subsection (and subsequent subsections) as an opportunity to consider 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 alternative payment approaches to enhance system-wide incentives, for example, to focus on prevention, integration of care, improved outcomes and improved patient experiences. Alternative payment approaches might include pathway, capitation or outcomes-based payments.

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 alternative payment approaches. We encourage commissioners and providers to share the results of any evaluation processes they complete.

These recommendations also apply to local modifications and local price setting.

In addition, NHS England and Monitor may conduct evaluations and analysis of agreed approaches for local variations, modifications and prices to identify those that appear to be most successful and most relevant for the future development of the payment system.

7.3 Local modifications

Local modifications are intended to ensure that health care services can be delivered where they are required by commissioners for patients, even if the cost of providing services is higher than the national price¹³¹.

There are two types of local modifications:

¹³¹ The legislation governing local modifications is laid 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.

- **Agreements** – where a provider and one or more commissioners agree to increase nationally determined prices for specific services; and
- **Applications** – where a provider is unable to agree an increase to nationally determined prices with one or more commissioners and applies to Monitor to determine whether the price should be increased.

Under the 2012 Act, Monitor is required to publish in the national tariff its method for deciding whether to approve local modification agreements and for determining local modification applications. As set out in this subsection, local modifications can be used to increase the prices paid to a provider where it faces unavoidable, structurally higher costs that make the provision of specific services uneconomic at the nationally determined price¹³².

For both agreements and applications, Monitor must be satisfied that it would be uneconomic for the provider to provide one or more specific services without local modification¹³³. If Monitor is not satisfied this is the case, we will not approve a local modification agreement or grant a local modification application.

Local modifications are distinct from local variations. As explained in the previous subsection, local variations allow providers and commissioners to vary from national prices and/or related currencies to support a different service model or mix of services that delivers better value for patients. This may involve increasing or decreasing national prices or changing a currency with a national price. Local variations must be agreed by commissioners and providers and must be published by commissioners, but do not require approval by Monitor to have effect. By contrast, local modifications can only be used to increase the price for an existing currency or set of currencies, and must be approved or granted by Monitor.

Figure 7-4 below summarises the principal differences between local modifications and local variations, including differences in the way they are funded by commissioners.

¹³² Each local modification applies to a single service with a national price (i.e. 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.

¹³³ 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 7-4: Identifying the appropriate payment approach

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

Our rules for local variations have been set out in Subsection 7.2 above.

The following subsections are structured as follows:

