Monitor
Making the health sector work for patients

NHS England

2014/15 National Tariff Payment System

Annex 1A: Glossary

17 December 2013

Publications Gateway Reference 00883

Annex 1A: Glossary of Terms

This glossary provides an explanation of a number of terms and expressions used in the consultation notice, to assist readers. It is not intended to have any particular legal effect or to be relied on to provide legal definitions.

Readers should always consider the meaning of an expression in its context in the consultation notice. In addition, where an expression explained here is also used in the Health and Social Care Act 2012 (the 2012 Act), this glossary does not modify or replace the meaning given in the 2012 Act. In such cases, the glossary should be read in conjunction with the 2012 Act (and its Explanatory Notes).

TERM	DESCRIPTION
2012 Act	Health and Social Care Act 2012
Acute care	Medical treatment, usually provided in a hospital, for patients having an acute illness or injury or receiving treatment.
Admitted Patient Care (APC)	A hospital's activity (patient treatment) after a patient has been admitted to a hospital.
Allied Health Professionals (AHP)	A group of statutory-registered healthcare practitioners who deliver diagnostic, therapies and other types of care to patients.
Average Length of Stay (AvLos)	**Length of stay** refers to the number of days a patient is in hospital, from admission to discharge. **Average length of stay** describes the average stay for a group of patients at a provider or for all patients within an HRG.
Best Practice Tariffs (BPTs)	Tariffs which are designed to encourage providers to deliver best practice care and to reduce variation in the quality of care. There are a range of different best practice tariffs covering a range of different treatments and types of care.
Block contract	Contract that usually involves a fixed sum to purchase healthcare services during a given period.

TERM	DESCRIPTION
Capital expenditure (CAPEX)	Expenditure made to acquire or upgrade fixed assets. Examples of physical capital assets include property, plant and equipment.
Care Quality Commission (CQC)	A statutory body which monitors, inspects and regulates health and social care services provided by registered providers, to ensure they meet standards of quality, effectiveness and safety.
Casemix	A way of describing and classifying healthcare activity. Patients are grouped according to their diagnoses and the interventions that are carried out.
Choose and Book	The national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
Classification	Clinical classification systems are used to describe information from patient records using standardised definitions and nomenclature. This is required for creating clinical data in a format suitable for statistical and other analytical purposes such as epidemiology, benchmarking and costing.
Clinical commissioning groups (CCGs)	CCGs are statutory corporate bodies, whose members are providers of primary medical services (e.g. GP practices) and are responsible for commissioning health services for their patients and population. They are overseen by NHS England at a national level.
CCG Quarterly Assurance Process	The CCG Assurance Framework sets out the way in NHS England will assess the performance of CCGs (as required under 14Z16 of the National Health Service Act 2006). It provides assurance to NHS England, and other stakeholders, that CCGs are meeting their statutory duties. Assurance meetings are held quarterly between NHS England and CCGs.
Clinical Negligence Scheme for Trusts (CNST)	CNST, administered by the NHS Litigation Authority, provides an indemnity to members and their employees in respect of clinical negligence claims. It is funded by contributions paid by members' trusts. In the tariff calculation, cost increases associated with CNST payments are targeted at certain prices to take account of cost pressures arising from these contributions.

TERM	DESCRIPTION
Commissioners	The organisations that make arrangements for the provision of NHS health care services. This includes NHS England (and its teams), clinical commissioning groups (CCGs) (including where they act through commissioning support units), and local authorities exercising NHS commissioning functions under partnership arrangements.
Commissioning Data Set (CDS)	Information on care provided for all NHS patients by providers, including independent providers.
Commissioning support unit (CSU)	An organisation providing a range of commissioning and business service support to one or more CCGs.
Community services	Locally-based health or social care services provided to patients in and around their home.
Co-morbidities	The presence of one or more disorders (or diseases) in addition to a primary disease or disorder (e.g. patient diagnosed with cancer and diabetes).
Commissioning for Quality and Innovation (CQUIN)	A national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of payment for services provided to the achievement of quality improvement goals.
Competition Commission	An independent public body which helps to ensure healthy competition between companies in the UK for the ultimate benefit of consumers and the economy. It conducts in-depth investigations into mergers and markets and also has certain functions with regard to the major regulated industries.
Currency	A unit of healthcare activity such as spell, episode or attendance. The currency is the unit of measurement by which a national price is paid. Under the 2012 Act, the national tariff must 'specify' the health services subject to national prices – a currency is a specification for the purposes of the Act.
Directory of services	A list and description of each provider's services – including any Service Specific Booking Guidance – compiled and made available to commissioners and patients to underpin the operation of Patient Choice and as required by Department of Health guidance.

