

# Q&As on tariff arrangements for 2015/16



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### List of changes

Version	Date published	Changes made
1	26/02/15	First version published
2	27/02/15	New Q&A added – Q5.7 – and spreadsheet published alongside Q&A document
3	04/03/15	New Q&As added and amendments made to provide further information to assist implementation of the ETO/DTR choices.  New Q&As added: Q1.22, Q1.23, Q2.8, Q5.8, Q5.9, Q5.10, Q5.11, Q6.8, Q7.6, Q7.7  Amendments made to: Q5.3, Q7.1
4	17/03/15	New Q&As added: Q5.12, Q7.8  Amendments made to: Q2.4
5	23/03/15	New Q&A added: Q1.24  Amendments made to: Q6.7, Q7.3
6	01/04/15	New Q&A added: Q1.25  Amendment made to: Q5.1
7	16/04/15	New Q&A added: Q7.9  Amendment made to: Q7.7

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## 1 Enhanced Tariff Option

**Q1.1** If the provider chooses to adopt the ETO, must the commissioner accept the provider's preference?

**A.** *Yes – the commissioner will need to adopt local variations in accordance with the rules set out in section 7 of the 2014/15 National Tariff Payment System.<sup>1</sup>*

**Q1.2** Under these arrangements, can a provider opt for the ETO for different contracts it holds? For example, could an integrated provider of acute and community services choose the ETO for its community service contracts and the DTR for its acute contracts?

**A.** *No. The basis of the offer from NHS commissioners will be that a provider must adopt the ETO for all its contracts or none of its contracts. Providers will need to make a single overall assessment and choice.*

**Q1.3** Do providers only have one opportunity to opt for the ETO or DTR? Can they choose to adopt neither?

**A.** *Providers have one opportunity to make their choice, and must communicate their choice by 6pm on 4<sup>th</sup> March 2015 by e-mailing a completed 'Formal Provider tariff Selection Document for 2015/16' form to [localvariations@monitor.gov.uk](mailto:localvariations@monitor.gov.uk). There will be no opportunity to adopt the ETO after this date. There isn't the option to adopt neither the ETO nor the DTR – the DTR is the legal default for any provider that does not communicate a choice, and as a DTR provider they will not be eligible for CQUIN payments.*

**Q1.4** What happens if Monitor decides to refer the 2015/16 tariff methodology to the Competition and Markets Authority?

**A.** *That won't itself have an impact on the implementation of the ETO or DTR options, as until the outcome of the CMA process there would still be no new tariff for 2015/16. The outcome of the CMA and any final 2015/16 tariff would have implications for 2015/16 prices in the DTR, but would not affect the withdrawal of CQUIN for providers for 2015/16 who have not opted for the ETO. In any event, changes arising from a CMA referral would not be backdated to 1<sup>st</sup> April 2015 for those providers on the DTR.*

**Q1.5** Tariff proposals are usually accompanied by an impact assessment. Will one be provided in support of the ETO and DTR options?

**A.** *No. This is not a proposed new tariff, but a set of voluntary interim pricing arrangements. As set out in our letter of 18<sup>th</sup> February we estimate that the ETO is*

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<sup>1</sup> <https://www.gov.uk/government/publications/national-tariff-payment-system-2014-to-2015>

worth £500m if all providers opt for it, as compared with the previously consulted on 2015/16 tariff proposals.

**Q1.6** What happens if providers do not opt for the ETO?

**A.** *They will be on DTR and will continue to use the 2014/15 prices, subject to any local variations or local modifications, but will not be eligible for CQUIN payments.*

**Q1.7** The ETO package includes a revised gross tariff deflator of 3.5%, down from 3.8% in the 2015/16 tariff consultation notice. After accounting for allocated costs of CNST, how much lower will the national prices agreed under the ETO be, on average, compared with the national prices under the 2014/15 national tariff?