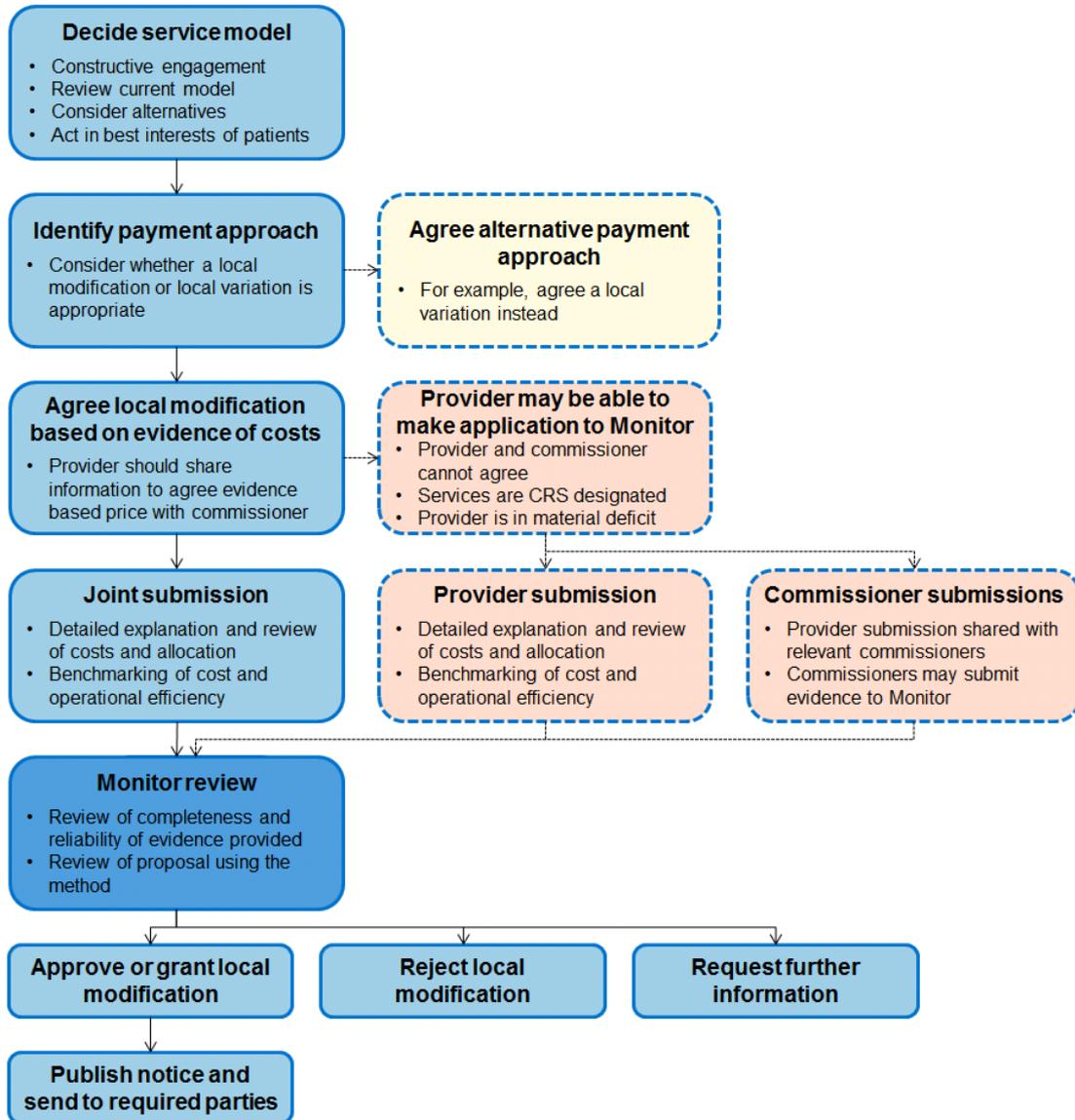
- Firstly, we describe the high-level process for local modification agreements and applications (7.3.1).
- Secondly, we set out our method for determining whether services are uneconomic (7.3.2).
- Thirdly, we explain the parts of our method that apply specifically to local modification agreements (7.3.3). The next subsection does the same for local modification applications (7.3.4).
- Fourthly, we describe Monitor’s publication obligations relating to local modifications (7.3.5).
- Finally, we discuss Monitor’s responsibility to issue notifications of significant risk under certain circumstances (7.3.6).

7.3.1 Required process for local modifications

Our method requires that commissioners and providers apply the principles set out in Subsection 7.1, determine whether the services in question are uneconomic, comply with our conditions for agreements and applications, and submit evidence to Monitor to support their proposed local modification.

Figure 7-5 below summarises the required process for commissioners and providers.

Figure 7-5: Overview of process for local modifications¹³⁴



¹³⁴ Commissioner Requested Services are referred to in the diagram as 'CRS'.

As illustrated in Figure 7-5 above, our process for local modifications requires providers and commissioners to engage constructively with each other to review the current model of service provision, consider alternatives, and decide on a delivery model that is in the best interests of patients. After the service model has been chosen, the provider and commissioner must identify the appropriate payment approach and, in the case of a local modification, agree a modification to the nationally determined price. Throughout this process, the commissioner and provider must apply the principles set out in Subsection 7.1. They must then submit evidence to Monitor to demonstrate that their proposed modification is appropriate, based on the method set out below.

If the provider and commissioner are not able to agree on a local modification, and the provider meets the additional requirements set out in our method, the provider can submit a local modification application to Monitor. In this case, Monitor will request separate submissions from commissioners in response to the application by the provider.

Monitor will then decide whether to approve local modification agreements or grant local modification applications, using our method. If an agreement is approved, or an application granted, Monitor is required by the 2012 Act to send a notice of the decision to various parties and publish the notice, which will contain details of the modification.

Separate supporting guidance, *Guidance on locally determined prices*, provides further information on the process for submitting a local modification agreement or application to Monitor.

7.3.2 Determining whether services are uneconomic

For a service or group of services to be considered uneconomic for the purposes of a local modification, the provider of the service or services must be able to demonstrate that:

- 1) the average cost of providing each service is higher than the nationally determined price;
- 2) the provider's average costs are higher than nationally determined prices as a result of structural issues that are:
 - **Specific** – the structurally higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable;
 - **Identifiable** – the provider must be able to identify how the structural issues it faces affect the cost of the services;

- **Non-controllable** – the higher costs should be beyond the direct control of the provider, either currently or in the past¹³⁵; and
 - **Not reasonably reflected elsewhere** – the costs should not be reasonably adjusted for elsewhere in the calculation of national prices, rules or variations.
- 3) the provider is reasonably efficient when measured against an appropriately defined group of comparable providers, given the structural issues that it faces¹³⁶; and
 - 4) the provider has tried to engage constructively with its commissioners to consider alternative service delivery models, and it is not feasible to deliver the care required at the nationally determined prices.