TERM	DESCRIPTION
Elective care	Elective care is planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP.
Enforcement guidance	Monitor's enforcement guidance explains the action that it can take to enforce compliance with the provider licence and other regulatory obligations on providers.
Excess bed day payment	For patients who for clinical reasons remain in hospital beyond an expected length of stay, there is additional reimbursement known as an excess bed day payment (sometimes referred to as a long stay payment). The 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.
Financial Information Management System (FIMS)	This system is used to capture reported financial data from NHS Trusts.
Finished Consultant Episode (FCE)	An FCE or consultant episode is a completed period of care for a patient requiring a hospital bed, under the care of one consultant within one healthcare provider. If a patient is transferred from one consultant to another, even if this is within the same provider, the episode ends and another one begins.
Foundation Trust	An NHS trust that has been authorised as an NHS foundation trust by Monitor. They have unique governance arrangements and are accountable to local people, who can become members and governors. They have a greater degree of freedom than NHS trusts.
Grouper	Software, created by the Health and Social Care Information Centre (HSCIC), which takes diagnosis and procedure information from patient records to classify it into clinically meaningful groups. The outputs from the grouper are used as activity currencies for costing and pricing.

TERM	DESCRIPTION
Health and Social Care Information Centre	The Health and Social Care Information Centre is a statutory body, provided for in the 2012 Act. It acts as a data, information and technology resource for the health and care system. It supports the delivery of IT infrastructure, information systems and standards to ensure information flows efficiently and securely across the health and social care system to improve patient outcomes.
Healthcare Resource Groups (HRGs)	Groupings of clinically similar treatments that use similar levels of health care resource. HRG4 is the current version of the system in use for payment.
Hospital Episode Statistics (HES)	HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. This data is collected during a patient's treatment at a hospital and is submitted to enable hospitals to be paid for the care they deliver. HES data is designed to enable secondary use, that is use for non-clinical purposes, of this administrative data.
International Classification of Disease (ICD- 10)	The ICD is a medical classification list produced by the World Health Organization (WHO). It codes for diseases, signs and symptoms and is regularly updated. Version 10 is currently in use.
Inlier	Admitted patient care activity where the length of stay of the patient does not go beyond the excess bed day trim point.
Inpatient	The informal term for Admitted Patient Care.
Independent sector providers	All providers other than NHS trusts, NHS foundation trusts and other statutory bodies providing NHS-funded services.

TERM	DESCRIPTION
Licensed providers	Providers of health care services for the purposes of the NHS who have been granted a Monitor licence. Monitor's provider licence is the main tool with which it will regulate providers of NHS services. The licence contains obligations for providers of NHS services that will allow Monitor to fulfil its new duties in relation to: setting prices for NHS-funded care in partnership with NHS England; enabling integrated care; preventing anti-competitive behaviour which is against the interests of patients; and supporting commissioners in maintaining service continuity.
Local modifications	A local modification is a modification to the price for a service determined in accordance with the national tariff, as provided for in sections 124 to 126 of the Health and Social Care Act 2012. These are intended to ensure that health care services can be delivered where required by commissioners, even if the cost of providing these services is higher than the nationally determined prices. Local modifications can be made by one of 2 routes. **Agreements**: where a provider and one or more commissioners agree to increase nationally determined prices for specific services. **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. In this case, Monitor is required to publish its method for deciding whether to approve local modification agreements and for determining local modification applications.
Local prices	For many NHS services, there are no national prices. Some of these services have nationally specified currencies, but others do not. In both instances commissioners and providers must work together to set prices for these services. The 2012 Act allows Monitor to set rules for local price setting where it believes this is appropriate.