**A.** *The difference in nationally determined prices between 2014/15 and the previously proposed 2015/16 tariff is approximately 0.8%. A revision of nationally determined prices under the ETO would broadly result in an increase over the proposed 2015/16 tariff of approximately 0.3%. Therefore under the ETO, national prices will only be approximately 0.5% lower, on average, than the prices in the 2014/15 national tariff.*

**Q1.8** In the 2015/16 tariff consultation notice, some elements of the overall inflation figure of 1.93% were subject to confirmation. Are you making any changes to these estimates for the ETO?

**A.** *No.*

**Q1.9** How will ETO prices differ from those published in the 2015/16 tariff consultation notice? Will providers have to calculate prices themselves?

**A.** *The ETO prices will be those published in the 2015/16 tariff consultation notice, increased by 0.3%. Once the choice has been made, for those organisations opting for the ETO, we will publish an updated price list so providers won't need to calculate prices themselves.*

**Q1.10** As well as adopting prices which reflect the lower gross tariff deflator, are other changes being made to the prices set out in the 2015/16 tariff consultation notice last year, for example in response to feedback about specific proposed prices?

**A.** *We will not make material revisions that would change the impact on providers and commissioners. For example, we will not be making any changes to the ETO price list to reflect Section 118 consultation feedback other than the changes outlined in the letter. For the purposes of the ETO, we intend to correct a small number of unintended errors, such as inconsistencies between different worksheets.*

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**Q1.11** Under the ETO arrangement, should providers and commissioners take into account the overall price adjustment used in the ETO prices when negotiating prices for services that do not have a national price? If so, what figure should be used; is it -1.6% rather than -1.9%?

**A.** *Yes, it should be -1.6%.*

**Q1.12** What are the arrangements for Best Practice Tariffs under the ETO?

**A.** *These would be as set out in the 2015/16 tariff consultation notice, subject to any minor amendments such as those referred to in Q1.10.*

**Q1.13** If a provider and commissioner sign up to the ETO, does that mean that other agreed local variations they have must be scrapped?

**A.** *No. Where local areas have agreed a specific alternative payment arrangement in line with the rules for local variations (for example a capitated budget), these arrangements can continue and will have to be notified to Monitor in accordance with current rules.*

**Q1.14** What is the cost to commissioners of the ETO package, and will they receive additional funds in recognition of the increase in prices from the 2015/16 consultation notice and changes to the marginal rate rule?

**A.** *We estimate that the ETO package is worth around £500 million more to providers than the original 2015/16 tariff proposals, if all providers adopted the package. The majority of these extra costs will ultimately be borne by NHS England, who will offer targeted additional funding support to CCGs to help offset some of the pressures arising.*

**Q1.15** What materials are being published to support the operation of the ETO?

**A.** *Monitor and NHS England are working on a package of materials to support the practical implementation of the ETO.*

**Q1.16** Will an ETO local variation template be made available?

**A.** *NHS England is working on a sample pre-filled Monitor local variation template, but providers should not wait until it is available before deciding whether they want to go for the ETO or DTR options. The deadline for making a decision is 6pm on 4 March 2015.*

**Q1.17** Will commissioners need to publish any local variation template(s) for the ETO, as they would do for any other local variation?

**A. Yes.**

**Q1.18** Does the ETO / DTR choice apply to independent sector providers of NHS funded care as well as NHS providers?

**A. Yes.**

**Q1.19** Is it necessary for very small providers (care homes, voluntary bodies, pharmacies etc) providing low-value services entirely under local prices, to make a DTR / ETO return by 4 March, and must local variations be submitted in relation to such providers?

**A.** *The letter of 18 February was sent directly by Monitor to major providers of NHS-funded care, and it is essential that all such providers make a return by 4 March. We are conscious that there are many other non-NHS organisations which provide NHS-funded care on a much smaller scale under contracts held with CCGs. By no means all of these providers are known to us centrally at NHS England / Monitor, and the 18 February letter will not have reached all such providers.*

*Where commissioners subsequently negotiate an acceptable local price with such a provider for 2015/16, having regard to the -1.6% deflator, NHS England's position is that they should offer that provider a CQUIN scheme in accordance with CQUIN guidance.*

**Q1.20** What do we use as the MFF for payment under the ETO option?

**A.** *You should continue to use the MFF as published as part of the 2014/15 National Tariff Payment System. Where there have been mergers or new NHS providers have come into existence, we will provide revised MFF values as guidance.*

**Q1.21** What list of excluded drugs and devices will be used under the ETO?

**A.** *The list to be used is that set out in the 2015/16 tariff consultation notice. This will need to be reflected in the local variation.*

**Q1.22** Under the ETO, when the national pay award is finalised will any resulting cost pressure be reflected in an uplift to ETO prices?