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 patients¹³⁷. Only structurally higher costs that cannot be avoided by the provider can justify a local modification.

¹³⁵ 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.

¹³⁶ 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.

¹³⁷ 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 programmes (CIPs). It could also be possible to provide the services required using an alternative service delivery model.

Determining whether the provision of a service is uneconomic therefore requires a detailed understanding of why average costs exceed nationally determined prices¹³⁸. It also requires analysis of whether the provider could reduce its costs while still delivering the quality of patient care required.

The provider (and, in the case of an agreement, the commissioner) should therefore provide sufficient evidence to enable Monitor to determine whether the service is uneconomic¹³⁹. 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.

Further information on the type of evidence that should be provided is set out in the supporting document *Guidance on locally determined prices*.

7.3.3 Local modification agreements

Local modification agreements are agreed between the commissioner and the provider of a service. If there is more than one commissioner of a service from a single provider, the agreement may involve more than one of those commissioners. We encourage agreements between a provider and multiple commissioners or a lead commissioner acting on behalf of multiple commissioners. A local modification agreement has effect only for the services specified in the agreement, and for the parties to that agreement. Local modifications apply to specific services, but NHS England and Monitor encourage agreements that cover multiple services.

¹³⁸ 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.

¹³⁹ 2012 Act, sections 124(4) and 125(2), require that an agreement or application submitted to Monitor must be supported by such evidence as Monitor may require.

Under the 2012 Act and our method for local modification agreements:

- 1) 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 tariff¹⁴⁰;
- 2) 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; and
- 3) 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.

In cases where a local modification 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 of the services covered. For example, a provider and commissioner could agree a modification which increases the price at low volumes of activity, to take into account fixed costs associated with providing certain services, but does not increase the price at higher levels of activity. A local modification may also apply only in certain circumstances or certain areas – in which case, the agreement should make provision for determining the circumstances or areas in which the modification is to apply.

Given that the modification is based on an agreement between commissioners and providers, we require commissioners and providers to prepare joint submissions to Monitor to demonstrate that they have complied with the conditions above. Monitor will then decide whether or not to approve the agreement.

¹⁴⁰ 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.

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 price¹⁴¹.

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 £1.0 million.

From 2015/16 onwards, 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.

7.3.4 Local modification applications

Local modification applications can only be made where a provider has failed to reach an agreement on a local modification with its commissioner¹⁴².

Under our method, we 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 agreement¹⁴³.

¹⁴¹ Providers and commissioners should refer to the latest available [guidance on the NHS Standard Contract](#).

¹⁴² See the 2012 Act, section 125(1).

¹⁴³ Note that Condition P5 of the Monitor licence requires licensed providers to engage constructively with their commissioners, with a view to reaching a local modification agreement.

To comply with our method for local modification applications, the applicant provider must:

- 1) specify the services affected by the proposed local modification, the circumstances or areas in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the current financial year;
- 2) demonstrate that it has engaged constructively with its commissioners to try to agree alternative means of providing the services at the nationally determined price and, if unsuccessful, a local modification agreement;
- 3) demonstrate that the services are Commissioner Requested Services (CRS)¹⁴⁴ or, in the case of NHS trusts or other providers who are not licensed, the provider cannot reasonably cease to provide the services;
- 4) demonstrate that it has a deficit equal to or greater than 4% of revenues at an organisation level in the previous financial year (i.e. 2013/14 for the 2014/15 national tariff);
- 5) 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 Subsection 7.3.2; and
- 6) 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.

An application must be supported by sufficient evidence to enable Monitor to determine whether a local modification is appropriate, based on our method for determining whether a service or services are uneconomic and the conditions above. We provide further guidance in the *Guidance on locally determined prices*.

¹⁴⁴ See: *Guidance for commissioners on ensuring the continuity of health care services; Designating Commissioner Requested Services and Location Specific Services*, 28 March 2013.

If an application for a local modification is successful, Monitor will determine the date from which the modification will take effect. We propose that, 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 be updated to reflect the modification¹⁴⁵.

In addition, Monitor will determine the circumstances or areas in which the modified price is to be payable. Once determined by Monitor, the modified prices will 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).

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

The proposed requirements for local modification applications are more extensive than for agreements. Conditions (2), (3) and (4) are not included in the requirements for agreements.

Condition (2) is intended to ensure that providers have constructively engaged with commissioners to try to reach agreement before submitting an application to Monitor¹⁴⁶.