TERM	DESCRIPTION
Local variations	Local variations can be used by commissioners and providers to agree adjustments to national prices, or the currencies for national prices, where it is in the best interests of patients to support a different mix of services or delivery model. This includes cases where services are bundled or where care is delivered in new settings or where there is use of innovative clinical practices or arrangements to change the allocation of financial risk.
Marginal Rate Rule for emergency admissions **(also known as Marginal rate emergency rule)**	The rule is a national variation to national prices for the services covered by the rule. The rule requires that a provider receives payment at 30% of the tariff price for all emergency activity above the baseline in 2008/09. The marginal rate is calculated at a contract level using as a baseline the tariff income value calculated by applying the current tariff level to 2008/09 emergency admissions activity. Commissioners are required to invest the remaining 70% of the tariff income in demand management schemes which prevent inappropriate hospital admissions by improving patient care outside of hospital.
Market Forces Factor (MFF)	An index used in tariff payment and commissioner allocations to estimate the unavoidable regional cost differences of providing healthcare. Each NHS organisation receives an individual MFF value, used to establish the level of unavoidable regional costs they face relative to other NHS organisations. The variation of national prices by application of the MFF is one of the national variations provided in the national tariff.
Monitor	Monitor is the sector regulator of NHS funded health care services. Under the Health and Social Care 2012 Act its main duty is to protect and promote the interests of patients. The Act also gave Monitor and NHS England joint responsibility for the NHS payment system with NHS England specifying the services to be priced and Monitor designing and applying the methodology for pricing them.
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	A closely linked set of centrally-funded national clinical audit projects commissioned and managed by the Healthcare Quality Improvement Partnership.

TERM	DESCRIPTION
NHS England	NHS England oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012. The body was established by the Act as the NHS Commissioning Board.
NHS Litigation Authority (NHSLA)	Administers the Clinical Negligence Scheme for Trusts (CNST). It a Special Health Authority established under the National Health Service Act 2006.
Specialised services (formerly NHS Specialised Services)	Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Responsibility for commissioning these services now lies with NHS England (see section 3B of the National Health Service Act 2006).
NHS Standard Contract	The contract issued by NHS England for use when commissioning NHS health care services (other than those commissioned under primary care contracts). It is adaptable for use for a broad range of services and delivery models.
NHS Trust Development Authority (NHS TDA)	The organisation that is responsible for overseeing the performance management and governance of NHS trusts, including clinical quality, and managing their progress towards foundation trust status. It a Special Health Authority established under the National Health Service Act 2006.
NHS TDA's Accountability Framework for NHS trust boards	A framework that supports NHS trusts in their progression towards achieving foundation trust status. It sets out how the NHS TDA will work with NHS trusts on a day-to-day basis, how they will assess the progress NHS trusts are making and how they will provide the development support each organisation needs.
National variations	Adjustment of national prices determined at a national level, reflecting a range of factors such as complexity of treatment or regional cost differences.

TERM	DESCRIPTION
National Institute for Health and Care Excellence (NICE)	A statutory body provided for in the Health and Social Care Act 2012. It provides independent and evidenced-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.
Non-elective care	Medical care or surgery that is unplanned (e.g. emergency hospital admission).
Office of Population Censuses and Surveys Classification of Interventions and Procedures (OPCS – 4)	A classification for the coding of surgical procedures and interventions. Version 4 is currently in use. The next version for implementation by the NHS is OPCS 4.7 due to come into use from 1 April 2014.
Operating expenditure (OPEX)	A category of expenditure that a provider incurs as result of performing its normal business operations (e.g. patient activity).
Pathway payments	Single payments that cover a bundle of services that may be provided by a number of providers covering a whole pathway of care for a patient.
Patient-level costing	Patient-level costing is the system to measure the hospital resources used by individual patients.
Patient-level costs	These are calculated by tracing resources actually used by a patient and the associated costs in providing a service.
Patient Level Information and Costing Systems (PLICS)	Systems that support the collection and recording of patient level costs.
Patient Reported Outcome Measures (PROMS)	These allow the NHS to measure and improve the quality of treatments and care that patients receive. Patients are asked about their health and quality of life before they have an operation, and about their health and effectiveness of the operation afterwards.
Payment by Results (PbR)	Payment by Results was an approach to paying providers on the basis of activity undertaken, in accordance with national rules and a national tariff. This term is being phased out as the national tariff gives Monitor and NHS England a broader set of responsibilities for the payment system.

TERM	DESCRIPTION
Pharmaceutical Price Regulation Scheme (PPRS)	This is the mechanism that ensures that the NHS has access to good quality branded medicines at reasonable prices. It involves a non-contractual agreement between the UK Department of Health and the Association of the British Pharmaceutical Industry (ABPI). The scheme applies to all branded, licensed medicines available on the NHS. The purpose of the scheme is to achieve a balance between reasonable prices for the NHS and a fair return for the pharmaceutical industry.
Primary care	Services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners, together with district nurses and health visitors.
QIPP	The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large scale programme developed by the Department of Health to drive forward quality improvements in NHS care at the same time as making significant efficiency savings.
Relative Resource Intensity (RRI)	In mental health, this is used as a relative measure of the resources required to deliver care for a particular cluster.
Relevant providers	Providers, as defined by the Health and Social Care Act 2012 and regulations made under the Act, who are able to challenge the method which Monitor proposes to use to calculate national prices, by means of a statutory consultation and objection process Specifically they are: (a) licensed providers (including NHS foundation trusts), and (b) non-licensed providers (currently NHS trusts and independent providers) who provide NHS services that are subject to national prices.
Reference costs	The collection of detailed costs to the NHS of providing services in a given financial year. NHS health care providers are required to submit Reference Costs data to the Department of Health. The costs are published on an annual basis.
Secondary care	Hospital or specialist care to which a patient is referred by their GP.

TERM	DESCRIPTION
Secondary Uses Service (SUS)	The Secondary Uses Service (SUS) is a single comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the delivery of NHS healthcare services.
Service specific booking guidance	Guidance for use by commissioners and their agents in making referrals and bookings on behalf of patients. It gives details of any criteria to be used systematically by a provider to determine patients' eligibility for specific services.
Service development	The service development element of the tariff uplift factor reflects the additional costs to providers of meeting certain requirements set out in the NHS England Mandate.
Specialist top-up	Top-up that is applied to specialist activity (defined by the Specialised Services National Definition Sets).
Spell	The period from the date that a patient is admitted into hospital until the date they are discharged, which may contain one or more episodes of treatment.
Staff index	This index is part of the MFF. It estimates the unavoidable variation in staff costs arising from geographical differences in staff costs across the country.
Stakeholders	The term stakeholders covers all parties operating within the system, and groups within those stakeholders, including clinicians and managers. It also includes patients and members of the public.
Terminology Reference-data Update Service (TRUD)	A service hosted by the UK Terminology Centre, which provides a mechanism to license and distribute reference data to interested parties.
Terms of authorisation	The terms under which NHS foundation trusts were authorised to provide services under the National Health Service Act 2006. Since 1 April 2012, the terms of authorisation have been replaced by the licence issued by Monitor under Part 3 of the Health and Social Care Act 2012.

TERM	DESCRIPTION
Top-up payments	Top-up payments are applied as a percentage increase to the tariff price. They are designed to recognise that patients who receive some types of specialised care may be more expensive than those allocated to the same HRG who do not require specialised care. Top-up payments are an example of a national variation.
Treatment threshold	A treatment threshold is the clinical threshold above which a specific treatment is judged appropriate for a specific condition.
Treatment Function Code (TFC)	Outpatient attendance national prices are based on TFCs. Main Specialty codes represent the specialty within which a Consultant is recognised or contracted to the organisation. Outpatient activity is generally organised around clinics based on TFC specialties and they are used to report outpatient activity.
Trigger point	A pre-agreed level of referrals and/or activity, indicating unplanned increases in demand.
Trim point	For each HRG, the trim point is calculated as the upper quartile length of stay for that HRG plus 1.5 times the inter-quartile range of length of stay. After the spell of treatment exceeds this number of days, a provider will receive a payment for each additional day that the patient remains in hospital. This is referred to as an excess bed day payment or a long stay payment.
UK specialist Rehabilitation Outcomes Collaborative (UKROC) database	The UK specialist Rehabilitation Outcomes Collaborative (UKROC) was set up through a Department of Health NIHR Programme Grant to develop a national database for collating case episodes for inpatient rehabilitation.
Unavoidable costs	Refers to the costs that providers are unable to significantly influence.
Unbundling	The separation of a sub-set of activity (or activities), treatment or service from the main activity (such as an admitted patient spell or an outpatient attendance) for the purposes of counting, costing or pricing separately. For example, unbundling diagnostic imaging activity from an outpatient attendance or unbundling a patient's care in critical care from the inpatient spell.