**A. No**

**Q1.23** Can you summarise the various efficiency requirement and uplift figures?

*A. Please see table below.*

	2014/15 tariff	2015/16 consultation	ETO prices
Efficiency requirement	-4.0%	-3.8%	-3.5%
Cost uplift factors (incl. Service Development but excl. targeted CNST)	+2.5%	+1.9%	+1.9%
<i>Net tariff deflator</i>	-1.5%	-1.9%	-1.6%
CNST uplift targeted at HRG sub chapter level	+0.3%	+1.1%	+1.1%
Average adjustment to national prices	-1.2%	-0.8%	-0.5%

**Q1.24** Is there a deadline by which commissioners need to submit completed Local Variation templates to Monitor?

*A. Commissioners are asked to submit completed templates within 30 days of agreement being reached with providers.*

**Q1.25** Which anti-tuberculosis drugs are reimbursed outside of ETO prices?

*A. As part of the ETO guidance package, we have published a list of high cost drugs, devices and listed procedures. On the worksheet titled 'Detailed HCDs,' two anti-tuberculosis drugs are listed - Bedaquiline and Delamanid. Other anti-tuberculosis drugs are reimbursed through the relevant HRG ETO price, unless there is a local agreement between providers and commissioners.*

## 2 Default Tariff Rollover

**Q2.1** What is the net deflator for national prices under the DTR option?

*A. There is no deflator applied to national prices under the DTR option, as the 2014/15 national prices continue to apply. But CQUIN worth up to 2.5% is foregone for the entirety of 2015/16.*

**Q2.2** If a provider selects the DTR tariff option, how should contracts and plans reflect the risk of moving part year onto a final 2015/16 national tariff?

*A. The contracts and plans should be prepared on the basis of the information available at the time of planning. At this time there are no indications as to the*



*possible timing or content of a final 2015/16 national tariff, therefore contracts and plans should be prepared for the full year based on the DTR tariff option if this is selected. When a new tariff is ultimately issued, we will provide further guidance on planning and contracting as appropriate.*

*Please also see the document ‘Technical guidance on applying Monitor’s 2015/16 financial assumptions’ which is available on the Monitor website<sup>2</sup>.*

**Q2.3** If a provider opts for the DTR, can they still agree local variations or local modifications with commissioners?

**A.** *Yes, provided that the commissioners are willing to do so and the proposed variation or modification is in accordance with the rules set out in section 7 of the 2014/15 National Tariff Payment System.*

**Q2.4** Under the DTR option, do 2014/15 prices agreed locally for services without national prices simply roll forward unamended?

**A.** *The 2014/15 National Tariff Payment System (NTPS) continues in effect after 1st April 2015, pending a new national tariff. This includes the rules for local pricing in Section 7.4 of the NTPS. The rules must be applied as they are drafted and set out in that Section. Rule 2 in Section 7.4.1 states that –*

*“Commissioners and providers should have regard to the tariff efficiency and cost uplift factors for 2014/15 (as set out in Section 5 of [the NTPS]) when setting local prices for services without a national price for 2014/15.....”*

*The wording of the rule clearly applies to services without a national price for 2014/15, but does not specify any requirement in relation to services without a national price for 2015/16. In addition, the rule refers to the efficiency factor and cost uplifts for 2014/15, and does not impose any obligation in relation to the efficiency factor and cost uplifts for 2015/16, albeit they are to be applied, with modification, in varying national prices under the ETO. Rule 2 therefore has no practical effect for local pricing in 2015/16.*