Condition (3) means that only services which are required by commissioners can be the subject of a local modification application. Under Monitor's provider licence, providers may not stop providing a Commissioner Requested Service, or make material changes to that service, without the consent of the relevant commissioner. Monitor published guidance on designating Commissioner Requested Services and Location Specific Services in March 2013¹⁴⁷. This guidance also provides advice on exploring alternative means of provision and de-designating services.

¹⁴⁵ In exceptional cases (and in particular where the delay of the local modification would cause unacceptable risk of harm to patients), Monitor would consider making the modification effective from an earlier date.

¹⁴⁶ Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.

¹⁴⁷ See: *Guidance for commissioners on ensuring the continuity of health care services; Designating Commissioner Requested Services and Location Specific Services*, 28 March 2013.

Condition (4) is intended to take into account possible cross-subsidies, where providers receive a price that is greater than cost for some services with national prices but less than cost for others with national prices. In light of this, our approach is intended to focus resources on cases where the refusal of commissioners to agree a local modification is most likely to pose a risk to patients. We consider this to be most likely where the provider is in significant deficit at an organisational level. Monitor and NHS England may revise this requirement in future if we are satisfied that these issues are properly addressed by other parts of our method for setting prices.

As a guideline, we suggest that providers should not apply for a local modification unless the expected increase in revenue for the specified services is greater than £1.0 million. However, Monitor will consider applications of lower value if they comply with the method set out above.

7.3.5 Publication requirements for local modifications

Promoting transparency is one of the three principles that apply to all local variations, modifications and prices. As required by the 2012 Act, and in line with our aim to increase transparency, Monitor will publish key information on all local modification agreements and applications that are approved¹⁴⁸. This will include:

- whether the local modification is an agreement or application;
- the name and location of the provider and commissioner or commissioners covered by the local modification;
- a list of the services affected and the changes to their prices as a result of the local modification, including the circumstances or areas in which the modification applies;
- the start date and duration of the local modification;
- an explanation of the structural issues faced by the provider and why a local modification was required; and
- any other information that Monitor considers to be relevant.

Monitor will make this information publicly available. Further information is available on [Monitor's website](#).

¹⁴⁸ Monitor is required to send a notice to the Secretary of State and such CCGs, 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).

7.3.6 Notifications of significant risk

Under the 2012 Act, if Monitor receives an application from a provider and Monitor is satisfied that the continued provision of Commissioner Requested Services (by the applicant or any other provider) is being put at significant risk by the configuration of local health care services, Monitor is required to notify NHS England and any clinical commissioning groups (CCGs) it considers appropriate¹⁴⁹. These bodies must then have regard to the notice from Monitor when deciding on the commissioning of NHS health care services¹⁵⁰.

7.4 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 cases, commissioners and providers must work together to set prices for these services. The 2012 Act allows NHS England and Monitor to set rules for local price-setting for such services, including rules specifying national currencies for such services¹⁵¹.

We have set both general rules and rules specific to particular services.

There are two types of general rule:

- Rules that apply in all cases when a local price is set for services without a national price. These are explained in Subsection 7.4.1.
- Rules that apply only to local price-setting for services with a national currency (but no national price). These are explained in Subsection 7.4.2.

¹⁴⁹ 2012 Act, section 126(1) to 126(3).

¹⁵⁰ 2012 Act, section 126(5).

¹⁵¹ 2012 Act, sections 116 (4)(b) and 118(5)(b).

The remainder of this subsection sets out the rules specific to particular services, including the national currencies specified by those rules¹⁵². The subsection is divided into further subsections as follows:

7.4.3 Acute services with no national price

7.4.4 Mental health services

7.4.5 Ambulance and transport services

7.4.6 Primary care

7.4.7 Community care

7.4.1 General rules for all services without a national price

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

Rule 1: Providers and commissioners must apply the principles in Subsection 7.1 when agreeing prices for services without a national price.

Rule 2: Commissioners and providers should have regard to the national tariff efficiency and cost uplift factors for 2014/15 (as set out in Section 5 of this document) when setting local prices for services without a national price for 2014/15, if those services had locally agreed prices in 2013/14¹⁵³.

7.4.2 General rules for services with a national currency but no national price

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

¹⁵² The rules for local price-setting may include specifications or currencies for services – see the 2012 Act, section 116(5).

¹⁵³ The cost uplift for service development, used for national prices, includes an element for costs which apply specifically to the acute sector (costs relating to the *Francis* and *Keogh* reports). When agreeing local prices for non-acute services, commissioners should discount that element of the cost uplift. As explained in Section 5.5 of this document, this suggests a price adjustment of -1.8%, rather than -1.5%, as a basis for local negotiation in such cases.