*Nonetheless, where commissioners are agreeing local prices with any provider which chooses ETO, we expect them to use the revised -1.6% deflator as the starting point for negotiation. This is not a binding requirement under the 2014/15 national tariff, but Monitor and NHS England consider it to be appropriate, given that under the ETO the provider will be varying their national prices by reference to this deflator.*

**Q2.5** Under the DTR option, will the 2014/15 list of excluded drugs and devices be updated?

**A.** *No.*

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<sup>2</sup> <https://www.gov.uk/government/publications/annual-planning-review-201516-guidance-for-foundation-trusts>

**Q2.6** Under the DTR option, do the Best Practice Tariff schemes remain the same as in 2014/15?

**A.** Yes.

**Q2.7** Under the DTR option, will the 2014/15 national variations to support transition to new payment arrangements for maternity, diagnostic imaging in outpatients, chemotherapy delivery and external beam radiotherapy remain in operation?

**A.** Yes.

**Q2.8** If DTR is chosen, what will happen part-way through 2015/16 when a new tariff is published?

**A.** *The new tariff will supersede the 2014/15 tariff and the DTR, and the new national prices and rules will apply. Providers should not assume that they will be eligible for CQUIN payments following a new tariff*

### **3 Mental health**

**Q3.1** Are commissioners still required to increase in real terms their investment in mental health services? What assurance mechanisms will be put in place to monitor if CCGs are meeting this planning guidance requirement?

**A.** *Yes, the operation of either ETO or DTR should have no impact on the requirement that commissioners must demonstrate a real terms, year-on-year increase in expenditure on mental health services at least as large as the increase in their programme allocation.*

*NHS England will be checking, through the planning process, the level of increase in mental health spend that each CCG is planning for, which will give us a basis to check and challenge where required.*

**Q3.2** The letter suggests that where a mental health provider opts for the DTR, they would be denied access to the additional funds being made available for early intervention in psychosis (EIP), even if the CCG wishes to provide this funding. Is that right?

**A.** *The additional funding made available for early intervention in psychosis in 2015/16 comes from efficiencies in our existing budget. Where providers accept the ETO, commissioners must take account of the additional funding required for EIP in their local tariff negotiations on mental health. As the DTR does not release the same level of efficiency savings as the ETO, commissioners will have to take a judgement on whether they can afford to invest in EIP given the other pressures.*

*EIP services are subject to local agreement on pricing, and so NHS England's position is that commissioners should ensure that, in line with the planning guidance requirements, increases in the level of local investment take into account baseline performance against both elements of the EIP standard to ensure delivery of the new standard from 1 April 2016:*

- *Referral to treatment waiting times; and*
- *Current levels of NICE concordance – access to the range of evidence-based biological, psychological and social interventions as recommended by NICE guidelines for psychosis and schizophrenia in children and young people CG155 (2013) and in adults CG178 (2014).*

## **4 Marginal rate emergency tariff**

**Q4.1** The letter from David Bennett and Simon Stevens states that the 70% reimbursement rate for increases in the value of emergency admissions “covers all volumes above the agreed local baseline, not just increases over the 2014/15 outturn.” Does this mean that the 2008/09 baseline has been scrapped under the ETO and replaced with a new baseline of 2014/15 outturn?

**A.** *No. The ability to vary the 2008/09 baseline by agreement remains under the ETO, but we are not introducing a new default baseline of 2014/15 outturn.*

**Q4.2** The letter states that under the ETO, the move from 30% to 70% reimbursement for increases in emergency admissions above the agreed baseline is expected to deliver around £130 million to providers which should be used to support ongoing winter resilience schemes. Is this the sole purpose for which this money can be used?

**A.** *No. This money is separate from the winter resilience funding confirmed in the Joint Planning Guidance that has been added to CCG allocations. This money, which would otherwise have been spent by CCGs on admission avoidance measures, is now available to providers to be invested in acute services, including but not limited to winter resilience schemes.*

**Q4.3** Under the ETO, can providers and commissioners agree changes to the marginal rate emergency tariff baseline above which the 70% reimbursement will apply?

**A.** *Yes. Adjustments to the baseline could be made where appropriate as per para 6.3.1 of the 2015/16 tariff consultation notice<sup>3</sup>.*

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<sup>3</sup> <https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice>

**Q4.4** Under the DTR option, can the marginal rate emergency tariff activity baseline be changed?

**A.** *Yes, the ability to amend the baseline as set out in the 2014/15 National Tariff Payment System will continue.*

## **5 Acute specialised services marginal cost arrangements**

**Q5.1** The 2015/16 tariff consultation notice suggested that for any under activity in specialised services below the base rate, NHS England would retain 50% of the difference. What happens to the rate of under activity under the ETO? Also, what is the impact on high cost drugs and devices?

**A.** *There is no change to the scope of the gain and loss sharing arrangements – it would still cover all acute prescribed specialised services (for those providers adopting the ETO), including the high cost drugs and devices used in the provision of those services (these are listed at Annex 7B of the 2015/16 national tariff consultation document).*

*Where the gross specialised actual contract value for the financial year 2015/16 exceeds the stated base value, the amount payable to the provider in respect of the provision of acute prescribed specialised services (other than excluded services<sup>4</sup>) is the sum of the Stated Base Value (which, under the ETO, now incorporates all contract variations agreed as at the end of January 2015) and 70% of the amount by which the Stated Base Value has been exceeded, up from 50% in the initial proposal.*

*Where the gross specialised actual contract value for the financial year 2015/16 is less than the Stated Base Value, the amount payable to the provider in respect of the provision of acute prescribed specialised services (other than excluded services) is the Stated Base Value, less 70% of the difference between the two values.*

**Q5.2** Under the ETO, is the base value for the acute specialised services gain and loss share arrangement now 2014/15 outturn?

**A.** *No. The base value is 2014/15 plan incorporating all contract variations agreed as at the end of January 2015.*

**Q5.3** Under the ETO, can adjustments be made to the baseline for the specialised services gain and loss share arrangement?

**A.** *Yes – under the ETO, the ability to adjust the baseline is at the discretion of the commissioner to reflect such things as the forecast introduction of new drugs and devices. Other potential examples were set out in para 8.3.2 (G) of the 2015/16 tariff*

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<sup>4</sup> To clarify, the reference to ‘excluded services’ here relates to Stated Base Value setting Rule C – “Deduct the 2014/15 EACV for NHS England commissioned services in the contract that are not acute prescribed specialised services in 2015/16,”

*consultation notice. Providers should engage with their local NHS England commissioners as part of contract round discussions to inform their working assumptions about how discretion would be exercised in line with guidance in these areas where relevant to local circumstances.*

**Q5.4** Under the ETO, should non-elective activity included in the specialised services gain and loss sharing arrangement baseline at the marginal rate emergency tariff rate of 30% be rebased to the revised rate of 70%?

**A.** *Yes, as per para 8.3.2 (F) of the 2015/16 tariff consultation notice.*

**Q5.5** The letter suggests that the revised specialised services gain and loss share arrangement would save the provider sector £170 million. How has this figure been arrived at, given that the original impact assessment in the statutory consultation notice indicated that the introduction of the rule at 50% would see a reduction in provider incomes by £170 million?

**A.** *The Impact Assessment published alongside the 2015/16 tariff consultation notice assumed that activity growth in specialised commissioning in 2014/15 would be in line with plan. More recent estimates on in-year growth suggest that specialised commissioning activity in 2014/15 will be higher than plan. When taking account of this higher growth, the estimate of the impact of the 50% specialised commissioning risk share on provider income increases to around £350m.*

*When the risk share is adjusted to a marginal rate of 70% and contract variations up to the end of month 10 are taken into account, the impact of the risk share comes down to around £180m, a saving to the provider sector of £170m.*

**Q5.6** Will NHS England specialised commissioners be instructed to make up for the money lost under this revised arrangement by increasing the efficiency ask on non-acute services that are not covered by the rule, such as specialised mental health services?