The services with national currencies covered by the requirements in this subsection are:

- Working age and older people mental health services
- Ambulance services
- Specialist rehabilitation
- Critical care – adult and neonatal
- HIV adult outpatient services
- Renal transplantation
- Positron emission tomography and computerised tomography (PET/CT)
- Cochlear Implants
- Transcatheter Aortic Valve Implantation (TAVI)
- Complex therapeutic endoscopy
- Dialysis for acute kidney injury (HRGs LE01A, LE01B, LE02A, LE02B)

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 2014.

(d) The national currencies specified for the purposes of these rules are the currencies specified in Annex 7A (acute services), Subsection 7.4.4 (mental health services) and Subsection 7.4.5 (ambulance services).

The templates referred to in Rule 3 can be found in the *Guidance on locally determined prices*.

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 Subsection 7.2;

(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 Subsection 7.2.3 when preparing and updating the written statement; and

(e) the commissioner must submit the written statement to Monitor.

The template referred to in Rule 4(c) is the same template that is used for local variations. The template and related guidance can be found in *Guidance on locally determined prices*. Instructions on how to publish written statements and how to submit these to Monitor can be found on Monitor's website.

7.4.3 Acute services with no national price

Where acute services, commissioned by a CCG or by NHS England, do not have a national price, providers and commissioners are required to set prices locally. For some of those services, these rules specify a national currency which should be used as the basis for setting local prices. For others, there is no nationally specified currency. This subsection covers both types. There are also a number of high cost drugs, devices and listed procedures that are not reimbursed through national prices and whose price must be negotiated locally. These are therefore also covered below.

Acute services without national currencies

In addition to the general rules set out in Subsection 7.4.1, the following rule applies:

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

The national currencies for acute services without national prices are:

- Specialist rehabilitation (25 currencies based on patient complexity and provider/service type)
- Critical care – adult and neonatal (13 HRG-based currencies)
- HIV adult outpatient services (three currencies based on patient type)
- Renal transplantation (nine HRG-based currencies)
- PETCT (HRG RA42Z – Nuclear Medicine category 8)
- Cochlear implants (HRGs CZ25N (without CC) and CZ25Q (with CC))
- TAVI (HRG EA53Z)
- Complex therapeutic endoscopy (HRG FZ89Z)
- Dialysis for acute kidney injury (HRGs LE01A, LE01B, LE02A, LE02B)

Currency specifications and the guidance around using these currencies are set out in Annex 7A.

Rule 6: Providers and commissioners must use the national currencies specified in Annex 7A 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 Subsection 7.4.2.

High cost drugs, devices and listed procedures

A number of high cost drugs, devices and listed procedures are not reimbursed through national prices. These used to be known as “excluded” high cost drugs, devices and procedures. They were “excluded” for one or more of the following reasons:

- the intervention was new and not captured in national prices;

- currencies had not yet been developed or adjusted for the use of the interventions; or
- intervention was specialist and carried out by a small number of providers.

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 high cost, a provider using one of these drugs, devices or procedures more frequently than the 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.

For continuity with previous years, we are listing these drugs, devices and procedures in the *2014/15 National Tariff Payment System*, even though they are not national currencies. For the *2014/15 National Tariff Payment System*, we have updated the list of drugs, devices and procedures using the same criteria adopted in previous years. 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 the selection process. [Annex 7B](#) sets out details of the high cost drugs, devices and listed procedures for 2014/15.

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 providers¹⁵⁴.

Rule 7:

(a) As high cost drugs, devices and listed procedures are not national currencies, Rules 3 and 4 in 7.4.2, including the requirement to disclose unit prices, do not apply.

¹⁵⁴ 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”. For example, an agreement could be structured such that, if a provider manages to negotiate a reduction in the unit cost of “excluded” pharmaceuticals, the commissioner pays the provider the new lower price plus 50% of the negotiated reduction.

- (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)** As the price agreed should reflect the actual cost to the provider, the requirement to apply the national tariff efficiency and cost uplift factors detailed in Rule 2 in 7.4.1 does not apply.

7.4.4 Mental health services

People with mental health problems on average have poorer physical health outcomes relative to those with similar physical health conditions who do not have mental health problems. Further, individuals with physical health conditions often have mental health needs that go unrecognised. One of NHS England's objectives in the *Mandate* is to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole.

Mental health services have historically been funded through block payment arrangements. The level of block payment has generally been based on historic levels of funding or influenced by available budget. The main funding driver has not necessarily been an assessment of what will most efficiently and effectively meet patient needs. In addition, aligning payment to patient outcomes has historically not been part of the payment approach in mental health.