**A.** *NHS England specialised commissioners will continue to work with all providers of acute and non-acute services to develop quality, innovation, productivity and prevention (QIPP) schemes to deliver the best value from available funds. These activities will continue to be directed by the Forward View Into Action and the 2015/16 Commissioning Intentions and look to maximise the opportunities for improvement across all sectors and providers, irrespective of which tariff option is opted for.*

**Q5.7** Is there any information that NHS England can make available to help providers of acute prescribed specialised services understand what their specialist commissioning baseline value is for contracting purposes? A potential area for uncertainty is around new, excluded high cost drugs and devices in 2015/16.

**A.** *A list of all excluded drug groups within specialised services used in the calculation of the Stated Base Value is set out in a spreadsheet published alongside this Q&A document. These drugs are not excluded from the risk share rule, however it is the planned extra cost of providing these drugs which will be used when uplifting a specific provider's Stated Base Value.*

*The current estimated extra cost of the drugs that attracted a specific NICE uplift, totalling £76m, is included in the spreadsheet. This is based on increase to 2014/15 drug contract figures and excludes VAT. This increase will not be applied evenly to every provider as not all providers will be impacted by the new drugs. An estimated breakdown of the £76m by provider is also included.*

*Please note that the calculation of the impact of NICE drugs is based on the best available information at a point in time. NHS England would expect area teams to work with these providers to validate this information.*

**Q5.8** Will Stated Base Values (SBVs) be published?

**A.** *The SBVs were calculated in December 2014 in line with the published calculation methodology and shared with Area Teams. The expectation is that local commissioning teams and providers will adjust the SBV if required to reflect signed recorded contract variations up to the end of 31 January 2015 and report any changes to NHS England. There is no intention to centrally publish SBVs so providers should review directly with their Area Team as part of contract round discussions.*

**Q5.9** Are there any plans to update the 'Estimated Excluded Drug Groups NICE Impact by Provider' figures contained in the spreadsheet published on 27 February?

**A.** *There are no plans to produce further updates.*

**Q5.10** On the worksheet titled 'List of Excluded Drug Groups Used in the 15/16 Stated Base Value for Specialised Commissioning', there is no mention of new Hepatitis C drugs such as sofosbuvir. Is this an oversight?

**A.** *No. Due to the complexities of the new Hep C drugs they have been removed from this national adjustment and are being separately reviewed and calculated so that they do not impact on the opening SBV adjustment. Once this review is complete, NHS England will provide further guidance and information. Therefore those agreed pilot sites, that are currently commissioned to provide the new Hep C drugs, should continue to excluded these costs from contracts and will be funded in line with the current regime until the new guidance is issued.*

**Q5.11** Under ETO how will any new in-year NICE approvals be managed in respect of adjustments to provider baselines?



**A.** The national impact of all known new NICE drugs for 2015/16 has been estimated by the NHS England pharmacist including those expected to be approved in year. The details of these estimates are described in Q&A 5.7 above.

**Q5.12** Will you be amending the worked example published in November in support of setting the baseline for the acute specialised services gain and loss share rule (see extract below)? In particular, will you be amending the tariff deflator to reflect the impact of CNST costs allocated to specific HRG sub chapters?

	A	B	C	D
1	<b>APPENDIX Worked example of 50/50 risk sharing agreement</b>			
2				
3	<b>Key:</b>			
4		Cells for manual input		
5		Cells containing formulae		
6		Tariff deflator figure		
7				
8	<b>Setting a Stated Base Value</b>			
9				
10	A	2014/15 'Expected Annual Contract Value' (EACV)	€10,000	
11				
12		2014/15 high cost drugs and devices (included in the EACV above)	€2,000	* See instructions
13				
14	B	Signed contract variations by 1/10/14	€50	
15				
16	C	Services other than acute prescribed specialised services in the 2014/15 EACV	€100	
17				
18	D1	Non-recurrent, cancer drug fund, CQUIN and other payments in 2014/15	€25	
19				
20	D2	Value of services for which alternative innovative payments have been agreed	€0	
21				
22	E	Tariff deflator for 2015/16	-1.9%	
23				
24		Applying the 2015/16 tariff deflator to all relevant items (i.e. excluding high cost drugs and devices)	€7,774	
25				
26	F	Impact of emergency admissions marginal rate amendment to 50%	€10	
27				
28	G	Other adjustments including forecast of new high cost drugs and devices (see para 8.3.2)	€200	
29				
30		<b>(A+B-C-D1-D2)*(1-E) STATED BASE VALUE (SBV)</b>	<b>€9,984</b>	
31				
32				

**A.** For the ETO, we will amend the references in the worked example to '50:50' and 'Expected Annual Contract Value' and we will amend the tariff deflator figure to -1.6%. We will not however reduce this figure further to reflect the CNST costs allocated to specific HRG sub chapters (1.1%). We do not think that making such a change is warranted, not least because the sub chapters attracting the highest CNST cost uplifts are maternity and A&E, neither of which are prescribed specialised services.

## 6 Standard Contract and CQUIN

The following questions and answers are prepared by NHS England, which is responsible for the Standard Contract and CQUIN scheme

**Q6.1** When will further guidance be issued about CQUIN?

**A.** Details of the 2015/16 CQUIN scheme are being published alongside this Q&A<sup>5</sup>.

<sup>5</sup> <http://www.england.nhs.uk/nhs-standard-contract/15-16/>

**Q6.2** What happens if a provider with a multi-year contract has agreed a multi-year local CQUIN scheme with its commissioner and rejects the ETO? It's already in their contract, so what should happen?

**A.** *The existing 2014/15 CQUIN guidance makes it clear, with references on pages 6, 8-9 and 48, that:*

- *CQUIN monies remain non-recurrent;*
- *commissioners and providers will have to consider the potential for changes to the national pricing and incentive rules and agree how they would handle any multi-year CQUINs should this occur; and*
- *commissioners and providers will need to agree how they will handle any future changes to CQUIN rules for multi-year schemes, e.g. what happens if the total % available for CQUIN goes up or down.*

*Therefore where a provider has elected to remain on the DTR, and no national CQUIN is available, the contract will need to be varied to remove these references for 2015/16.*

**Q6.3** Will organisations opting for DTR be expected to meet the minimum national requirements for CQUIN if they are not eligible for CQUIN under the DTR option? By what mechanism will this be mandated, as the usual CQUIN incentive basis will not be in place?

**A.** *No. However where DTR applies and no CQUIN scheme is implemented, commissioners may, for example, seek to negotiate with providers specific quality standards or Service Development and Improvement Plans for inclusion in their contracts; this is a matter for local negotiation.*

**Q6.4** Will CQUIN targets be built into the revised Standard Contract for 2015/16?

**A.** *No. The Standard Contract will refer to the CQUIN guidance. The Standard Contract will contain a schedule for the agreed CQUIN scheme to be included.*

**Q6.5** Is there a risk that commissioners will simply increase QIPP requirements for providers opting for DTR?

**A.** *Health economies will need to live within available financial resources, and NHS England will offer targeted additional funding support to CCGs to help offset some of the financial pressures. NHS England expect that all commissioners will continue to work with all providers of acute and non-acute services to develop quality, innovation, productivity and prevention (QIPP) schemes to deliver the best possible value for patients, irrespective of the tariff option chosen.*



**Q6.6** Can commissioners increase CQUIN requirements to reclaim funds from providers opting for the ETO?

**A.** No.

**Q6.7** From a contract perspective, what happens if a provider does not submit a form to notify a choice of either ETO or DTR?

**A.** *If a provider does not express a preference for ETO or DTR, they will legally default to the DTR (subject to the answer to question 1.19 above regarding small providers). In this instance, commissioner and provider should still work together to agree and sign the 2015/16 NHS Standard Contract, but - in line with CQUIN guidance - no CQUIN scheme will be available under that Contract for a DTR provider.*

**Q6.8** Will the NHS Standard Contract for 2015/16 apply to both the ETO and DTR options?

**A.** Yes.

## 7 Other issues

**Q7.1** Providers opting for the ETO will be required to join a sector-wide collaborative cost data sharing and joint efficiency initiative. How should they go about getting involved in this?