In 2012/13, 21 national 'cluster' currencies for adult mental health services were introduced to the PbR payment system. Clusters are national currencies that group patients based on common characteristics, such as level of need and similar resources being required to meet those needs. This subsection specifies the cluster currencies for use when agreeing local prices for mental health services, and explains the cluster currency system and the rules for using it, including how and when to assign a care cluster classification to patients. This subsection also sets out the rules that providers and commissioners must follow when setting local prices using the clusters, including the requirement to facilitate patient choice and to agree and monitor quality indicators. We then set out the rules that providers and commissioners must follow when setting local prices without using the clusters.

The cluster currencies do not cover all mental health services. This subsection therefore also covers payment for mental health services which are not included in the clusters.

Cluster currencies for adult mental health services

The currencies, known as care clusters, cover most mental health services for working age adults and older people. The care clusters were mandated for use from April 2012 by the Department of Health, following a four-year national programme (involving clinicians, senior managers, finance and data professionals from providers and commissioners across England). There are 21 needs-based care clusters in use, organised under three categories: non-psychotic, psychotic and organic, and includes a variance cluster, cluster zero. This approach aims to:

- support providers to understand better the care they provide to patients and the resources used to deliver that care;
- support clinicians to make decisions that deliver the best possible outcomes for patients and improve the quality of care provided; and
- provide information that will enable commissioners and patients to compare provider organisations and to make well-informed decisions.

The care clusters are set out in Table 7-6 below.

Table 7-6: Adult mental health clusters

Cluster	Cluster label	Cluster review period (max)
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
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

Using the adult mental health cluster currencies

Providers and commissioners must adhere to Rule 8 below when using the adult mental health cluster currencies (“care clusters”).

Rule 8:

(a) The 21 care clusters specified above must be used as the currencies for agreeing local prices for the services covered by the clusters in 2014/15, unless an alternative payment approach has been agreed in accordance with Rule 4 in Subsection 7.4.2.

(b) When using the care clusters, patients must be allocated to a cluster in the following situations:

- i) when initial assessment is completed (typically within two contacts, or two bed nights);
- ii) when scheduled re-assessment occurs; or
- iii) when any re-assessment occurs following a significant change in need.

(c) Patient allocations must be regularly reviewed in line with the maximum cluster review periods, which are included in Table 7-6 above.

(d) Providers must use the mental health clustering tool (Annex 7C) to assign a care cluster classification to patients, and record and submit the cluster allocation to the Health and Social Care Information Centre (HSCIC) as part of the Mental Health Minimum Data Set.

(e) 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 conclude or continue. If the patient’s interaction with the provider continues, all ongoing assessments and reassessments form part of the allocated cluster.

(f) Cluster 0 must only be used when it is not possible to determine which cluster should be assigned to a patient at the end of the initial assessment.

Full guidance on implementing the mental health care clusters can be found within the NHS England and Monitor document *Guidance on mental health currencies and payment*.

Agreeing local prices using the care clusters

In addition to the general rules set out in Subsections 7.4.1 and 7.4.2, providers and commissioners must adhere to the requirements of Rule 9 below when agreeing local prices using the care clusters. A key part of developing the mental health care clusters has been the development of quality and outcomes metrics to support delivering better care for patients. The requirements below therefore include the agreement and monitoring of such metrics.

Rule 9:

- (a)** For each care cluster, quality indicators must be agreed between providers and commissioners. The recommended quality indicators can be found in Section 4 of the *Guidance on mental health currencies and payment*.
- (b)** The agreed quality indicators must be monitored on a quarterly basis by both providers and commissioners.
- (c)** Providers must complete the Mental Health Minimum Data Set in all cases.
- (d)** Providers and commissioners must ensure that any agreed payment approach enables appropriate patient choice.
- (e)** Once agreed, the local prices for the care clusters must be submitted to Monitor by providers in line with the requirements of Rule 3 set out in Subsection 7.4.2.

While enabling patient choice in mental health care will be undertaken at a local level, the *Guidance on mental health currencies and payment* provides information on how this implementation can be supported by local price-setting.

Agreeing local prices when not using the care clusters

Providers and commissioners of services covered by the care cluster currencies may wish to adopt alternative payment approaches, for example, to support new models of care or where service transformation is taking place. This may include integrating physical and mental health services for older people, possibly also incorporating social care.

Rule 10:

(a) Providers and commissioners of services covered by the care cluster currencies may agree prices without using the care clusters as the basis for payment. In doing so, they must adhere to the requirements set out in Rule 4 in Subsection 7.4.2.

(b) Providers must complete the Mental Health Minimum Data Set in all cases, including the cluster allocation, whether or not they have used the care clusters as the basis for payment.

Completion of the Mental Health Minimum Data Set, including the cluster allocation, will allow activity and quality benchmarking of mental health providers, facilitate any transfer of patients between providers for part of their pathway of care, and support the introduction of patient choice which is planned to come into force from April 2014.

To support providers and commissioners to move away from block payment arrangements to payment based on the clusters, a risk-sharing approach based on the number of patients on their active caseload and using a revenue cap or collar¹⁵⁵ is set out in Section 3 of the *Guidance on mental health currencies and payment*. This approach, although optional, will also facilitate meeting legal requirements to offer patient choice in mental health.

Mental health services not covered by adult cluster currencies

When agreeing prices for mental health services not covered by the adult cluster currencies, providers and commissioners must adhere to the general rules set out in Subsection 7.4.1.

For clarity, a list of services not captured by the adult cluster currencies can be found in the *Guidance on mental health currencies and payment* published by NHS England and Monitor.

¹⁵⁵ Where the service provider agrees to accept any cost variance within a given minimum and maximum range and the commissioners bears the risk, or benefits from, any cost variation above or below that range.

7.4.5 Payment rules for ambulance and patient transport services

Ambulance services are often the first point of contact with NHS services for people with serious or life-threatening conditions. They also provide a range of other urgent and planned health care and transport services, and form an important part of urgent care provision. Ambulance crews can also refer patients to social services, directly admit patients to specialist units and administer a wide range of drugs to deal with conditions such as diabetes, asthma and heart failure.

National currencies for emergency and urgent ambulance services were first introduced in April 2012. This subsection sets out the rules for local price-setting for ambulance services with national currencies, including the rules that providers and commissioners must follow if they do not wish to use the national currencies. However, there are a range of activities, often provided by ambulance trusts, which are not included within the ambulance currencies. This subsection therefore also describes these ambulance activities without national currencies and sets out the rules that must be followed when setting local prices for them.

Ambulance services with national currencies

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.

The four national currencies for ambulance services are:

- urgent and emergency care calls answered:
 - The number of emergency and urgent calls presented to switchboard and answered.
 - Include 999 calls, calls from other healthcare professionals requesting urgent transport for patients, calls transferred or referred from other services (such as other emergency services, 111, other third parties).
 - Include hoax calls, duplicate/multiple calls about the same incident, hang-ups before coding complete, caller not with patient and unable to give details, caller refusing to give details, response cancelled before coding complete.
 - Exclude calls abandoned before answered, patient transport services requests, calls under any private or non-NHS contract.

- The unit is the price per call.
- hear and treat/refer:
 - The number of patients – following emergency or urgent calls – whose issue was resolved by providing clinical advice by telephone or referral to a third party
 - Include patients whose call is resolved - without despatching a vehicle or where a vehicle is despatched but is called off from attending the scene before arrival - by providing advice through a clinical decision support system or by a healthcare professional providing clinical advice or by transferring the call to a third party healthcare provider.
 - An ambulance trust healthcare professional does not arrive on scene.
 - The unit is the price per patient.
- see and treat/refer:
 - The number of incidents resolved with the patient(s) being treated and discharged from ambulance responsibility on scene; there is no conveyance of any patient.
 - Include incidents where ambulance trust healthcare professionals on scene refer (but do not convey) the patient(s) to any alternative care pathway or provider.
 - Include incidents where, upon arrival at scene, ambulance trust professionals are unable to locate a patient or incident.
 - Include incidents despatched by third parties (such as 111 or other emergency services) directly accessing the ambulance control despatch system.
 - The unit is the price per incident.
- see, treat and convey:
 - The number of incidents – following emergency or urgent calls – where at least one patient is conveyed by ambulance to an alternative healthcare provider
 - Alternative healthcare provider includes any other provider who can accept ambulance patients, such as A&E, MIU, walk-in centre, major trauma centre, independent provider etc.

- Include incidents despatched by third parties (such as 111 or other emergency services) directly accessing the ambulance control despatch system.
- Exclude patient transport services and other contracts with non-NHS providers.
- The unit is the price per incident.

In addition to the general rules in Subsections 7.4.1 and 7.4.2, providers and commissioners must adhere to the requirements of Rule 11 below:

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 Subsection 7.4.2.

(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 Subsection 7.4.2.

Providers and commissioners may wish to agree prices without using the four ambulance currencies, for example, to support the redesign of urgent care services to align with the introduction of 111.

Ambulance services without national currencies

When agreeing prices for ambulance services not covered by the national currencies, providers and commissioners must adhere to the general rules set out in Subsection 7.4.1.

Activities not included within the national ambulance currencies are:

- 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);
- other patient care services such as: patient transport services, neonatal transfers and patient education; and
- 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.

7.4.6 Primary care services

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:

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

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

The rules on local price-setting (as set out in Subsection 7.4) 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 2014/15, the national tariff will not apply to payments for these services.

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

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 national tariff rules for local price-setting must be applied. This includes:

- services, previously known as “locally enhanced services”, now commissioned by CCGs through the NHS Standard Contract, e.g. where a GP practice is commissioned to look after patients living in a nursing or residential care home; and

- other services commissioned by a CCG in a primary or community care setting using its power to commission services for its local population¹⁵⁶ – e.g. walk-in or out-of-hours centre services for non-registered patients.

The price paid to providers of NHS services in a primary care setting in the majority of these instances will be locally agreed, and providers and commissioners of these services must therefore adhere to the general rules set out in Subsection 7.4.1.

7.4.7 Community Services

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.

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.

Community health services provided for the purposes of the NHS continue to be largely funded through locally negotiated block payment arrangements. Payment for community health services must therefore adhere to the general rules set out in 7.4.1. This allows continued discretion at a local level to determine payment approaches that deliver good-quality care for patients on a sustainable basis.

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 Subsection 7.2 above). We would like to encourage innovation in payment approaches to support pathways that include rehabilitation and re-ablement, for example cardiac and pulmonary rehabilitation. Where possible, we expect innovation to be supported by evidence and a clear rationale for a given approach provided.

¹⁵⁶ These are arrangements made under the NHS Act 2006, sections 3 or 3A.

8 Payment Rules

The 2012 Act allows for the setting of rules relating to the making of payments to providers where health services have been provided for the purposes of the NHS (in England)¹⁵⁷. In this section, we set out the rules for:

- billing and payment; and
- activity reporting.

8.1 Billing and payment

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, such as those in the NHS standard contract (e.g. sanctions for breach of the 18-week referral to treatment standard).

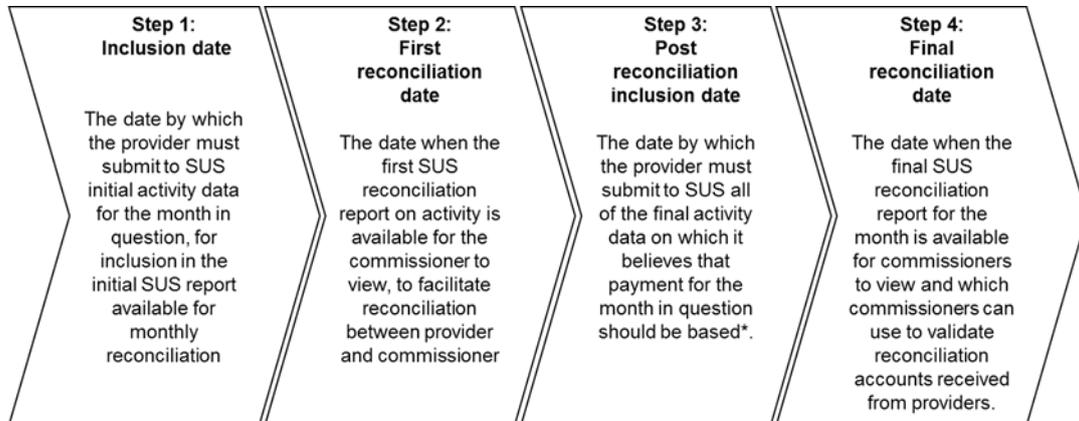
8.2 Activity reporting

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

For services with national prices, providers must submit data monthly to the Secondary Uses Service (SUS) system and comply with the four submission dates for each month, as set out in Figure 8-1 below.

¹⁵⁷ 2012 Act, section 116(4)(c).

Figure 8-1: SUS submission steps



** This submission may include amendments to take account of corrections identified by the provider's own 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 to be made by the commissioner.*

The actual dates for reporting monthly activity and making the reports available in 2014/15 will be published on the Health and Social Care Information Centre (HSCIC) [website](#).

HSCIC plan to publish the 2014/15 dates in January 2014. HSCIC will automatically notify subscribers to its e-bulletin when these dates are available.

The Secretary of State for Health has approved the NHS England application for support under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 (Section 251 Support). This allows clinical commissioning groups (CCGs) and commissioning support units (CSUs) to process personal confidential data (PCD) which are required for invoice validation purposes. This approval is subject to a set of conditions; NHS England has published advice¹⁵⁸ which explains these conditions and sets the actions that CCGs, CSUs and providers must take in order to ensure they are acting lawfully.

¹⁵⁸ Available online [here](#).



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