**A.** *The sector-wide collaborative cost data sharing and joint efficiency initiative is being undertaken by a team located in the Department of Health Procurement Investment & Commercial Division. This team will contact you in due course but should you wish to know more about the details of the programme please contact Steve Spray at [steve.spray1@dh.gsi.gov.uk](mailto:steve.spray1@dh.gsi.gov.uk)*

*The DH team will issue a template to request relevant information including staffing, pharmacy costs, procurement cost, and pathology / radiology costs. The information collected will be used to help NHS providers to understand their relative efficiency in a meaningful way and identify where they might focus effort to deliver the greatest efficiency gains. It is not intended that this information at organisation level is published and appropriate safeguards will be put in place regarding commercial confidentiality. This process is still being developed and will be subject to refinement in the light of experience as the first returns are received.*

**Q7.2** Will the HSCIC publish a 2015/16 local payment grouper to support implementation of the ETO?

**A.** Yes

**Q7.3** What about SUS PbR?

**A.** *We had initially advised that SUS will continue to apply the default 2014/15 rollover tariff. However, in view of the fact that the vast majority of providers have opted for the ETO, the decision has been taken for SUS to support the ETO rather than the DTR option.*

*We can confirm that the DTR tariff will initially be implemented on 30 March 2015 and we estimate that SUS will be in a position to replace this with the ETO grouper and prices in mid-May, in time for the reconciliation of April activity data. We can confirm that DTR providers will not need to resubmit their April/May data in SUS. However any data that is resubmitted after the ETO prices are implemented in SUS in mid-May will be processed with the ETO grouper and prices.*

*The DTR will be supported by Data Services for Commissioners Regional Offices (DSCROs) processing the activity data through the appropriate grouper and prices. The priced data will then be provided to commissioners. Providers who have chosen the DTR will also be able to access their activity data grouped and priced from DSCROs by contacting their CSU contracting teams.*

**Q7.4** Will there be a national publication setting out which providers are operating under which tariff arrangement?

**A.** *Monitor and NHS England will look to publish the list of organisations that have chosen to adopt the ETO in due course after the 4<sup>th</sup> March deadline.*

**Q7.5** For maternity services, should the lead provider cross-charge for services on the basis of the tariff they are operating under (DTR or ETO) or the tariff operated by the other provider, if they are operating a different tariff to the lead provider?

**A.** *The starting point is that the lead provider should adopt the arrangements under the 2014/15 tariff (if they are under the DTR) or the 2015/16 proposals (under the ETO). The latter would require a local variation to the maternity pathway currency to implement the 2015/16 arrangements. The prices for cross-charging are however non-mandatory, so it would be for lead providers to agree an appropriate price with other providers.*

**Q7.6** Will the 2015/16 local payment grouper contain any material differences from the engagement grouper published in November?

**A.** *No.*

**Q7.7** The tariff option chosen by providers applies to the contracts that they hold with all English commissioners. Does the chosen tariff option also have to be applied to agreements they may have with the devolved administrations?

**A.** *No, but we anticipate that providers may wish to seek agreement with devolved administration commissioners on an approach that is consistent with the reimbursement arrangements in place for the care provided to the local population.*

**Q7.8** Do the principles set out in Q7.5 above in relation to cross-charging also apply to the Cystic Fibrosis pathway tariff?

**A.** Yes

**Q7.9.** Department of Health guidance on implementing overseas visitor hospital charging regulations<sup>6</sup> states that trusts should use “the latest mandatory tariff (or equivalent)”. So which prices should providers use for these cases – ETO or DTR?

**A.** *“The latest mandatory tariff” means the 2014/15 National Tariff Payment System, varied by the MFF, specialist top-up national variations and any local modification in place. Local variations (such as the ETO) and other national variations are excluded.*

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<sup>6</sup> <https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations>