Monitor

Making the health sector work for patients

NHS England

2016/17 National Tariff Payment System: A consultation notice

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Foreword

2015/16 has been a difficult year for the NHS financially and operationally, but we have reasons to be more optimistic heading into 2016/17 that we can successfully rise to the challenges. Monitor and the NHS Trust Development Authority are helping providers to cut agency costs by implementing caps on agency spend and driving Carter efficiencies. Compared to other sectors, the NHS received a good settlement from the November spending review. Some of this has been used to introduce a new Sustainability and Transformation Fund, £1.8 billion of which will support many providers by providing additional funding.

The next piece of the jigsaw is to set an appropriate national tariff. We have developed proposals that offer the sector the stability and predictability necessary to plan and deliver financial balance. Our starting point is a roll-over of the prices included in last year's Enhanced Tariff Option (ETO). This would provide stability for the 88% of providers that implemented the ETO in 2015/16. However, it means that we are delaying proposals for the implementation of a number of planned changes until 2017/18. This includes delaying the introduction of HRG4+, which more accurately reflects different levels of complexity in the cost of treating patients, and delaying resetting national prices to reflect changes in underlying costs.

While we continue to believe these proposals remain relevant and appropriate, the priorities for the NHS in 2016/17 are to restore financial balance, maintain quality and begin the wider service redesign needed to ensure future sustainability. Requiring the sector to implement significant tariff changes at this time would be a distraction from the focus on restoring financial balance.

Our proposals recognise cost pressures from inflation, pensions and Clinical Negligence Scheme for Trusts (CNST) contributions, and continue to require providers to achieve efficiencies in 2016/17. The proposed efficiency factor is 2%. Taking into account cost uplifts, this would result in an average increase in ETO prices of 1.8%.

NHS Improvement (Monitor and the NHS Trust Development Authority) has set control totals for NHS trusts and foundation trusts based on an aggregate deficit in 2015/16 of £1.8 billion, and an efficiency requirement of 2% in 2016/17. Providers that fall short of the expected position in 2015/16 would need to outperform the 2% efficiency requirement in 2016/17 to achieve their control total.

In this consultation notice, we are asking for your feedback on tariff proposals for 2016/17, including the proposed method for determining national prices. Combined, we believe that the policies in this consultation notice, a good spending review settlement, additional transformation funding, the local sustainability and transformation plans and agency rules and support, will give providers the space to make a real push to restore financial balance. This in turn would ensure that providers and commissioners have a sound platform from which to build ambitious longer term plans for their local health economies.

Adrian Masters
Managing Director of Sector Development
Monitor

Paul Baumann
Chief Financial Officer
NHS England

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1. About this document

1. This is the statutory consultation notice for the 2016/17 National Tariff Payment System (NTPS).

2. We have changed the structure of this document from previous years to reflect feedback from the sector and make it more accessible to readers. The document is in three parts:

   a. Part A contains:

      i. an introduction that sets the context for the 2016/17 NTPS and explains how you can respond to this consultation notice

      ii. a summary of how we have engaged with the sector

      iii. what we propose to change from the 2014/15 NTPS and what we propose to retain.

   b. Part B contains a draft of the proposed 2016/17 NTPS. This is shown as it would appear in final form. This includes sections on:

      i. the scope of the tariff

      ii. the currencies that are the building block for national prices and some local prices

      iii. the method for determining national prices

      iv. national variations to national prices

      v. locally determined prices

      vi. payment rules.

   c. Part C contains the glossary of terms.

3. This document should be read in conjunction with the annexes (which, unless otherwise stated, form part of the national tariff) and the supporting documents.

Table 1: Annexes and supporting documents

Part	Description
A	Annex A1: A detailed summary of engagement and sector feedback
A	Annex A2: A detailed explanation of how to respond to this consultation and the statutory objection process
B	Annex B1: The national prices and national tariff workbook.
B	Annex B2: Technical guidance and information for services with national currencies
B	Annex B3: The model used to set national prices

Part	Description
B	Annex B4: Technical guidance for mental health clusters
B	Annex B5: Updated analysis to support the efficiency factor

Part	Description
SD	Impact Assessment
SD	Guidance on setting locally determined prices
SD	Guidance on mental health currencies and payments
SD	A guide to the market forces factor
SD	Guidance on for commissioners on the marginal rate emergency rule and the 30 day readmission rule

4. We have reduced the number of proposed workbooks, for example, by merging the market forces factor worksheet into the national prices workbook. We hope these changes will make the 2016/17 NTPS easier to use.

2. Context

5. In November 2014 we published our proposals for the 2015/16 NTPS. The majority of providers, calculated by share of supply, objected to the proposed method for determining national prices. As a result, the 2014/15 NTPS remained in place. 88% of providers subsequently agreed to adopt the Enhanced Tariff Option (ETO) which, through local variation agreements, adjusted the proposals for the 2015/16 NTPS. The remaining 12% of providers chose to remain on 2014/15 national prices under the default tariff rollover (DTR). These arrangements were an interim solution while we engaged with the sector and reflected on the achievability of the efficiency ask in 2015/16.

6. Over the summer of 2015, we consulted on many of our proposals for the 2016/17 NTPS.[1] In particular, we proposed to base the national tariff on the Healthcare Resource Group version 4+ (HRG4+) currency design, to update the costs on which prices are based, and to update the basis for paying top-ups for specialised services.

7. Since then the predicted size of the financial challenge facing the sector has become clear. We have also found that our proposals would have a significant impact on income and expenditure for some commissioners and providers, even if we smoothed the effects over a number of years. Some feedback from the sector suggested that the uncertainty over the financial effects of changing the HRG design could be risky if implemented in 2016/17.

8. We have therefore put a number of our proposals on hold and adjusted our priorities for the coming year to provide for a more predictable financial environment and to create the space needed for the sector to address these challenges. The national prices we propose are based on the ETO. Together with the investment of £1.8 billion from the Sustainability and Transformation Fund, this is intended to create the conditions needed to achieve financial balance.

9. In relation to 2015/16, we have not sought to introduce a new national tariff for the year, either by pursuing a reference to the Competition and Markets Authority or by publishing revised proposals for consultation. The interim arrangements under the ETO and DTR will be retained until the end of 2015/16.

10. As a consequence of adopting the ETO as the basis for our proposals, we are proposing to delay a number of planned changes until 2017/18. These include:

    a. the implementation of the HRG4+ currency design

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[1] https://www.gov.uk/government/collections/201617-national-tariff-proposals

b. changes to the distribution of income between services and prices to reflect the underlying costs of changes to clinical practice

c. a number of new national prices and updates to existing national prices

d. the revision of top-up payments to specialised services.

11. In this consultation notice, we are asking for your feedback on all of our proposals for 2016/17, including the proposed method for determining national prices. The headline proposals for the method are:

a. an inflation uplift of 3.1%. This includes a specific, one off adjustment for the effect of changes to pensions

b. an efficiency factor of 2.0%

c. a set of targeted adjustments to reflect the expected 17% increase in contributions to the Clinical Negligence Scheme for Trusts (CNST) equivalent to 0.7% on average across national prices.

12. Overall this would lead to an average increase in ETO prices of 1.8%.

13. We are also proposing to adopt a marginal rate emergency tariff of 70%. This is consistent with the approach adopted in the ETO. We do not propose to retain the marginal rate risk share for specialised services.

3. Responding to this consultation

3.1. Statutory consultation on the national tariff and the objection process

14. The proposals for the 2016/17 NTPS are subject to a statutory consultation process as required by the Health and Social Care Act 2012 (the 2012 Act). This provides an opportunity for stakeholders to tell Monitor and NHS England what they think about the proposals. It also provides an opportunity for Clinical Commissioning Groups (CCGs) and ‘relevant providers’ to object to the method we have proposed for determining national prices. **The consultation period ends on 10 March 2016.**

15. You can find further information on the statutory consultation, objection process and relevant legislation in Annex A2.

3.1.1. Whose objections are relevant for the statutory objection process?

16. The 2012 Act provides a statutory process for challenging the proposed method for determining national prices. If a sufficient number of objections to the proposed method are received from either CCGs or ‘relevant providers’, Monitor may not proceed with the tariff (without a reference to the Competition and Markets Authority or further statutory consultation).

17. There are two categories of relevant provider:

    a. Licence holders. This refers to providers holding a Monitor licence, including NHS foundation trusts and independent providers.

    b. Other relevant providers as defined in the National Health Service (Licensing and Pricing) Regulations 2013. The regulations state that an individual or body is a relevant provider if they do not hold a licence but provide an NHS service for which there is a national price proposed in this consultation notice. This refers to current providers of the service.

18. The definition of relevant provider includes all NHS trusts that provide nationally priced services.

19. The only commissioners whose objections to the method are relevant for the statutory objections process are CCGs: NHS England, in its role as a commissioner of specialised services, is not included in this definition.

3.1.2. Objections to the method

20. While we welcome comments on all our proposals, the 2012 Act makes it clear that the statutory objection process applies only to objections to the “method or

methods Monitor proposes to use for determining the national prices" of NHS healthcare services.[2]

21. The method includes the data, method and calculations used to arrive at the proposed set of national prices, but not the prices themselves.

22. The proposed method does not include:

    a. the proposed national currencies

    b. the proposed national variations, such as the market forces factor, top-ups for specialised services and the marginal rate for emergency admissions

    c. the rules for agreement of local variations

    d. the methods for approving or determining local modifications

    e. the rules for determining local prices.

3.2. Consequences of objections

23. The objection thresholds are:

    a. 66% or more of commissioners (measured by number)

    b. 66% or more of relevant providers (measured by number).

24. If either objection threshold is met Monitor cannot publish the 2016/17 NTPS unless it undertakes a further statutory consultation or makes a reference to the Competition and Markets Authority (CMA).

25. If Monitor reconsults, we will publish another consultation notice and the process will begin again. If Monitor decides to refer to the CMA, objecting parties will have the opportunity to set out details of their objection.

26. In either case, the 2016/17 NTPS would be delayed. If the 2016/17 NTPS is delayed beyond 1 April 2016, the 2014/15 NTPS would remain in effect until a new tariff is published. If this happens, Monitor and NHS England would issue further guidance on interim arrangements.

3.3. Other responses to the consultation

27. In addition to consulting on the method for setting national prices, Monitor and NHS England are consulting on the entire package of proposals in the consultation notice. We welcome feedback on any of these proposals and will consider your responses before making a final decision on the policies for the 2016/17 NTPS.

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[2] Health and Social Care Act 2012, Sections 118(3)(b) and 120(1)

28. Please submit your feedback through the online survey[3] or via email to **pricing@monitor.gov.uk**

29. **The deadline for submitting responses is 10 March 2016.**

[3] https://www.research.net/r/16-17Consultation

4. How we worked with the sector to develop our proposals

30. During 2015, Monitor and NHS England worked with the sector on proposals for the 2016/17 NTPS. The table below summaries our main engagement activities.

Table 2: Engagement programme

Area of work	Purpose	Publication
Price relativities	A review of the draft price relativities by clinical experts	Currency design and relative prices document
Adjustments workshop	Two roundtable meetings to discuss approaches to setting the efficiency factor and cost base	Currency design and relative prices document
Enhanced impact assessment	A project to compare the accuracy of the Monitor impact assessment with provider impact assessments	Included as an annex of the impact assessment for this document
Publication workshop	A series of national workshops and webinars to ensure stakeholders were aware of the proposals in our publications	Currency design and relative prices National variations and local determined prices
Mental health	A consultation with stakeholders regarding proposed payment rules for mental health	Proposed changes to local payment rules covering mental health services in the NHS
Specialist services	A project to develop the approach to specialist top ups and risk share	Proposed reforms to top-up payments for specialised services

31. Further details can be found in Annex A1, which contains a list of events and presents the feedback we received during our engagements events on currency design, relative prices, national variations and locally determined prices.

32. To date, we have run 78 events with more than 1,800 stakeholders. In total, the web pages containing the publications were viewed 38,500 times. The consultation documents were downloaded almost 12,000 times and approximately 400 people attended the workshops to discuss proposals. This generated over 400 responses to the proposals. We have used these discussions and the feedback to inform the policies on which we are consulting.

4.1. Expert review of draft price relativities

33. National tariff prices are based on average costs but these prices are only as accurate as the cost data that we collect. One of the simplest but most important quality checks we can use is to make sure that the prices look reasonable relative to each other.

34. For 2016/17, we first reviewed the draft price relativities with clinical experts from the National Casemix Office's Expert Working Groups (EWGs). The EWGs are responsible for the design of the casemix classification known as healthcare resource groups. They consist of clinicians nominated by their professional bodies and royal colleges.

35. More details on this process, the outputs and how we incorporate this into prices can be found in Section 7.6 Manual adjustments to relative prices.

4.2. Adjustment roundtables

36. Several factors affect our proposals for the final price levels. These are the level of the cost base, efficiency factor and market forces factor (MFF). We held two roundtable meetings to gather expert opinion on these areas. The meetings involved representatives from a range of national bodies and representative groups (see Annex A1).

37. The discussion at the first roundtable focused on broader policy areas, while the second roundtable focused on technical details. We received valuable feedback from these sessions that helped to guide our thinking. For example, the feedback we received on the MFF was that although it may not be perfect, it should be retained. We also heard that there are more pressing priorities in 2016/17 than undertaking a full review of the MFF at this stage. We will however consider further work on the MFF in future tariffs.

4.3. Enhanced impact assessment

38. In the responses to the 2015/16 statutory consultation, many sector colleagues told us that they valued the 'sense check' which was a feature of the Department of Health's (DH) Payment by Results (PbR) process. The process involved sharing draft prices with a group of providers and commissioners and asking them to model the impact using more recent data than was available to DH. We therefore decided to build a similar step in developing proposals for the 2016/17 NTPS, in the form of an enhanced impact assessment.

39. We ran the enhanced impact assessment project to allow trusts to do an independent impact assessment of our tariff proposals, and to compare our assessment with those done by trusts, so we could test and calibrate our process to improve it in future. We asked NHS Providers and NHS Clinical Commissioners to identify providers and commissioners that might want to participate in the enhanced impact assessment programme. In total we worked with thirteen providers (including one independent provider) who represented a range of provider types.

40. The participants received a copy of Monitor's preliminary impact assessment for their organisation. They then modelled the impact of the draft prices using their own data. We analysed the results and investigated all material differences. Our findings can be found in the Impact Assessment.[4]

41. The process helped us to understand the differences between Monitor's impact assessment and those of individual providers, and to identify how we can resolve such issues to make future impact assessments more robust.

4.4. Policy publications and engagement

42. Once we had developed our initial policy proposals, we published two engagement documents to seek feedback from stakeholders.[5]

43. We followed this with a series of webinars and workshops which were attended by over 400 stakeholders resulting in over 400 responses which have been used to shape the final policy proposals.

4.5. Mental health

44. We have continued to engage with the sector to develop the payment system for mental healthcare. In July we published a local payment example[6] with details of how an outcomes-based payment could be developed to pay for mental health services. In September, Monitor and NHS England published a survey to gain an understanding of the sector's collection and use of mental health data, and of progress being made towards developing more transparent payment approaches. We also consulted on proposed changes to mental health payment methods. The results are considered in 9.8 Mental Health.

4.6. Engagement on specialised services

45. We have reviewed existing policies on top-up payments for specialised services and proposals for a marginal rate (also referred to as a risk share) designed to help manage the risks associated with increasing expenditure on prescribed specialised services.

46. We established a Specialised and Complex Care Advisory group to provide feedback on the review of specialised top-ups. This group's remit was refreshed to consider wider issues in relation to specialised and complex care. The group established three separate subgroups focusing on the specialised services risk

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[4] https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201617-a-consultation

[5] https://www.gov.uk/government/collections/201617-national-tariff-proposals

[6] https://www.gov.uk/government/publications/local-payment-example-outcomes-based-payment-for-mental-healthcare

share, impact assessment for specialised services and the development of a medium term work plan for these areas.

47. Further details on the input of these groups can be found in Annex A1 and in Section 8.3 Reviewing top-ups for specialised services.

4.7. Constraints on engagement

48. We faced a number of constraints on our engagement activities including the timing of the Government Spending Review.

49. Our engagement activities did however yield a large amount of information and helped to improve the proposals contained in this statutory consultation.

50. We would like to thank everyone who has given their time to work with us. All of the feedback will be retained and despite the changes to what we are proposing for 2016/17, this feedback has allowed us to continue to develop and improve these policies for potential implementation at a later date.

5. Overview to our proposals

52. We have developed our policies for the 2016/17 NTPS taking into account our statutory duties and our principles for price regulation.

53. During 2015 we worked on proposals to introduce HRG4+ and a number of new best practice tariffs. We consulted on these proposals through the year.

54. As we have explained, we have now changed some proposals to reflect the need to offer the sector stability. We have done this by proposing:

    a. national prices for 2016/17 that are based on the prices adopted under the ETO

    b. to remove the specialised services risk share that was included in the ETO

    c. limited changes to the overall scope of the national tariff, currency design and national variations.

    d. a revision to the guidance about local pricing rules for mental health.

55. The feedback that we received has influenced how we developed our policies. Where it is relevant to policy proposals for 2017/18 and beyond, it will be taken into account. We have kept all responses and published these, where possible, in Annex A1.

56. We have retained some of our earlier proposals for 2016/17 that we consider are beneficial and do not have a significant effect on expenditure and income distribution within the sector.

57. In putting forward these proposals we have assumed that CQUIN payments will be made available in 2016/17 to providers who opted for the DTR in 2015/16.

58. The following sections contain details about our proposals for the 2016/17 NTPS.

6. Currency design

60. In order to pay for healthcare, we must group activity in a clinically meaningful way. These groupings, or currencies, are used to set prices for healthcare services.

61. There are different currencies for different types of healthcare activity. In this section we explain our proposals on the currencies to be included in the 2016/17 NTPS.

6.1. Overview of currency proposals

62. We propose to base the 2016/17 currency design on proposals that we originally made in the 2015/16 statutory consultation notice. These proposals have already been adopted by providers that chose the ETO.

63. Following our engagement on currency design[7] and taking into account the feedback we received, we propose:

    a. to make additional currency changes for the 2016/17 NTPS, beyond those in the ETO, by adding 2 devices and 32 drugs to the high cost drugs and devices lists, and to remove drugs that are no longer available

    b. to introduce a non-mandatory best practice tariff for non-ST segment elevation myocardial infarction, a type of heart attack, that could be adopted by commissioners and providers through local variation agreements.

64. A number of the currency proposals we considered earlier were associated with the potential move to HRG4+. These proposals have now been delayed. The following subsections explain our new proposals on currency design.

6.2. Currency design and scope

65. The currencies used for admitted patient care, some outpatient procedures and some A&E services are known as Healthcare Resource Groups (HRGs). HRGs are groupings of clinically meaningful treatments that use similar levels of healthcare resource. Spell-based HRGs are used as the unit for pricing.

66. The currency design proposed for 2016/17 is based on a version of HRG4. For national prices, the specific HRG design is that used to collect 2011/12 reference costs. This was the basis for the prices adopted under the ETO.

[7] 2016/17 National tariff proposals: Currency design and relative prices

6.2.1. What we previously proposed[8]

67. In our summer engagement, we proposed to move to a revised currency design, HRG4+, which the Health and Social Care Information Centre (HSCIC) has developed to improve the casemix allocation to better reflect complexity and comorbidities.

68. We proposed to expand the scope of national prices to include seven new HRGs and outpatient attendance prices. We also asked whether it would be appropriate to remove national prices for the six nuclear medicine HRGs and replace them with 68 HRGs without national prices.

6.2.2. What you told us

69. 80% of respondents to the summer engagement, including over 75% of providers, supported introducing HRG4+. However, about 25% of commissioners and providers that responded believed they were not able to make a fully informed decision on introducing HRG4+ for the following reasons:

    a. They did not have enough time to model the implications of the change and requested greater time to do this.

    b. Certain policy proposals that would affect final prices, particularly our proposals for setting the efficiency factor and cost uplifts, were outstanding.

    c. There was not enough information about how the final prices had been calculated. This was a particular concern for services where it was expected that income would change significantly from one year to the next.

70. We heard, in particular via NHS Providers, that there was considerable concern among providers and commissioners about the impact of introducing a new currency design at a time when the sector needs to focus on the financial challenges for 2016/17.

71. We also undertook our own preliminary impact assessment which suggested that the impact of introducing HRG4+ would vary across the sector, with some providers more significantly affected than others. This was the case even after we applied various mitigation steps such as smoothing.

6.2.3. How this has influenced our policy

72. Variable impacts on the sector from changes in prices are not necessarily a problem. It is through the expected impact of our proposals that we are able to

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[8] This was proposed in our summer engagement document *2016/17 national tariff proposals: Currency design and relative prices* - www.gov.uk/government/publications/201617-national-tariff-proposals-currency-design-and-relative-prices

update the pricing system to better reflect clinical practice, and to provide incentives to providers and commissioners to improve.

73. However, we have listened to concerns that the sector did not have enough information to fully model and account for the impact of the new currency design. We also recognise that this means we need to review how we engage with the sector in communicating changes to the tariff in future years.

74. We are therefore proposing to delay the introduction of HRG4+, and to use the currency design in the 2015/16 NTPS proposals (which was adopted by 88% of providers who opted for the ETO in 2015/16).

75. We proposed new national prices for eight services in the summer consultation. Most of these were consistent with the non-mandatory prices proposed for 2015/16. One price, EA53Z below, had already been proposed as a national price for 2015/16 and formed part of the ETO. The services were:

    a. CZ25a and CZ25B: Cochlear implants, with the cost of the device excluded from national prices and reimbursed on the basis of locally agreed prices.

    b. FZ89Z: Complex therapeutic endoscopic upper or lower gastrointestinal tract procedures.

    c. LE01A: Dialysis for acute kidney injury for adults.

    d. RA69Z: Complex computerised tomography scan.

    e. Outpatient attendances: neurosurgery.

    f. Outpatient attendances: neurology.

    g. EA53Z: Transcatheter aortic valve implantation (TAVI), with the cost of the device excluded.

76. Respondents to our summer consultation generally supported expanding the scope of national prices to include these HRGs. However, respondents did not support introducing national prices for neurology outpatients, as they considered the resources required too changeable to be covered by one price.

77. In any case, we no longer propose to introduce national prices for the first seven of these eight services in 2016/17, in order to support financial stability. Instead, we propose to introduce non-mandatory prices for the inpatient HRGs described above, with the intention of proposing them as national prices in 2017/18.

78. We propose to introduce the national price for TAVI as this was addressed in the ETO. Neurology already had a non-mandatory outpatient appointment price, so we propose to maintain this for 2016/17.

79. In line with the overall intention of using the ETO as the basis for the 2016/17 NTPS, we do not propose to remove the national prices for nuclear medicine. However we intend to publish non-mandatory prices for the new design in anticipation of these being proposed for use in 2017/18.

6.2.4. Final proposal

80. We propose to base the currency design for the 2016/17 NTPS on the 2015/16 proposals as adopted under the ETO. For most providers, this will provide the stability required to focus on restoring finances and improving performance.

81. We also propose to introduce

    a. non-mandatory prices for the services indicated above

    b. a new national price for TAVI.

82. We believe that moving to HRG4+ remains relevant and appropriate. We will continue work to better understand the effect of a move, with a view to consulting on implementing HRG4+ in the 2017/18 NTPS.

6.3. Changes to the short stay emergency adjustment

6.3.1. Context

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

84. For 2016/17, we previously engaged on moving to HRG4+, which would have included this adjustment in the currency design.

85. As we are no longer proposing to move to HRG4+ we are now revising this policy.

86. In the 2015/16 statutory consultation notice we proposed to update:

    a. the methodology for calculating the short stay emergency tariff bands

    b. the inputs into the calculation of the short stay emergency adjustment

    c. the list of HRGs to which the short stay emergency adjustment applies.

87. These proposals were based on commissioned research.[9]

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[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317569/Supporting_document_D_-_Deloitte_SSEM_for_publicationedd6.pdf

88. These changes have been adopted by providers on the ETO but would be a change for providers on the DTR.

6.3.2. Proposal

89. For 2016/17 we propose to update the short stay emergency adjustment percentages as shown in the table below.

Table 3: Update to the short stay emergency adjustment percentages

HRG Average length of stay	2014/15 percentages by band	2016/17 proposed SSEM percentages	Change within each band
< 2 days	100.0	100.0	0%
2 days	70.0	65.0	-5%
3 or 4 days	45.0	40.0	-5%
≥5 days	25.0	30.0	5%

90. We also propose to update the list of HRGs eligible for the short stay emergency adjustment on the basis of the list adopted under the ETO. This is shown in Annex B1.

6.3.3. Rationale

91. The proposal would make the short stay emergency adjustment consistent for all providers.

6.4. Changes to the maternity pathway payment

6.4.1. What we previously proposed[10]

92. We proposed to retain the approach to the maternity pathway payment set out in the 2014/15 NTPS but to make improvements by:

    a. adding six clinical factors to help better assign the correct level of complexity to the woman's antenatal phase. This was previously proposed for the 2015/16 national tariff

    b. updating the casemix assumptions for the antenatal phase to more accurately calculate price relativities. This is a new proposal for 2016/17.

93. These changes were proposed to better align the maternity pathway to the experience of clinicians, and improve the way providers are reimbursed for the care they provide.

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[10] This was proposed in our summer engagement document *2016/17 national tariff proposals: Currency design and relative prices* - www.gov.uk/government/publications/201617-national-tariff-proposals-currency-design-and-relative-prices

Table 4: Additional complexity factors to the antenatal pathway

Factor present	Proposed level of complexity
Cystic fibrosis	Intensive pathway
Previous organ transplant	Intensive pathway
Serious neurological conditions (excluding epilepsy)	Intensive pathway
Body mass index (BMI) >49	Intensive pathway
Serious gastroenterological conditions	Intermediate pathway
Women with a low PAPP-A reading	Intermediate pathway

94. We proposed to update casemix allocations for the antenatal pathway based on the addition of these six factors, and on the information received in early 2015 from providers. This would increase payment for more complex pathways.

Table 5: Update to casemix on the antenatal pathway

Pathway	Current allocations	Allocations based on proposed changes
Standard	65.5%	50.0%
Intermediate	27.3%	38.7%
Intensive	7.1%	11.3%

6.4.2. What you told us

95. 4% of the feedback we received opposed the proposals, 44% supported the proposals and 17% neither opposed nor supported them. 35% of respondents did not address this question. When considering responses from providers and commissioners only, a majority of both supported the proposals.

96. Respondents tended to raise issues relating to the operation of the pathway payment rather than to the proposals themselves. These included problems with data flows, cross-provider charging and how the percentage of women who will develop complications is factored into the calculation of the standard pathway payment.

97. Some respondents asked for more guidance on the risk factors.

6.4.3. How this has influenced our policy

98. We think that the implementation of the new Maternity and Children's Dataset[11] (MCDS) will help to resolve some of the issues raised as it will give providers better information to facilitate cross-charging. This includes providing a report to

[11] Information available at: www.hscic.gov.uk/maternityandchildren/maternity

the lead provider about maternity care given to the patient by any other providers.[12]

99. We will work with the sector to improve our guidance to providers, with a focus on clarifying the issues raised during our summer engagement. A costing exercise for maternity services is underway and this will help to inform prices for 2017/18.

6.4.4. Final proposal

100. We propose to improve the maternity pathway payment currencies by adding the six clinical factors that were previously proposed in 2015/16 and which were part of the ETO. This will better assign the correct level of complexity to the woman's antenatal phase.

101. As the update to the casemix assumptions was not included within the ETO, we no longer propose to make these changes. We do however intend to consult on the casemix proposals again in future.

6.5. Changes to the high cost drugs, devices and procedures lists

6.5.1. What we previously proposed

102. We update the high cost drugs and devices lists annually. These lists are for drugs and devices that pose a significant cost and are disproportionately borne by some providers. These are reimbursed outside of national prices (see 3.3 of the proposed 2016/17 NTPS).

103. In our engagement document *2016/17 National tariff proposals: Currency design and relative prices*[13] we proposed to update the high cost drugs and devices lists in Annex B1 of the 2014/15 NTPS. In particular, we wanted to:

    a. add 2 high cost devices, remove 5 device categories and partially remove 1 category

    b. add the 30 new drugs proposed in 2015/16

    c. add a further 33 new drugs, remove 10 drugs and partially remove blood products.

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[12] The MCDS have been developed for all NHS commissioned Maternity, Children and Young People's Health Services and Child and Adolescent Mental Health Services as a key driver to achieving better outcomes of care for mothers, babies and children. It comprises three separate information standards for Maternity Services, Children's and Young People's Health Services, and Child and Adolescent Mental Health Services.

[13] https://www.gov.uk/government/publications/201617-national-tariff-proposals-currency-design-and-relative-prices

104. We put forward these proposals to reflect changes in clinical practice, HRG design and the availability of drugs and devices. In particular, our proposals to remove certain drugs and devices were based on moving to HRG4+, which would have allowed the cost of these drugs and devices to be included in national prices.

105. We identified each of the drugs we proposed to add or remove by consulting with the High Cost Drugs Steering Group, which considered the drugs against agreed criteria. Following our earlier engagement, the group met again to consider updated information on other drugs identified through the UKMI Horizon scan.[14] This resulted in 17 additional drugs being added to the high cost list when compared to the list proposed in Annex C of our earlier proposals.[15]

6.5.2. What you told us

106. In general, respondents agreed with the proposal to include drugs and devices within national prices where possible, but only if the cost was covered by the price.

107. We received consistent feedback from providers of cardiac services that the price calculated did not cover the cost of procedures that included Implantable Cardioverter Defibrillators (ICDs) and ICDs with Cardiac Resynchronisation Therapy. This was because the costs of the device had not been consistently captured in reference costs.

108. We received specific feedback that the national price for some HRGs should be adjusted to include devices.

109. We also received requests for specific drugs to be added to the high cost list.

6.5.3. Final proposal

110. We are not able to propose the removal of some of drugs and devices that we had earlier proposed to remove from the high cost lists. This is because removing these drugs and devices relied on adopting HRG4+.

111. Following our earlier engagement, we received further recommendations for changes to the list from the High Cost Drugs Steering Group and we now propose to update the lists of high cost drugs and devices that are reimbursed subject to local pricing rules outside of national prices by:

    a. adding 2 high cost devices to the high cost devices list in the 2014/15 NTPS

    b. adding 86 drugs to the high cost drugs list in the 2014/15 NTPS

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[14] See: www.ukmi.nhs.uk/activities/newProducts/default.asp?pageRef=12
[15] https://www.gov.uk/government/publications/201617-national-tariff-proposal-annexes

c. removing drugs that are no longer available.

112. Annex B1 sets out the proposed high cost drugs and devices lists for 2016/17.

Molecular diagnostics

113. Since our earlier engagement events, NHS England has been looking at ways to support the independent cancer taskforce recommendations that the payment system must keep pace with advances in molecular diagnostics by unbundling certain tests from prices for a period of three years.

114. Because of the speed of progress in molecular diagnostics, bundling tests into prices may mean that the costs of these tests run ahead of the reference costs that inform national prices. To ensure that the payment system promotes innovation and equitable access, a list of procedures excluded from national prices and reimbursed directly by NHS England in line with mandatory NICE guidance or an approved NHS England clinical treatment policy has been produced. The revised list of procedures can be found in Annex B1 alongside the high cost drugs and devices lists.

115. It is the intention of NHS England to exclude the cost of the procedures on this list from national prices for three years. We propose to exclude them for 2016/17 and intend to propose their further exclusion in consultation on future tariffs.

116. For 2016/17 we are proposing to add the molecular diagnostic tests in the table below to the high cost procedures list.

Table 6: Molecular diagnostic test

Test	NICE Guidance
NRAS/KRAS Testing	TA176
Oncotype DX	DG10
BRAF Testing	TA269 & 321
KIT Testing	TA86 & 326
ALK Testing (1)	TA296
ALK Testing (2)	TA296

High cost devices

117. To support the ongoing work to centrally procure high cost devices, we are also proposing a change to local pricing Rule 7, which specifies how devices on the high cost lists should be reimbursed. This can be found in 9.5 Amending local pricing Rule 7.

6.6. Best practice tariffs

118. We proposed a number of changes to best practice tariff (BPT) arrangements in our engagement document *2016/17 National tariff proposals: Currency design and relative prices*.

119. As we now propose to retain the currency design and scope previously proposed for 2015/16, we propose to delay implementing several of these changes.

120. We received substantial feedback on BPTs and the sector was generally very supportive of our proposals. We will retain all feedback over the coming year to continue to develop and improve our proposals.

121. The table on the following pages summarises our previous proposals for BPTs and what we are now proposing for 2016/17.

Table 7: Changes to best practice tariffs

BPT	Proposal in the summer engagement	Final proposal for 2016/17
Non-ST elevation myocardial infarction (NSTEMI)	Introduce a new BPT to incentivise timely angioplasty within 72 hours of admission, as recommended by NICE guidelines.	We no longer propose a mandatory BPT for NSTEMI. Providers and commissioners may choose to introduce the NSTEMI BPT locally (by local variation). Further details are in 3.2.7 of Part B and in Annex B2.
Heart Failure	Introduce a BPT to support best practice in the care of patients with non-elective heart failure admissions as recommended by NICE clinical guidelines 108, Chronic heart failure: Management of chronic heart failure in adults in primary and secondary care, and quality standard QS9, Acute heart failure: diagnosing and managing acute heart failure in adults chronic heart failure.	We propose to introduce a BPT for non-elective heart failure admissions, in line with that incorporated within the ETO, that sets the following criteria: a. Data submission: at least 70% of eligible records, measured by HES, need to be submitted to the NHFA. b. Specialist input: at least 60% of patients recorded in the heart failure audit have received specialist input as defined by the NHFA. There would be a differential of 10% between the BPT and standard HRG prices. Providers must achieve both criteria to receive the BPT price.
Endoscopy	Change the endoscopy BPT to create extra incentives for units to meet standards. The endoscopy BPT was introduced in 2013/14 to encourage endoscopy units to achieve and maintain quality levels to meet the Joint Advisory Group (JAG) accreditation standard for endoscopy services. JAG accreditation provides formal recognition that an endoscopy service meets required competence and delivers against measures in the global endoscopy rating scheme.	We propose that only providers achieving level 1 accreditation would be paid the full BPT rate. Providers at levels 2 and 3 would receive a price 2.5% and 5% below the BPT level respectively. These changes have already been implemented by providers who adopted the ETO.

BPT	Proposal in the summer engagement	Final proposal for 2016/17
Day case	Expand the day case BPT to include an additional 22 procedures. The day case procedure BPT aims to increase the proportion of elective activity performed as a day case, where clinically appropriate. We also proposed to change the current target for two procedures already covered by the BPT based on the British Association of Day Surgery directory of procedures: operations to manage female incontinence and tympanoplasty.	We no longer propose to expand the day case BPT to include the additional procedures. We are proposing to increase the target rates for two clinical areas, operations to manage female incontinence and tympanoplasty to 60% and 65% respectively. These changes have already been implemented by providers who adopted the ETO.
Stroke	Change the stroke BPT to make one of the criteria, on brain imaging, consistent with guidelines from the Royal College of Physicians (RCP). The latest guidelines state that brain imaging should always be completed within 12 hours of admission whereas the current BPT criterion is 24 hours.	We propose to change the existing BPT so that payment is only made where initial brain imaging is within 12 hours of admission, as per the RCP's national clinical guidelines for stroke. This is an additional change to the 2014/15 BPT, and was not reflected in the ETO. Patients requiring urgent imaging should continue to receive imaging in the stated timescales. However this will not form part of the BPT due to data availability.
Hip and knee replacement	Change the BPT to increase the minimum threshold for submission of data to the National Joint Registry (NJR) to 85% from 75%, and to reduce the unknown compliance consent rate to below 15% from 25%. We also asked the sector whether it would be appropriate to make changes to the PROMs outlier identification and submission rates.	We propose to amend the criteria around NJR data submissions so that providers will only qualify for the BPT if they meet both of the following: a. a minimum NJR compliance rate of 85% b. an NJR unknown consent rate below 15%. These changes have already been implemented by providers who adopted the ETO. We do not propose to change the PROMs outlier identification and submission rates.

BPT	Proposal in the summer engagement	Final proposal for 2016/17
Outpatients	Increase the target rate of diagnostic hysteroscopies provided in outpatient settings to 70%.	We propose to increase the target rate of diagnostic hysteroscopies undertaken in outpatient settings to 70%. These changes have already been implemented by providers who adopted the ETO.
Interventional radiology (IR)	We proposed to remove the entire set of BPTs for IR. These were introduced to ensure adequate reimbursement for a set of interventional radiology procedures. With the proposed introduction of HRG4+, the BPTs would no longer be required as these procedures would be covered by new HRGs (chapter Y).	We are no longer able to implement these changes and propose to retain the IR BPT. This means that there will be no change for ETO and DTR providers.

7. Proposed method for determining national prices

7.1. Introduction

122. This section is about how we propose to determine national prices for 2016/17. We have changed our proposed approach from that contained in the engagement document *2016/17 national tariff proposals: Currency Design and Relative Prices.*[16] The following subsections explain these changes, our reasons for the changes and our new proposed approach.

7.1.1. Our principles

123. Our principles for setting national prices are that:

   a. Prices should reflect efficient costs. This means that the prices set should:

      i. reflect the costs that a reasonably efficient provider ought to incur in supplying services at the quality expected by commissioners

      ii. not provide full reimbursement for inefficient providers.

   b. Prices should provide appropriate signals by:

      i. giving commissioners the information needed to make the best use of their budgets and enabling them to make decisions about the mix of services that offer most value to the populations they serve

      ii. incentivising providers to reduce their unit costs by finding ways of working more efficiently

      iii. encouraging providers to change from one model of delivery to another where commissioners want this and where it is more efficient and effective.

124. We use these principles to inform how we set national prices within the constraints of the financial realities facing the NHS.

7.1.2. The changes to our proposals for setting prices

125. There are two stages to setting national prices for healthcare services:

   a. Setting relative prices: This refers to how the price of one procedure or treatment differs from another, taking into account the level of resources required to perform each one.

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[16] https://www.gov.uk/government/publications/201617-national-tariff-proposals-currency-design-and-relative-prices

b. Setting the level of prices: This refers to ensuring that a reasonably efficient provider can recover their costs after adjusting for any additional incentives. It is at this point that uplifts for cost inflation, service development, CNST and adjustments for efficiency are added.

126. Over the summer we consulted on our proposed method for setting relative prices. We did not consult on the method for setting price levels as we were waiting for the outcome of the Government Spending Review. The main policies that were not included in our earlier consultation were our proposals for the cost base, the cost uplifts used to set prices and the efficiency factor.

127. As outlined previously, we are now proposing national prices for 2016/17 that are based on the proposals for the 2015/16 NTPS as adjusted by the ETO. This is primarily to provide the sector with stability to enable it to focus on meeting the financial challenges ahead. In addition, we have confidence in the robustness of the 2015/16 prices (as adjusted by the ETO), which were based on significant analysis and a lengthy consultation process.

128. We recognise that this approach means the proposed 2016/17 NTPS will not move the payment system towards greater cost reflectivity. Prices would be set using costs from five years ago, rather than being updated to reflect a three-year-old cost base, as we originally proposed.

129. Although prices would be based on costs from five years ago, in setting prices for the 2015/16 statutory consultation, which became the basis for the ETO, we adjusted costs for inflation and assumed efficiency. This is the cost base. If there is a reason to believe that actual costs differ significantly from the cost base, it may be appropriate to make a further adjustment.

130. We remain convinced of the merits of HRG4+, and intend to propose this currency design for adoption in the 2017/18 NTPS.

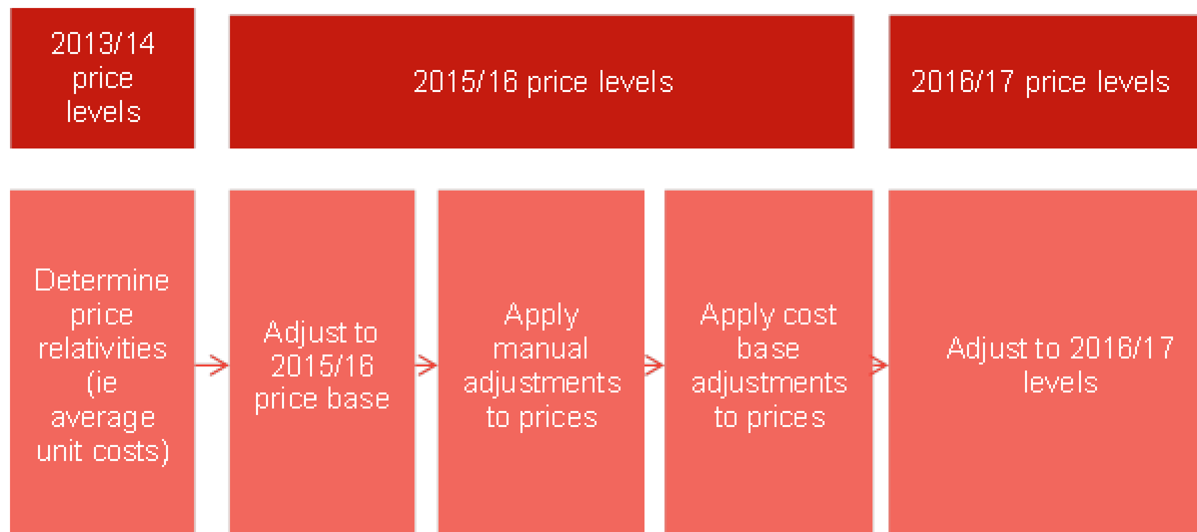
7.1.3. What we previously proposed

131. In our engagement paper on currency design and relative prices,[17] we proposed to model prices against the HRG4+ currency design using the same approach taken by DH for the 2013/14 PbR, with changes to make sure that manual adjustments are cost neutral and allow for up-to-date inputs and new calculation models. It was not possible for us to calculate final prices for 2016/17 for our engagement paper because we did not know the outcome of the Government Spending Review at that stage. However we did share draft relative prices.

132. Our original proposal is shown in the figure below.

[17] https://www.gov.uk/government/publications/201617-national-tariff-proposals-currency-design-and-relative-prices

Figure 1: Proposed approach to modelling prices



7.2. Our revised approach for determining national prices for 2016/17

133. For the 2016/17 NTPS, we propose to use the prices adopted under the ETO (which were the prices modelled in the proposals for the 2015/16 NTPS, with some modifications) and adjust them for:

a. our measure of cost inflation, which we estimate at 3.1%

b. the efficiency factor, which we estimate at 2%

c. CNST of about 0.7% across all prices (although this is allocated subchapter by subchapter)

134. We propose not to make any:

a. adjustment to the cost base

b. unit cost adjustment for service development.

135. For 2016/17, the emphasis is on maintaining stability based on last year's ETO prices. Apart from the cost uplifts for inflation, we are not proposing further adjustments to the cost base. The recently announced Sustainability and Transformation Fund provides a mechanism for helping hospitals to achieve financial balance.

136. We do not propose to change the service development uplift as NHS England has concluded that the requirements this year do not have unit cost implications.

137. The following subsections explain our proposals for the cost uplifts, efficiency factor and CNST in greater detail.

138. Figure 2 below shows how national prices for 2016/17 would be determined.

Figure 2: Proposed method for setting 2016/17 national prices

139. Once we have derived the unadjusted 2016/17 prices according to the methodology outlined above, we propose to make a small number of manual adjustments to correct known issues with particular prices.

7.3. Estimating cost uplifts

7.3.1. Context

140. Every year, the efficient cost of providing healthcare changes because of changes in wages, prices and other inputs over which providers have limited control. We therefore make a forward-looking adjustment to the modelled prices to reflect expected cost pressures in the year the tariff applies. We refer to this as the cost uplift.

141. To estimate the appropriate cost uplift for 2016/17, we propose to:

a. forecast the rate of inflation for each of the categories in Table 8 below

b. combine these into a single cost uplift factor by weighting each category by its average share of providers' expenditure. Cost weighting estimates are based on the total expenditure forecast for secondary care provided by DH.

Table 8: Cost uplift factor components

Category	Description	Recommended source	Frequency of update
Labour cost inflation	Expected pay settlement, pay drift, staff mix and pension changes	Provided by the Department of Health	Annually
Drugs cost inflation	Cost increase of all drugs	Provided by the Department of Health	Monthly
Non-pay, non-drugs inflation	General inflation of other operating expenses	Latest forecast of the Gross Domestic Product deflator from Office for Budget Responsibility	End of each quarter
Changes in capital costs	Anticipated changes in depreciation and PFI payments	Provided by the Department of Health	Annually
CNST	Expected increases in CNST contribution	Provided by the NHS Litigation Authority	Annually (October or

Category	Description	Recommended source	Frequency of update
	payments		November)
Service development	The expected additional cost of new requirements set out in the Governments mandate to NHS England	Estimated by NHS England based on its mandate	Annually (November/ December)

142. We have further observations on two specific components of the proposed cost uplift for 2016/17: labour cost inflation and CNST cost inflation.

143. The labour cost uplift we propose is based on the approach used in the 2014/15 NTPS and includes pay uplifts based on analysis by DH. However, we are considering using publicly available labour cost inflation forecasts from the Office of Budget Responsibility (OBR) when deciding on our cost uplift for labour costs to improve the transparency of our analysis.[18] In future, we will consider whether using OBR forecasts for labour costs would be preferable to DH estimates.

144. Most CNST costs are allocated to the relevant HRGs at a subchapter level. About 2% of CNST costs cannot be allocated to subchapters. Our proposed approach is that we apply this residual or unallocated CNST cost change to all HRGs by including an uplift to the cost uplift factor. We used data provided by the NHS Litigation Authority to calculate the uplift factor for unallocated CNST, and propose to adopt that approach for the final prices.

7.3.2. Proposal

145. Based on the approach that we have developed for cost uplift and the latest available data, we propose to use an inflation cost uplift of 3.1%.[19] A breakdown of this estimate, calculated using the approach described in the previous paragraph, is shown below.

Table 9: Summary of cost uplift factor estimates

Category	2016/17 uplift % estimate (A)	Tariff cost weight (B)	Weighted estimate (A x B)
Labour cost inflation	3.3%	65.4%	2.18%
Drugs cost inflation	4.5%	8.2%	0.37%
Non-pay, non-drugs	1.7%	20.2%	0.34%

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[18] Based on the latest forecast from 2015, the difference between labour cost forecasts by DH and OBR is 0.08%.
[19] This is rounded up from 3.06%.

Category	2016/17 uplift % estimate (A)	Tariff cost weight (B)	Weighted estimate (A x B)
inflation			
Changes in capital costs	3.1%	4.8%	0.15%
CNST cost inflation	1.2%	1.5%	0.03%
Service development	n/a	0.0%	0.00%
Overall		**100.0%**	**3.06%**

7.4. Setting the efficiency factor

7.4.1. Context

146. In competitive industries, service providers are likely to increase their productive efficiency[20] over time, as they discover better ways of undertaking the same processes. For example, a new technology may be adopted, or new procedures developed.

147. In the healthcare sector, we calculate the impact of these changes on input costs using an efficiency factor. For our purposes, this can be defined as the reduction in cost required by efficient providers to deliver the same services in 2016/17 as they delivered in 2015/16.

148. Crudely, assuming inflation of 0%, an efficiency factor of 2% means that the level of service which could be provided for £1 million in 2015/16 could be provided for £980,000 in 2016/17.

7.4.2. Proposal

149. We propose to base the national tariff calculations for 2016/17 on an efficiency factor of 2%.

7.4.3. Rationale

150. Setting the efficiency factor requires a significant degree of judgement. We have therefore developed a framework for estimating the efficiency factor for 2016/17. We have used the following sources:

[20] Productive efficiency measures the amount of outputs produced for a given level of inputs, such as labour or capital. A business is productively efficient if it could not produce any more from its level of inputs, given external factors such as the level of technology or prevailing wage rates. Productive efficiency is distinguished from allocative efficiency, which occurs when there is an optimal distribution of goods and services, taking into account consumers' preferences.

a. An econometric study by Deloitte,[21] using data from 2008/9 to 2012/13, and updated by Monitor using data for 2013/14. This gives a feasible estimate of 2.6% to 2.8%, based on a one-off catch up of 1.4% to 1.5% and trend efficiency of 1.2% to 1.3%.

b. A study by the Health Foundation,[22] which gave a backward looking estimate of 0.4% in the past 2 to 3 years.

c. A productivity index for the whole NHS developed by the Office for National Statistics and York University.[23] This results in a backward looking annual estimate of 0.8% to 1.3%.

d. Efficiency achieved by NHS foundation trusts in their cost improvement programmes (CIPs). Analysis of these for 2014/15 supports an efficiency factor of 2.7%.

e. Proposed cost reductions in the 2015/16 CIPs. These indicate an efficiency factor of 3.5%.

151. In reaching our judgement, we have placed different weight on the different sources of information. In particular, we have placed more emphasis on the econometric analysis by Deloitte and Monitor than productivity analysis, because econometric modelling is able to control for a number of provider-specific and time-specific factors, as well as accounting for input cost changes and productivity improvements. As such, econometric analysis is more suited to informing the forward-looking efficiency factor. Because the NHS productivity index covers the whole of the UK, rather than just England, we have used it as a check on our numbers, rather than relying on it in deriving them.

152. We have placed less weight on the work by the Health Foundation because of differences between the approach they have taken and the econometrics performed by Deloitte and updated by Monitor (see above). The main differences are that the Health Foundation's analysis:

a. excludes outpatients

b. adjusts for casemix at a less granular level

c. uses a general rather than health specific measure of inflation

d. uses one less year of data in their modelling.

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[21] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317572/Supporting_document_A_-_Deloitte_Efficiency_Factor_for_publication352b.pdf

[22] http://www.health.org.uk/node/1592

[23] http://www.ons.gov.uk/ons/rel/psa/public-sector-productivity-estimates--healthcare/2013/art-public-service-productivity-estimates--healthcare-2013.html

153. In each case we consider that Monitor's approach is preferable in the present context. We have placed less emphasis on planned CIPs than on achieved CIPs because the former overstated achieved CIPs by 0.9% in each of the last two years. We note that there has been a downward trend in achieved CIPs which suggests that the 2.7% achieved in 2014/15 may overstate what will be achieved in future.

154. After taking into account the relevance of different sources, we consider that the evidence above supports a range of 1.2% to 2.5% for the efficiency factor in any given year.[24] However, this assessment does not take into account previous efficiency factors as they apply through the indexation applied to costs when calculating the cost base. The efficiency factors applied in 2014/15 and 2015/16 of 4.0% and 3.5% respectively included an implicit level of catch up. Including further significant catch up in the 2016/17 NTPS could lead to double counting.

155. On balance, we think that it is reasonable for providers to answer some of the challenges by increasing their efficiency above the historic average. However, given previous efficiency expectations, we believe they should not be expected to increase efficiency as high as the top of the range. Taking account of these factors, we believe 2% efficiency improvement is a reasonable efficiency ask for 2016/17.

7.4.4. Options considered

156. In reaching this view we also considered and assessed the impact of efficiency factors of:

   a. 1.5%, which is consistent with our estimates of achieved efficiency with some element of catch up.

   b. 2.5%, which is consistent with the highest level of the efficiency factor supported by the evidence above.

   c. 3.5% to 4%, which is consistent with previous years' efficiency factor assumptions.

157. The impacts of these efficiency factors on the financial performance of the sector are summarised in the Impact Assessment.[25]

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[24] This does not take into account any policies that may have the effect of requiring additional efficiency savings (for example, risk share requirement).

[25] https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201617-a-consultation

7.5. Clinical Negligence Scheme for Trusts

158. CNST is an indemnity scheme for clinical negligence claims. Providers make a contribution to the scheme to cover the legal and compensatory costs of clinical negligence.[26] The NHSLA administers the scheme and sets the contribution that each provider must make to ensure that the scheme is fully funded each year.

159. Following the approach adopted in the 2014/15 NTPS, we propose to allocate the increase in CNST costs to core HRG subchapters (for admitted patient care), to the maternity delivery tariff and to A&E services in line with the average increase that will be paid by providers. This approach to the CNST uplift is different to other cost uplifts. While other cost uplifts are estimated and applied across all prices, the estimate of the CNST increase can be different for each subchapter (within admitted patient care), A&E services and for the maternity delivery tariff.

160. Each relevant HRG has received an uplift based on the change in CNST cost across specialties mapped to HRG subchapters. This means that our proposed cost uplifts reflect, on average, each provider's relative exposure to CNST cost growth, given their individual mix of services and procedures.[27]

161. The proposed CNST uplifts would account for a 17% increase in CNST costs. This reflects the CNST contribution increase estimated by NHSLA.

162. The table below shows the percentage uplift that we have applied to each HRG subchapter to reflect the increase in CNST costs.

Table 10: CNST tariff impact by HRG subchapter

HRG subchapter	% uplift	HRG subchapter	% uplift	HRG subchapter	% uplift
AA	0.93%	GA	0.74%	JA	0.89%
AB	0.50%	GB	0.43%	JC	0.55%
BZ	0.73%	GC	0.74%	JD	0.39%
CZ	0.46%	HA	0.79%	KA	0.73%
DZ	0.27%	HB	0.92%	KB	0.27%
EA	0.32%	HC	1.21%	KC	0.32%
EB	0.26%	HD	0.86%	LA	0.19%
FZ	0.59%	HR	1.00%	LB	0.34%
MA	-2.42%	QZ	0.72%	VB	1.79%

[26] CCGs and NHS England are also members of the CNST scheme.
[27] For example, maternity services have been a major driver of CNST costs in recent years. For this reason, a provider that delivers maternity services as a large proportion of its overall service mix would probably find that its CNST contributions (set by the NHSLA) have increased more quickly than the contributions of other providers. However, the cost uplift reflects this, since the CNST uplift is higher for maternity services. This is consistent with the approach previously taken by DH.

HRG subchapter	% uplift	HRG subchapter	% uplift	HRG subchapter	% uplift
MB	-1.12%	RC	0.79%	WA	0.38%
PA	1.16%	SA	0.54%	Maternity*	7.37%
PB	0.00%	VA	0.81%		

Note: * Maternity is delivery element only

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

7.6. Manual adjustments to prices

164. We have identified a number of manual adjustments that we propose to make to the prices in the ETO.

165. These were identified through feedback from the sector, where feedback was given to us with enough time to investigate, and enough evidence that an adjustment was required along with the size and type of adjustment.

166. We propose to make the following manual adjustments to the ETO price list:

Table 11: Proposed manual adjustments for 2016/17

HRG name	Adjustment made	Rationale	Implementation rule
FZ84Z, FZ85Z – Bariatric Surgery Prices	Increase the price for Bariatric surgery	Ensure that the price covers the cost of the service	FZ84Z and FZ85Z price adjusted upwards
FZ42A,FZ42B – Wireless Capsule Endoscopy	Set price in outpatient procedure setting	Ensure this is consistent with previous tariffs, to enable appropriate reimbursement for this service and for it to be delivered in an appropriate setting	Set FZ42A and FZ42B to the DC/EL price for FZ42B in all settings
JC20Z, EA47Z and EA45Z – Some cardiology tests and skin therapy	Equalise the price between outpatient procedure and day case / elective setting	The price for the outpatient procedure was illogical, as it was lower than the day case/elective price	The OPROC prices are less than the DC/EL price, against policy intent. Set JC20Z, EA47Z and EA45Z DC/EL to same as OPROC price
FZ50Z, FZ51Z, FZ52Z, FZ54Z, FZ55Z, FZ57Z, FZ59Z, FZ60Z,	Set the same price across day case, elective and outpatient	For consistency with historic tariffs, and as the procedure can be carried out in	Endoscopy prices are not setting independent, against policy intent. Set

FZ61Z – Various Endoscopy	procedures	any setting without differential costs	OPROC price equal to the DC/EL price for all these HRGs
RA69Z	Set the price of RA69Z to £203 with the cost of reporting set to £20	Feedback from the expert working group suggested that this should be set at £203	Set the price of RA69Z to £203 with the cost of reporting set to £20
HA11C	Price difference between BPT and base tariff to equal the additional payment	The difference was due to rounding	Set HA11c base price to 2015/16 ETO price minus £0.5

167. We are proposing to reintroduce the outpatient procedure price for wireless capsule endoscopy (FZ42A and FA42B). This price was included in the 2014/15 NTPS but was not included in the proposals for the 2015/16 NTPS. This omission was an error that we now propose to correct.

8. National variations

168. National variations refer to variations to national prices specified in the national tariff (s116(4)(a) of the 2012 Act). They relate to circumstances where it is appropriate to make national variations to national prices (as distinct from local variations agreed between commissioners and providers). National variations may reflect certain features of costs that are not fully captured in national prices or seek to share risk more appropriately between providers and commissioners. The national variations in the 2014/15 NTPS aimed to do one of the following:

    a. improve the extent to which prices reflect location-specific costs (eg the market forces factor)

    b. improve the extent to which prices reflect patient complexity (eg top-ups for specialised services)

    c. create incentives to share responsibility for preventing avoidable unplanned hospital stays (eg the marginal rate emergency rule)

    d. share financial risk appropriately following (or during) a move to new payment approaches (eg national variation to support the implementation of the BPT for hip and knee replacements).

169. We propose to make the following changes to national variations for 2016/17.

    a. To update the marginal rate emergency rule to reflect a reimbursement rate of 70%. This formed part of the ETO.

    b. To remove transitional national variations for

        i. the maternity pathway payment

        ii. unbundled diagnostic imaging in outpatients

        iii. chemotherapy delivery and external beam radiotherapy.

170. We do not propose to make changes to:

    a. Specialised service top-ups. As we are proposing to retain the existing HRG4 currency design, we propose to delay implementing revised specialised services top-up arrangements.[28] We intend to introduce this proposal for 2017/18.

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[28] Details of which were published in November 2015 at https://www.gov.uk/government/publications/201617-national-tariff-top-up-payments-for-specialised-services

b. The market forces factor. We have received written feedback asking us to review the market forces factor. We have decided not to do so as feedback from the Policy Adjustment Roundtable (see 4.2 Adjustment roundtables) that this should not be a priority in 2016/17.

c. The national variation to support the transition to the hip and knee BPT. We believe it is appropriate to give the sector more time to adapt to the hip and knee BPT. We will consider whether to put forward further proposals for the 2017/18 NTPS.

d. The national variation to reduce emergency readmissions within 30 days. We believe that risk should be allocated to those best able to manage it. We consider that this variation is the most appropriate way to create an incentive for the sector to reduce avoidable emergency readmissions.

8.1. Marginal rate emergency rule

8.1.1. What we previously proposed

171. In our engagement document, *2016/17 national tariff proposals: National variations and locally determined prices*[29], we proposed to change the marginal rate rule to pay providers 70% of the national price for increases in the value of emergency admissions above the baseline. This proposal was adopted by providers that opted for the ETO in 2015/16.

172. We made this proposal to recognise the efforts providers have made to manage the pressure of rising emergency admissions, and to ensure that financial risks are shared appropriately between providers and commissioners.

8.1.2. What you told us

173. We received a lot of feedback on this proposal, mainly from providers. While the proposed increase in the marginal rate was welcomed, a number felt that it should be removed. Some commissioners were concerned about the impact on their budgets and potentially supplier-induced demand as seen in the years prior to the introduction of the marginal rate.

174. Providers asked for clearer guidance on setting the baseline to reduce the risk of local disagreements. A number of providers called for more transparency on how savings from the rule are used, and a greater say in investment decisions.

175. Some commissioners opposed changing the reimbursement rate, on the basis that it would reduce the funds available to support admission avoidance measures. Commissioners were also concerned that the proposal would reduce

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[29] https://www.gov.uk/government/publications/201617-national-tariff-proposals-national-variations-and-locally-determined-prices

incentives for providers to work with commissioners on demand management measures for admitted emergency care.

8.1.3. How this has influenced our policy

176. Strong arguments were made for and against changing the reimbursement rate from 30% to 70%. We feel that the proposal strikes a fair balance between allowing providers to keep more tariff income and commissioners to keep funds to manage demand for emergency care. We therefore plan to proceed with the proposed increase in the reimbursement rate to 70%.

177. We recognise the 2008/09 activity data used to set the baseline is seen by some as being very out of date. However, we do not propose to adopt a new baseline because the proposals allow for uplifting or rebasing according to local circumstances. Our expectations are that:

    a. Providers and commissioners should take a pragmatic approach to agreeing a baseline value, for example, by applying an uplift to a previously agreed baseline to reflect any service changes agreed locally.

    b. Where a provider requests a review of the baseline, a joint review involving the provider(s) and commissioner(s) must be undertaken. Following this, baseline adjustments should be made if there have been material changes in the demand for, or supply of, emergency care in a local health economy, or where material changes are planned.

178. Monitor and NHS England will issue revised guidance around baseline setting.

8.1.4. Final proposal

179. We propose to change the reimbursement rate for the value of emergency admissions above the baseline from 30% to 70%.

8.2. Removing transitional national variations

8.2.1. What we previously proposed

180. In our consultation document *2016/17 national tariff proposals: National variations and locally determined prices*, we proposed to remove the transitional national variations for:

    a. the maternity pathway payment

    b. unbundled diagnostic imaging in outpatients

    c. chemotherapy delivery and external beam radiotherapy.

181. These transitional variations were introduced three years ago to allow the sector to adapt to new payment approaches.

8.2.2. What you told us

182. Some providers felt that removing these variations would simplify payment arrangements and remove areas of contention between commissioners and providers. However, one provider stated that the removal of the transitional variation for chemotherapy delivery and external beam radiotherapy in 2016/17 would have an unmanageable impact on their finances, and they were sceptical about commissioners' willingness to agree local variations.

183. Some commissioners commented that they were not seeing sufficient improvements in data quality or systems to have enough confidence to support removing these transitional measures. Some felt that the proposal was reasonable in the context of the continuing ability for providers and commissioners to agree local variations.

184. Some concerns were expressed that the removal of the transitional variation for maternity services, at the same time as implementing six new characteristics, may lead to financial risks for either providers or commissioners.

8.2.3. How this has influenced our policy

185. Although some specific concerns were raised, a clear majority of respondents supported removing these transitional national variations.

186. The most significant concerns expressed related to chemotherapy delivery and external beam radiotherapy, but it was unclear from the feedback why more progress had not been made over the past three years in the transition from local to national prices. We feel that the arguments presented were not sufficiently strong or widespread to support a change to our proposal.

187. Providers and commissioners may wish to discuss a local variation where there is a significant difference between local and national prices, having regard to the rules governing local variations and the principles underpinning local price-setting.

8.2.4. Final proposal

188. We propose to remove the transitional national variations for the maternity pathway, unbundled diagnostic imaging in outpatients and chemotherapy delivery and external beam radiotherapy.

8.3. Reviewing top-up payments for specialised services

8.3.1. Context

189. Under the 2014/15 NTPS, prices paid to providers reflect average costs. HRGs, used as the currency for admitted patient care and for A&E and some outpatient procedures, are intended to be resource homogenous. This means that all

patients allocated to the same HRG have the same expected resource requirement on average, with any variation in actual costs from the expected level being random.

190. This payment arrangement works well if variation in costs within HRGs is random across patients and hospitals. But if there is systematic variation in costs associated with particular groups of patients, problems arise: the payment system may either deter hospitals from treating these patients or penalise hospitals that do. The policy of concentrating specialised services in particular providers may give rise to or accentuate such problems.

191. Top-ups for specialised services were introduced in 2005/06 to reflect the additional costs for providers that systematically serve more patients requiring these services.

192. Currently these providers are paid for a set of services and procedures defined within the Specialised Services National Definitions Set (SSNDS).[30] These services fit into four areas, spinal surgery, neurosciences, orthopaedic and children's services (the latter attracting one of two payment bands).

193. The top-up payment is triggered by particular diagnoses or procedure codes. Providers must be deemed eligible in order to receive a top-up for spinal surgery, neurosciences and children's services. For orthopaedics, the top-up is applied to the HRG payment for services that meet specific diagnoses or procedure codes delivered by any provider. The top-up rates that currently apply under the 2014/15 NTPS (whether a provider is adopted the DTR or the ETO) are shown in the table below.

Table 12: SSNDS top-up rates

SSNDS code	SSNDS description	Rate
SS08	Neurosciences	28%
SS34	Orthopaedic	24%
SS91	Children Specialised - Low	44%
SS93	Children Specialised - High	64%
SS06	Spinal surgery	32%

194. Top-ups for specialised services amount to approximately £250 million to £300 million per year. About 70% of top-ups are paid for specialised children's services. The approach to calculating and allocating top-ups has not changed for a number of years although the rates were updated in the 2013/14 Payment by Results tariff. The value of the top-up payment is top-sliced from the cost base used to set national prices.

[30] Source: http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/library/standard/238

195. NHS England is responsible for commissioning specialised services. These services are prescribed in regulations made by the Secretary of State. In determining which services are to be prescribed, the Secretary of State must take appropriate advice and consult NHS England.

196. The Identification Rules set out the existing service definitions including the set of diagnoses, procedures, specialist and Treatment Function Codes. These changes are reflected in the Prescribed Specialised Services (PSS) 2015/16 Shadow Monitoring Tool.[31]

197. In 2014, Monitor and NHS England established a stakeholder group, the Specialised and Complex Care Advisory Group (SCCAG) to review our proposals to revise top-up payments for specialised services. This group included a range of stakeholders from providers and commissioners. The group oversaw a review of specialised top-ups conducted by the University of York.

198. The University of York used econometric analysis assessing the PSS definition set and the new HRG4+ classification to identify areas where the costs of providing services defined as specialised are systematically different to non-specialised services and where this difference is positive and statistically significant. [32] A summary of this work can be found on Monitor's website.[33]

8.3.2. Proposal

199. We propose to retain the existing top-up areas and percentages using the SSNDS. These are the same under both the ETO and DTR.

200. We intend to continue developing top-ups for specialised services over the next year, to move toward alignment with the PSS definitions in 2017/18.

8.3.3. Rationale

201. Our review of top-ups was predicated on the assumption that the currency design to which it would apply would be HRG4+. While it would be possible to use econometric analysis to set new top-ups to the proposals based on the ETO approach, this would not be consistent with our overall approach to the 2016/17 NTPS. In coming to this view, we gave consideration to the overall objective of financial stability and the degree of risk that would be associated with applying new top-ups to an alternative currency specification.

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[31] http://www.hscic.gov.uk/casemix/prescribedspecialisedservices

[32] http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP118_costs_prescribed_specialised_services.pdf

[33] https://www.gov.uk/government/publications/201617-national-tariff-top-up-payments-for-specialised-services

9. Locally determined prices

202. Over half of the £70 billion of NHS activity covered by the national tariff is subject to local pricing arrangements.

203. Subject to compliance with local pricing rules and methods, national prices can be adjusted to allow commissioners to innovate in the design of services for patients (local variations) or where they do not adequately reimburse efficient costs because of structural issues (local modifications). These changes must be published and, in the case of local modifications, Monitor must agree to the proposals applying its methods.

204. In setting local prices, commissioners and providers must adhere to three principles.

    a. The approach must be in the best interests of patients.

    b. The approach must promote transparency to improve accountability and encourage the sharing of best practice.

    c. The provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches.

205. For 2016/17 we are proposing:

    a. To change the submission date for local variation templates. This is to create greater transparency and to encourage sharing of good practice.

    b. To establish a deadline for local modification applications. This is to encourage constructive engagement and to give commissioners some predictability in planning their resources to best meet the needs of patients.

    c. To clarify the treatment of CNST costs under Monitor's method for determining eligibility for local modifications.

    d. To clarify Monitor's approach to payments from the Sustainability and Transformation Fund in the method for determining local modifications.

    e. To amend Rule 7 of the local pricing rules relating to the reimbursement of high cost drugs, devices and listed procedures.

    f. To revise the guidance for locally determined prices.

    g. To update and simplify the existing payment rules for mental health.

9.1. Local variations

9.1.1. What we previously proposed

206. In *2016/17 national tariff proposals: National variations and locally determined prices*, we proposed to amend the rules on local variations to require commissioners to submit local variation templates to Monitor, where the local variation is documented in the commissioning contract, by 30 June.

207. Where local variations are agreed after this date, the commissioner should submit a local variation template within 30 days of the change being agreed between the commissioner and provider.

208. We proposed this deadline because, of the 326 local variations that we received in the 2014/15 financial year, 80% were submitted after the beginning of September 2014. This is an issue because:

    a. Submissions made so late in the year make it significantly less likely that Monitor will be able to identify non-compliance with the rules and to work with commissioners to improve their compliance in the year.

    b. Submissions after September reduce the likelihood that other commissioners and providers will be able to use examples of good practice to inform their commissioning intentions for the following year. This slows the spread of good practice.

9.1.2. What you told us

209. 63% of respondents to the online survey supported this proposal, compared with 18% who opposed it. Some respondents expressed the following concerns:

    a. setting a date would force providers and commissioners into inappropriate or risky contracts.

    b. the information collected might not feed into the commissioning cycle.

    c. the database of local variations published by Monitor[34] should offer greater search functionality

9.1.3. How this has influenced our policy

210. We do not think that setting a deadline for submitting local variations to Monitor will force providers and commissioners into inappropriate contracts, as providers and commissioners are already expected to have contracts in place by the beginning of the financial year. Where agreements are reached after the

[34] https://ldp.monitor-nhsft.gov.uk/Pages/Search.aspx

deadline, we would expect to receive a template within 30 days of the agreement. This is consistent with requirements already in place.

211. We have recently updated the local variations website to improve the search functionality. We will continue to review the accessibility of the information on this website, the forms that we use to collect information and the usefulness of the information that we collect to the sector.

9.1.4. Final proposal

212. We propose to set a deadline of 30 June 2016 for commissioners to submit local variation templates to Monitor, where the local variation is documented in the commissioning contract.

213. Where local variations are agreed after this date, the commissioner must submit a local variation template within 30 days of the change being agreed.

9.2. Local modifications

9.2.1. What we previously proposed

214. In *2016/17 national tariff proposals: National variations and locally determined prices*, we proposed a deadline for local modification applications of 30 September 2016. Late submissions would only be allowed in exceptional circumstances, for example, where there is a risk to patients.

215. A deadline of 30 September 2016 would allow commissioners to factor the application into their planning for the following year, with the expectation that this would allow them greater scope to mitigate the impacts.

9.2.2. What you told us

216. 62% of respondents were in favour of this proposal. 27% opposed it.

217. A number of concerns were raised about setting a deadline of 30 September. Some respondents told us that:

    a. Setting a deadline for applications before the following year's tariff is proposed may create extra work that might not be necessary if providers are allowed to wait a few more weeks.

    b. The deadline proposed is too late for commissioners to plan for the following year and that 30 September should be the date for Monitor's final decision, rather than applications to Monitor.

    c. Our approach is unfairly slanted towards commissioners and that providers may not have had time to perform the level of analysis required to submit an application.

218. A few providers raised other issues with local modifications policy, such as the requirement for a provider to have a 4% deficit before it is able to apply for a local modification, or the requirement that local modification agreements must be submitted to Monitor before they can be implemented.

9.2.3. How this has influenced our policy

219. After considering all the feedback, we feel that this proposal strikes an appropriate balance between allowing enough time for providers to develop an application and commissioners to plan and manage any uplift in prices.

220. The requirement that a trust must have a deficit equal to, or greater than, 4% before it can apply for a local modification was established in order to prioritise providers whose deficits placed them in the upper quartile of NHS acute providers. We propose to review this policy in developing future tariffs.

9.2.4. Final proposal

221. We propose to set a deadline for local modification applications of 30 September 2016.

222. Late submissions would only be allowed in exceptional circumstances, for example, where there is a clear and immediate risk to patients.

9.3. Changes to the method for determining local modifications to reflect additional funding

9.3.1. Context

223. Many NHS providers will receive additional funding from the Sustainability and Transformation Fund in 2016/17.

224. Under our existing methods, Monitor does not take payments from the Sustainability and Transformation Fund into account when determining whether to approve a local modification. This means there is a risk of double counting if a provider receives payments from the Sustainability and Transformation Fund to address structural issues, but also seeks a local modification.

9.3.2. Proposal

225. Monitor proposes to change the methods for granting or approving local modifications so that:

   a. Monitor will consider and take into account any funds received from the Sustainability and Transformation Fund in 2016/17 when granting or approving a local modification.

9.3.3. Rationale

226. Unless the methods are amended there is a risk that additional funding for structural issues will be duplicated.

9.4. Clarifying the treatment of CNST in relation to local modifications

9.4.1. Context

227. Monitor's methods for determining local modifications requires a provider to demonstrate that its higher costs are a result of structural issues that are, among other things, non-controllable. That is, the higher costs should be beyond the direct control of the provider, either currently or in the past.

228. Although the 2014/15 NTPS does not currently provide guidance on this point, Monitor considers that increased CNST costs are controllable because NHS trusts are responsible for managing clinical risk as part of their governance arrangements.

9.4.2. Proposal

229. Monitor proposes to add guidance to clarify that it treats CNST costs as controllable and will not consider them when assessing whether provision of a service is uneconomic in accordance with Monitor's method.

9.4.3. Rationale

230. This would clarify the requirements that need to be met for local modifications.

9.5. Amending local pricing Rule 7 to support the central procurement of high cost devices

9.5.1. Context

231. NHS England plans to introduce national procurement of high cost devices for 2016/17. Under these arrangements, commissioners would be able to require providers to use a nominated devices supplier or framework. This means providers would pay prices to device suppliers based on nationally procured prices, rather than locally negotiated prices. NHS England's intention to introduce such arrangements was flagged in the recent Planning Guidance[35] (Section 38). This is to be supported by changes to the NHS Standard Contract which would allow a commissioner to require a provider to use a nominated supplier or framework.

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[35] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

232. High cost devices and drugs are excluded from national prices. The price paid by the commissioner to the provider for such devices and drugs are subject to local pricing rules. Local pricing Rule 7 requires that:

a. The price (currently paid by the commissioner) for the device must be paid in addition to the relevant national price for the service, but must be adjusted to reflect any part of the cost already captured by the national price.

b. The price agreed should reflect the actual cost to the provider. The national tariff rule regulates the price paid by the commissioner to the provider, not the price paid by the provider to any suppliers.

9.5.2. Proposal

233. Monitor proposes to change local pricing Rule 7 to require that the price agreed by the commissioner and provider must be the actual price, or the price payable by the provider under the new nominated supplier or framework arrangements, whichever is lower. We also propose to introduce further guidance on this issue.

9.5.3. Rationale

234. Without amending Rule 7, a commissioner would have to pay a price equivalent to the actual cost of the device, even if that resulted from the provider agreeing higher prices outside of the new national supply arrangements. Under the rule change the commissioner would not be required to reimburse the higher price in such cases.

9.6. Changes to the rules for local prices for services that do not have a national price

9.6.1. Context

235. 88% of providers adopted the ETO in 2015/16. The ETO included an efficiency factor of 3.5% and a cost uplift factor of 1.9%. Under Rule 2, commissioners and ETO providers were also expected to have regard to these factors in setting prices locally.

236. In 2015/16 DTR providers remained on the 2014/15 NTPS. Rule 2 specifically referred to 2014/15 and had no application to DTR providers although in practice some might have taken it into account.

237. For 2016/17 the proposed national prices are based on a rollover of the ETO prices. This means they incorporate the efficiency and cost uplift factors adopted under the ETO. However, commissioners and DTR providers who did not take these factors into account when agreeing local prices for services without a national price in 2015/16 would remain out of step without an adjustment to local pricing rules.

9.6.2. Proposal

238. We propose to amend Rule 2 to provide that commissioners and providers must have regard to the efficiency and cost uplift factors adopted under the ETO in 2015/16 and the efficiency and cost uplift factors set out in Section 7 of this document when setting prices for 2016/17.

9.6.3. Rationale

239. This change would ensure that all providers and commissioners have regard to the same factors when setting local prices.

9.7. Introducing guidance on setting local prices for services that do not have a national price

9.7.1. What we previously proposed

240. In *2016/17 national tariff proposals: National variations and locally determined prices*, we proposed to clarify the guidance that supports Rules 1 and 2 for setting prices for services without a national price.

    a. Rule 1 states that providers and commissioners must apply the principles for locally determined prices when agreeing prices for services without a national price.

    b. Rule 2 states that commissioners and providers should have regard to the national tariff efficiency and cost uplift factors when setting prices for services without a national price.

241. We provided example guidance setting out:

    a. The responsibilities on providers and commissioners in setting prices locally.

    b. Clarity on what it means for providers and commissioners to have regard to the cost uplift and efficiency factor.

    c. Clarity on the types of factors that should be considered in agreeing local prices.

242. This was originally proposed as we had received requests from providers and commissioners for greater clarity regarding the application of these rules.

243. We developed guidance following feedback from the sector that it was needed to implement these rules effectively. This was originally proposed in the 2015/16 statutory consultation notice.

244. We have made these proposals again for 2016/17.

9.7.2. What you told us

245. 69% of respondents to the survey supported this proposal and 12% opposed it.

246. We received limited feedback to this proposal. Some of the concerns raised were:

a. that this would reward provider inefficiency if linked to local reference costs

b. that we should be moving to national prices for a much greater range of areas rather than entrenching local prices

c. that it might not be practical to renegotiate national prices every year

d. that the application of acute cost uplift and efficiency for non-acute services may not be appropriate as the evidence is from a different service type.

247. Some respondents suggested we use trust Materiality and Quality Scores (MAQS)[36] as part of local pricing rules.

9.7.3. How this has influenced our policy

248. Given the broad level of support, we propose to implement these proposals. We will continue to review the ways in which we can improve local pricing guidance for future tariffs.

9.7.4. Final proposal

249. We propose to include guidance in the 2016/17 NTPS that provides greater clarity to providers and commissioners agreeing local prices.

9.8. Mental health

9.8.1. What we previously proposed

250. In our consultation letter[37] dated 20 October 2015 we proposed changes to the local payment rules covering mental health. These proposals would require commissioners and providers of adult and older people's mental healthcare to adopt one of two payment models in 2016/17:

a. A payment approach based on episode of treatment or year of care, as appropriate to each of the mental healthcare clusters.

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[36] Available at: www.hfma.org.uk/costing/standards
[37] https://www.gov.uk/government/consultations/proposed-changes-to-local-payment-rules-covering-mental-health-services-in-the-nhs

b. A payment approach based on capitation, informed by care cluster data and other evidence required to understand population needs and what it costs to meet these needs efficiently.

251. We proposed this because:

a. a proportion of payment could be linked to the achievement of locally agreed quality and outcome measures to offer a clear focus for providers and commissioners regarding delivery of safe and effective care that is in the best interest of patients.

b. It did not restrict commissioners and providers from agreeing an alternative payment approach, as long as that approach was consistent the rules for local pricing

252. We excluded:

a. IAPT as we plan to further test our proposed payment approach in 2016/17.

b. CAMHS and secure and forensic mental health services as they were covered by separate arrangements.

9.8.2. What you told us

253. In total, we received 109 responses to our consultation letter. The vast majority of providers and commissioners (80%) replied to the question on whether they were most likely to adopt a capitated payment approach, or episodic or year of care payment approach. Of those who responded, around half opted for a capitated payment approach and half for an episodic or year of care approach.

254. Some were able to implement proposals in 2016/17, with support and guidance from Monitor and NHS England. However, many noted this would be very difficult due to limited availability of robust data and analytics, and that there are significant lead times required to negotiate new types of contractual arrangements. In all cases, providers and commissioners requested further detailed guidance on how to develop these payment approaches locally.

9.8.3. How this has influenced our policy

255. Based on feedback received, we consider a significant number of providers and commissioners are not in a position to implement proposed rule changes in 2016/17. They will need additional lead time to prepare and develop the building blocks needed to implement the payment approaches proposed in the consultation letter. The building blocks include:

a. collection, reporting and use of accurate mental health care data

b. use of robust quality and outcome measures

c. use of mental health care clusters.

256. Other providers and commissioners, however, have some or all of the building blocks already in place. We recommend that they move forward in 2016/17 to test and implement the payment approaches that we intend to propose for 2017/18.

257. We expect to include proposals that commissioners and providers adopt either a capitated, or episodic or year of care, payment approach in the statutory consultation notice for the 2017/18 NTPS. Assuming that this approach is adopted we expect all providers and commissioners to be able to implement these proposals as part of the 2017/18 payment arrangements. This includes having the necessary building blocks in place to implement robust, data driven and evidence based payment approaches that meet patients' needs. In any case, the building blocks should be developed to inform care delivery that meets patient needs, and ensure efficient use of resources.

   a. Poorly specified contracts are not acceptable – they do not incentivise access to timely evidence based care such as that set out in the Five Year Forward View or the mental health access and wait time standards which come in to force in April 2016.

   b. The current payment approaches require local payment arrangements to be made transparent and linked to evidence of patient needs, clinical best practice drawing on NICE concordant care and costs of resources. This means providers, commissioners and patients have clarity over the expected scope of service, providers receive appropriate levels of reimbursement and commissioners have assurance about the quality of care provided.

258. To support the sector to implement the payment approaches outlined above, we have developed a series of sector support material and local workshops for providers and commissioners[38] and have updated the existing rules to clarify the requirements on providers and commissioners.

9.8.4. Final proposal

259. As outlined in our consultation letter, we consider a payment based on either a capitated approach, or episodic or year of care approach, and linked to outcomes best supports the delivery of mental healthcare that is patient centred. It enables an increased focus on prevention, early intervention and recovery. It also helps facilitate increased accountability and transparency in quality and service expectations under locally agreed payment arrangements.

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[38] These resources, and further information on the workshops, can be found at: https://www.gov.uk/government/publications/nhs-national-tariff-payment-system-201617-a-consultation-supporting-documents

260. For 2016/17 we have decided to update the local payment rules covering mental health to clarify and simplify the existing drafting. The proposed rules outline what is required from providers and commissioners in 2016/17 regarding data collection and submission, the transparency of payment arrangements and the use of mental health care clusters. As part of the statutory consultation on the 2017/18 national tariff, we intend to propose rule changes based on the proposals outlined in our letter of 20 October 2015. As many organisations noted such payment approaches would take more than a few months to put in place, we would like the sector to take the necessary preparatory steps so they would be in a position to implement the proposals in 2017/18.

Monitor
Making the health sector work for patients

NHS England

Proposed 2016/17 National Tariff Payment System

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1. Introduction

1. This document is the national tariff, specifying the currencies, national prices, the method for determining those prices, the local pricing and payment rules, the methods for determining local modifications and related guidance that make up the national tariff payment system for 2016/17 (2016/17 NTPS).

2. This national tariff has effect for the period beginning on 1 April 2016 and ending on 31 March 2017 or the day before the next national tariff published under section 116 of the 2012 Act has effect, whichever is the later.

3. The document is split into 6 sections and 5 annexes The 6 sections are:

   a. the scope of the tariff

   b. the currencies used to set national prices

   c. the method for determining national prices

   d. national variations to national prices

   e. locally determined prices

   f. payment rules

Table 1: Annexes to the 2016/17 NTPS

Part	Description
B	Annex B1: The national prices and the national tariff workbook. This amalgamates a number of the separate annexes that were published in previous years.
B	Annex B2: Technical guidance and information for services with national currencies
B	Annex B3: The model used to set national prices
B	Annex B4: Technical guidance for mental health clusters
B	Annex B5: Evidence for efficiency for 2016/17

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

Table 2: Supporting Documents to the 2016/17 NTPS

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

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

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

2.1. Public health services

6. The national tariff does not apply to public health services[1]:

   a. provided or commissioned by local authorities or Public Health England

   b. commissioned by NHS England under its 'Section 7A' public health functions agreement with the Secretary of State.[2]

2.2. Primary care services

7. The 2016/17 NTPS does not apply to primary care services (general practice, community pharmacy, dental practice and community optometry) where payment is substantively determined by or in accordance with regulations or directions, and related instruments, made under the provisions of the National Health Service Act 2006 ('the 2006 Act').[3]

8. Where the payment for NHS services provided in a primary care setting is not determined by or in accordance with regulations or directions, or related instruments, made under the 2006 Act then the 2016/17 NTPS rules on local price setting apply. For instance, local price setting rules apply to minor surgical procedures performed by GPs and commissioned by clinical commissioning groups (CCGs). The rules governing payments for these services are set out in Section 6.

2.3. Personal health budgets

9. A personal health budget (PHB) is an amount of money to support the identified health and wellbeing needs for a particular patient, planned and agreed between that patient and their local NHS.

10. There are three types of PHB:

    a. Notional budget – no money changes hands. The patient and their NHS commissioner agree how to spend the money. The NHS will then arrange the agreed care.

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[1] See the meaning of 'health care service' given in section 64 of the 2012 Act; and the exclusion of public health services in section 116(11).
[2] For the section 7A agreement, see: Public Health Commissioning in the NHS 2015 to 2016.
[3] See chapters 4 to 7 of the 2006 Act. For example, the Statement of Financial Entitlements for GP services, and the Drug Tariff for pharmaceutical services.

b. Real budget held by a third party – an organisation legally independent of the patient and their NHS commissioner will hold the budget and pays for the care within the agreed care plan.

c. Direct payment for health care – the budget is transferred to the patient to buy the care that has been agreed between the patient and their NHS commissioner.

11. Payment to providers of NHS services from a notional budget is within the scope of the 2016/17 NTPS. This will either be governed by national prices as set out in Annex B1 (including national variations set out in Section 5) or subject to the local pricing rules: see Section 6.4.1.

12. In some cases a notional budget may be used to buy integrated health and social care services to facilitate more personalised care planning. Where these services and products are not NHS services, the 2016/17 NTPS does not apply.

13. If a PHB takes the form of a direct payment to the patient or third party budget, the payments for health and care services agreed in the care plan and funded from the direct payment are not within the scope of the 2016/17 NTPS. Direct payments for healthcare are governed by regulations made under sections 12A(4) and 12B(1) to (4) of the 2006 Act[4].

14. The following are not within the 2016/17 NTPS, as they do not involve paying for the provision of healthcare services:

    a. payment for assessing an individual's needs to determine a PHB

    b. payment for advocacy – advice to individuals and their carers about how to use their PHB

    c. payment for the use of a third party to manage an individual's PHB on their behalf.

15. More information about implementing PHBs can be found on the NHS Personal Health Budgets page.[5]

2.4. Integrated health and social care

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

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

[5] http://www.england.nhs.uk/healthbudgets/

17. Where NHS healthcare services are commissioned under these arrangements ('joint commissioning'), they remain within the scope of the 2016/17 NTPS even if commissioned by a local authority.

18. Payment to providers of NHS services that are jointly commissioned are governed either by a national price as set out in Annex B1 (including national variations set out in Section 5) where applicable, or by a local price (including a local variation in Section 6.2).

19. Local authority social care or public health services which are commissioned under joint commissioning arrangements are outside of the scope of the 2016/17 NTPS.

2.5. Contractual incentives and sanctions

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

2.6. Devolved administrations

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

22. Table 3 summarises how the 2016/17 NTPS applies to various cross-border scenarios. 'DA commissioner' or 'DA provider' refers to a commissioner or provider in Scotland, Wales and Northern Ireland.

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

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

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

23. In the final scenario above, the commissioner in England is bound to follow the prices and rules in the 2016/17 NTPS, but there is no such requirement for the DA provider. The commissioner in England may wish or need to pay a price set locally within the country in question, or use a different currency from that mandated by the national tariff. In such cases, the commissioner must follow the rules for local pricing (see Section 6). If there is a national price for the service, a local variation would be required to pay a different price to the DA provider or to make a change to the currency. If there is no national price, the commissioner should follow the rules for local price setting.

24. Providers and commissioners should also be aware of rules for cross-border payment responsibility set by other national bodies. The England–Wales Protocol for Cross-Border Healthcare Services sets out specific provisions for allocating payment responsibility for patients who live near the Wales–England border. NHS England also provides comprehensive guidelines on payment responsibility in England.[6] The scope of the 2016/17 NTPS does not cover payment responsibility rules as set out in these documents. These rules should therefore be applied in addition to any applicable provisions of the 2016/17 NTPS.

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

3. Currencies with National Prices

25. Currencies are one of the 'building blocks' that support the NTPS. They include the clinical grouping classification systems for which there are national prices in 2016/17.

26. Under the Health and Social Care Act 2012 ('the 2012 Act'), the national tariff must specify certain NHS healthcare services for which a national price is payable.[7] The healthcare services to be specified must be agreed between NHS England and Monitor.[8] In addition, the 2012 Act provides that the national tariff may include rules for determining which currency applies where there is more than one currency and price for the same service.

27. We are retaining the HRG4 currency design and scope used under the Enhanced Tariff Option (ETO). This was based on an updated version of HRG4 used to in the 2014/15 NTPS.

28. This section should be read in conjunction with the information set out in the following annexes:

    a. Annex B1: National tariff workbook. This contains:

        i. The list of national prices (and related currencies)

        ii. Maternity data requirements and definitions

        iii. The lists of high cost drugs and devices

    b. Annex B2: Technical guidance and information for services with national currencies

3.1. Classification, grouping and currency

29. The NHS payment system relies on patient level data. To operate effectively, the payment system needs:

    a. a way of capturing and classifying clinical activity – this enables information about patient diagnoses and healthcare interventions to be captured in a standard format

    b. a currency – the large number of codes for admitted patient activity in the primary classification system makes it impractical as a basis for payment; instead casemix groupings are used as the currency for admitted patients, outpatient procedures and accident and emergency (A&E). For outpatient

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[7] 2012 Act, section 116(1)(a)
[8] 2012 Act, section 118(7)

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

30. Clinical classification systems describe information from patient records with standardised definitions and nomenclature. The 2016/17 NTPS relies largely on two standard classifications to record clinical data for admitted patients. These are:

    a. the World Health Organization International Classification of Diseases, 10th revision (ICD-10) for diagnoses[9]

    b. Office of Population Censuses and Surveys 4 (OPCS-4) for operations, procedures and interventions.[10]

31. 'Grouping' is the process of using clinical information such as diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E only) to classify patients to casemix groups structured around Healthcare Resource Groups (HRGs). HRGs are groupings of clinically similar conditions or treatments that use similar levels of healthcare resources. The grouping is done using grouper software produced by the Health and Social Care Information Centre (HSCIC).[11] The HSCIC also publishes comprehensive documentation giving the logic and process behind the software's derivation of HRGs as well as other materials that explain and support the development of the currencies that underpin the national tariff.[12]

32. A 'currency' is a unit of healthcare for which a payment is made. Under the 2012 Act, a healthcare service for which a national price is payable must be specified in the national tariff. A currency can take one of several forms. For 2016/17, we use spell based HRGs as the currency to be used for admitted patient care and some outpatient procedures. The currencies for A&E services are based on A&E attendances.

33. The HRG currency design used for the 2016/17 NTPS is known as HRG4 and is arranged into chapters, each covering a body system. Some chapters are divided into subchapters. The specific design for the 2016/17 NTPS is that used to collect 2011/12 reference costs.

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[9] The 5th edition update of ICD-10 was published in April 2015.
[10] OPCS version 4.7 (which was introduced in April 2014) has been incorporated into the currency design used for 2016/17 prices.
[11] http://www.hscic.gov.uk/casemix/payment
[12] http://www.hscic.gov.uk/casemix/payment

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

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

35. Section 3.2.1 describes the currencies for which there are national prices in 2016/17.

36. Details of the methods we have used to determine the national prices are provided in Section 4. The list of national prices and related currencies can be found in Annex B1.

37. In specific circumstances we specify services in different ways, and attach different prices, for example, setting best practice tariffs to incentivise improved outcomes for particular cohorts of patients. As well as specifying the currencies, this section (in combination with Annex B1 and Section 2 of Annex B2) provides the rules for determining which currencies and prices apply where a service is specified in more than one way.

38. The rules for the local pricing of services with mandatory currencies but no national prices – such as adult mental health and ambulance services – are set out in Section 6.

3.2.1. Admitted patient care

39. Spell-based HRG4 is the currency design for admitted patient care covering the period from admission to discharge. If a patient is under the care of one consultant for their entire spell[13], this would comprise one finished consultant episode (FCE). Occasionally, a patient will be under the care of more than one consultant during their spell; this would mean that the spell had multiple FCEs.

40. National prices for admitted patient care cover the care received by a patient during their spell in hospital, including the costs of services such as diagnostic imaging. The national price to be applied is determined by date of discharge.

41. The costs of some elements of the care pathway are excluded from national prices, such as critical care and high cost drugs. These costs are reimbursed under the rules applicable to local pricing.

42. To promote movement to day case settings where appropriate, most elective prices are for the average of day cases and ordinary elective case costs, weighted according to the proportion of activity in each group.

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[13] A spell is a period from admission to discharge or death. A spell starts following the decision to admit the patient.

43. For a small number of HRGs there is a single price across outpatient procedures and day cases, or a single price across all settings. This approach has been taken where a price that is independent of setting is clinically appropriate.

44. When a patient has more than one distinct admission on the same day[14] (eg the patient is admitted in the morning, discharged, then re-admitted in the afternoon), each admission is counted as the beginning of a separate spell, although a short stay adjustment may apply to the first admission.

45. Short stay emergency adjustments[15] and long stay payments[16] apply to admitted patient care. These are explained in detail below.

Changes to the scope of services with national prices

46. In 2016/17 we are adopting the scope of services set out in the ETO. This means an additional national price for Transcatheter Aortic Valve Implantation (EA53Z: TAVI). The cost of the device used in this procedure should be reimbursed as a high cost device under local pricing rules (See annex B1 and section 6).

Short stay emergency adjustment

47. The short stay emergency adjustment is a mechanism for ensuring appropriate reimbursement for lengths of stay shorter than two days, where the average HRG length of stay is longer. It applies whether the patient is admitted under a medical or a surgical specialty providing all of the following criteria are met:

    a. the patient's adjusted length of stay is either zero or one day

    b. the patient is not a child, defined as aged under 19 years on the date of admission

    c. the admission method code is 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented Commissioning Data Set (CDS) version 6.2)

    d. the average length of non-elective stay for the HRG is two or more days

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[14] Calendar day not 24 hour period.

[15] 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.

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

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

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

Table 4: HRG short stay emergency adjustment percentages

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

49. The short stay emergency adjustment will apply to all best practice tariffs except for acute stroke care, fragility hip fracture and same-day emergency care.

50. Any adjustments to the tariff, such as specialised service top-ups,[17] are applied to the reduced tariff. Annex B1 lists the HRGs to which the reduced short stay emergency tariff is applicable.

Long stay payment

51. A long stay payment on a daily rate basis applies to all HRGs where the length of stay of the spell exceeds a specified trim point[18] specific to the HRG and point of delivery.

52. The trim point is defined in the same way as for reference costs, but is spell based and there are separate elective and non-elective trim points. The trim point for each HRG is shown alongside national prices in Annex B1.

53. In 2016/17 we are continuing with the approach first adopted in 2011/12, whereby there is a trim point floor of five days.[19] For 2016/17, there will be two long stay payment rates per chapter – one for child-specific HRGs and one for all other HRGs. This approach was first introduced in 2013/14.

54. If a patient is medically ready for discharge and delayed discharge payments have been imposed on local authorities under the provisions of the Community

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

[18] The trim point is defined as the upper quartile length of stay for the HRG plus 1.5 times the inter-quartile range of length of stay.

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

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

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

3.2.2. Chemotherapy and radiotherapy

Chemotherapy

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

57. Chemotherapy payment is split into three parts:

    a. a core HRG (covering the primary diagnosis or procedure) – this has a national price

    b. unbundled HRGs for chemotherapy drug procurement – these have local currencies and prices

    c. unbundled HRGs for chemotherapy delivery – these have national prices.

58. The regimen list that assigns activity to a delivery and procurement HRG is updated for the 2016/17 NTPS[21].

Radiotherapy

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

60. HRG4 groups for radiotherapy include:

    a. Radiotherapy Planning – for pre-treatment (planning) processes

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[20] http://www.hscic.gov.uk/article/1922/SUS-Payment-by-Results
[21] http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/chemoregimens

b. Radiotherapy treatment (delivery per fraction) – for treatment delivered, with a separate HRG allocated for each fraction delivered.

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

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

63. The HRGs for radiotherapy treatment cover the following elements of care:

    a. external beam radiotherapy preparation – this has a national price

    b. external beam radiotherapy delivery – this has a national price

    c. brachytherapy and molecular radiotherapy administration – this has local currencies and prices.

64. Further information on the structure of the chemotherapy and radiotherapy HRGs and payment arrangements can be found in Annex B2.

3.2.3. Post-discharge rehabilitation

65. Post-discharge national currencies cover the entire pathway of treatment post discharge. They are designed to help reduce avoidable emergency readmissions and provide a service agreed by clinical experts to facilitate better post-discharge rehabilitation and reablement for patients.

66. Post-discharge currencies cover four specific rehabilitation pathways:

    a. cardiac rehabilitation[22]

    b. pulmonary rehabilitation[23]

    c. hip replacement rehabilitation

    d. knee replacement rehabilitation.

67. For 2016/17, we are continuing with national prices for these four post-discharge currencies for the care of patients where a single provider provides both acute and community services. Where services are not integrated, the

[22] Based on the pathway of care outlined in the Department of Health's 'Cardiac Rehabilitation Commissioning Pack'.

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

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

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

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

70. The post-discharge activity and national price will not be identified by the grouper or by SUS. Therefore, in deriving a contract for this service, commissioners and providers need to locally agree the number of patients expected to complete rehabilitation packages. This forecast should be reconciled to the actual numbers of packages completed at year end.

71. Further detail on all four post-discharge currencies, their scope and their specific rules can be found in Annex B2.

3.2.4. Outpatient care

72. National prices for consultant-led outpatient attendances are based on clinic type categorised according to Treatment Function Code (TFC).[24] There are separate prices for first and follow-up attendances, for each TFC, as well as for single professional and multi-professional clinics.[25]

73. The outpatient attendance national price remains applicable only to pre-booked, consultant-led attendances. The pre-booking requirement is not limited to Choose and Book,[26] and may include local systems and accept patients based on GP letters or phone calls. Prices for other outpatient attendances that are not pre-booked or consultant led must be agreed locally.

74. When an attendance with a consultant from a different main specialty during a patient's admission replaces an attendance that would have taken place, it should attract a national price provided it is pre-booked and consultant led.

75. When a patient has multiple distinct outpatient attendances on the same day (eg one attendance in the morning and a second separate attendance in the

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[24] 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’.

[25] Multi-professional attendances are defined as multiple care professionals (including consultants) seeing a patient together, in the same attendance, at the same time. For more detail see Annex B2

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

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

76. Outpatient attendances do not have to take place in hospital premises. Therefore consultant-led outreach clinics held in a GP practice or a children's centre should be eligible for the national price. For these clinics, it is important to make sure the data flows into SUS PbR to support payment for this activity. However, home visits are not eligible for the outpatient care national price and are instead subject to local price-setting.

77. If, following an outpatient attendance, a patient attends an allied health professional (eg a physiotherapist), the costs of the latter attendance are not included in the national price for the original attendance and these attendances will be subject to local negotiation on price (in accordance with the rules on local pricing).

78. Commissioners and providers should use the NHS Data Model and Dictionary to determine the categorisation of outpatient attendance and day case activity.[27] Furthermore, providers must ensure that the way they charge for activity is consistent with the way they cost activity in reference costs, and consistent with any conditions for payment that are included within contracts.

79. For some procedures that are undertaken in an outpatient setting, there are national prices based on HRGs. If more than one of these procedures is undertaken in a single outpatient attendance, only one price is applicable. The grouper software will determine the appropriate HRG, and the provider will receive payment at the relevant price.

80. Where a procedure-driven HRG is generated, SUS PbR determines whether the HRG has a mandatory national price and, if so, applies it. Outpatient procedures for which there is no mandatory HRG price will be paid according to the relevant outpatient attendance national price.

81. For TFCs with no national price, the price should be set through local negotiation between commissioners and providers (in accordance with the rules on local pricing). The national price for any unbundled diagnostic imaging associated with the attendances must be used in all cases. National prices for diagnostic imaging in outpatients are mandatory, regardless of whether or not the core outpatient attendance activity has a national price.

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

3.2.5. Direct access

82. There are national prices for activity accessed directly from primary care, which are listed in Annex B1. One example is where a GP sends a patient for a scan and results are sent to the GP for follow up. This is in contrast to such a service being requested as part of an outpatient referral.

83. A field was added to the outpatient Commissioning Data Set version 6.2 which can be used to identify services that have been accessed directly.[28]

84. Where direct access activity is processed through the grouper, both a core HRG and an unbundled HRG will be created. When the activity is direct access, the core HRG should not attract any payment but the direct access service should attract a payment.

85. In the case of direct access diagnostic imaging services for which there are national prices, the costs of reporting are included in prices. These costs are also shown separately in Annex B1 so that they can be used in case a provider provides a report but does not carry out the scan.

86. There is also a non-mandatory price for direct access plain film x-rays.

3.2.6. Urgent and emergency care

87. There are national prices for A&E services and minor injury units, based on 11 HRGs (subchapter VB – Emergency and Urgent Care). The A&E currency is based on investigation and treatment.

88. Where a patient is admitted following an A&E attendance, both the relevant A&E and non-elective prices are payable. Please note that the tariff for patients who are 'dead on arrival' (DOA) should be that applying to VB09Z.

89. For 2016/17, Type 1 and Type 2 A&E departments continue to be eligible for the full range of A&E HRGs and corresponding national prices; Type 3 A&E departments are eligible for VB11Z only.

90. Services that are provided by NHS walk-in centres, which are categorised as Type 4 A&E services by the NHS Data Dictionary, will not attract national prices. Information on local price-setting can be found in Section 6.

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[28] SUS R16 release (April 2016) has a requirement to add new functionality to implement the CDS6.2 new data item 'Direct access indicator'.

3.2.7. Best practice tariffs

91. A best practice tariff (BPT) is a national price that is designed to incentivise quality and cost-effective care. The first BPTs were introduced in 2010/11 following Lord Darzi's 2008 review.[29]

92. The aim is to reduce unexplained variation in clinical quality and to spread best practice. BPTs may introduce an alternative currency to a HRG, including a description of activities that more closely corresponds to the delivery of outcomes for a patient. The price differential between best practice and usual care is calculated to ensure that the anticipated costs of undertaking best practice are reimbursed, while creating an incentive for providers to shift from usual care to best practice.

93. Where a BPT introduces an alternative currency, that currency should be used in the cases described here, and in Annex B1 and sub-section 2.5 of Annex B2.[30]

94. Each BPT is different, tailored to the clinical characteristics of best practice for a patient condition and to the availability and quality of data. However, there are groups of BPTs that share similar objectives, such as:

    a. avoiding unnecessary admissions

    b. delivering care in appropriate settings

    c. promoting provider quality accreditation

    d. improving quality of care.

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

    a. high impact (that is, high volumes, significant variation in practice, or significant impact on patient outcomes)

    b. supported by a strong evidence base and clinical consensus on what constitutes best practice.

96. A summary of the full 2016/17 BPT package and its evolution is provided in Table 3. The BPT prices can be found in Annex B1, and further information is provided in sub-section 2.5 of Annex B2.

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[29] 'High Quality Care For All', presented to Parliament in June 2008.

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

97. For 2016/17 we have introduced a new mandatory BPT for non-elective admissions for heart failure, which is designed to incentivise improved adherence to National Institute for Health and Care Excellence (NICE) guidance.

98. We have introduced a non-mandatory BPT designed to incentivise timely angioplasty for patients diagnosed with non-ST-elevation myocardial infarction (NSTEMI), a subtype of heart attack. Providers and commissioners may choose to implement this BPT locally for 2016/17, assuming that they comply with the local variation rules in Section 6.

99. We have also amended five existing BPTs: day-case procedures, stroke, outpatient procedures, endoscopy, and primary hip and knee replacement outcomes.

100. Further detail on the new and amended BPTs is included in Annex B2.

101. Some BPTs relate to specific HRGs while others are more detailed and relate to a subset of activity within an HRG. The BPTs that are set at a more detailed level are identified by BPT 'flags', listed in Annex B1. These BPTs will relate to a subset of activity covered by the high level HRG. There will be other activity covered by the HRG that does not relate to the BPT activity, and so a 'conventional' price is published for these HRGs to reimburse the costs of the activity unrelated to the BPT.

102. Top-up payments for specialised services and long stay payments apply to all of the relevant BPTs. The short stay emergency adjustment will apply to all BPTs except for acute stroke care, fragility hip fracture and same-day emergency care.

Table 5: Summary of best practice tariffs

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

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

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

3.2.8. Looked after children health assessments

103. Looked after children[31] are one of the most vulnerable groups in society.

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

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

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

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

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

107. To address this variability in the arrangements for children placed out of area and to enable more timely assessments, a currency was devised and mandated for use by DH in 2013/14, including a checklist for the components that must be included in the assessment. The aim was to promote consistency and enable more timely assessments. Non-mandatory prices were made available for use in 2013/14, and national prices were introduced in 2014/15 for children placed out of area.

108. For 2016/17 national prices will continue to apply for children placed out of area. These prices are not mandatory for health assessments undertaken for children placed in area. A checklist for implementing the currency is included in Annex B2.

3.2.9. Pathway payments

109. Pathway payments are single payments that cover a bundle of services[32] which may be provided by several providers for an entire episode or whole pathway of care for a patient. These payments are designed to encourage better organisation and co-ordination of care across a pathway and among different healthcare providers. Improving the co-ordination of care, including across different settings of care (eg primary, secondary, community services and social care), has the potential to improve patient outcomes by reducing complications and readmissions.

110. There are two pathway-based payment systems. These relate to:

a. maternity healthcare services

b. healthcare for patients with cystic fibrosis.

Maternity pathway payment

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

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

[33] Antenatal care for uncomplicated pregnancies https://www.nice.org.uk/guidance/cg62/chapter/guidance

112. Women may still receive some of their care from a different provider for clinical reasons or to support a woman's choice. This care is paid for by the lead provider who will have received the entire pathway payment from the commissioner.

113. For 2016/17 we have added six clinical factors to the antenatal pathway. These changes allow the maternity pathway allocation to more closely reflect the experience of clinicians, and improve the way providers are reimbursed for the care they give. Details of the six clinical factors are listed in Table 6.

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

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

114. Further information on the pathway payment approach can be found in Annex B1 and Annex B2.

Cystic fibrosis pathway payment

115. The cystic fibrosis pathway currency is a complexity-adjusted yearly banding system with seven bands of increasing complexity of patient need. The tariff relates to a year of care. The pathway does not distinguish between adults and children.

116. The cystic fibrosis pathway currency was designed to support specialist cystic fibrosis multidisciplinary teams to provide care in a seamless, patient-centred manner, removing any incentives to hospitalise patients whose care can be well managed in the community and in their homes. Furthermore, it allows early intervention (following international guidelines) to prevent disease progression, for example, through the use of antipseudomonal inhaled/nebulised antibiotics and mucolytic therapy.

3.3. High cost drugs, devices and listed procedures

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

118. For the 2016/17 NTPS we have updated the list of drugs, devices and procedures using the same criteria used in previous years.[34] Annex B1 sets out details of the high cost drugs, devices and listed procedures for 2016/17. The related local pricing rule (Rule 7), which has also been revised for 2016/17 to reflect the new arrangements for national procurement of devices, is set out in Subsection 6.4.3.

New listed procedures: Molecular and Companion Diagnostics and personalised medicine

119. It is the intention of NHS England to exclude a list of molecular diagnostic tests for three years. These tests are, therefore, excluded for 2016/17. Details of the excluded tests can be found under the heading of listed procedures on the high cost drugs, devices and listed procedures list in Annex B1.

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

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

4. Method for determining national prices

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

    a. our approach to producing the base prices, before applying cost uplifts, the efficiency factor and manual adjustments

    b. how we estimate cost inflation

    c. how we estimate the efficiency factor we use

    d. how we have made manual adjustments where appropriate.

4.1. Overall approach

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

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

Figure 1: Stages in our method for setting national prices

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

    a. an efficiency factor of 2%

    b. our expectation of cost inflation, which we estimate at 3.1%

    c. uplifts specific to individual HRGs reflecting increases in costs of the clinical negligence scheme for trusts (CNST), equivalent to around 0.7% across all prices (however, actual adjustments vary by subchapter).

    d. make various manual adjustments.

4.2. Cost uplifts

125. Our starting point for setting 2016/17 prices reflects 2015/16 cost levels. We have therefore updated these prices to reflect costs that are expected to be incurred by providers in the 2016/17 tariff year. We did this by applying a set of cost uplifts, which reflect changes in input costs between 2015/16 and 2016/17. These are outlined below.

126. Our approach to determining the cost uplift adjustment includes consideration of six categories of cost pressures. These are:

    a. pay costs

    b. drugs costs

    c. other operating costs

    d. changes in the cost associated with CNST payment

    e. changes in capital costs (ie changes in costs associated with depreciation and Private Finance Initiative payments)[35]

    f. additional costs associated with NHS England's Mandate. We call these changes 'service development' costs. There are no adjustments from the Mandate for service development in 2016/17.

127. In setting the total cost uplift factor, each cost category has to be assigned a weight reflecting the proportion of total expenditure. These weights are based on aggregate provider expenditure obtained from DH's published 2014/15 financial accounts. Figure 2 shows the weights applied to each cost category.

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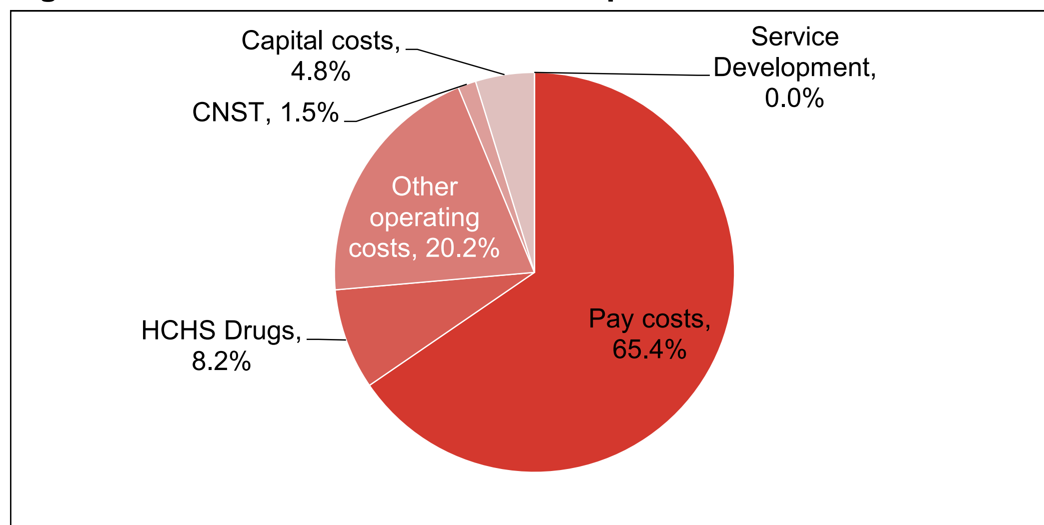
[35] In line with DH's past approach, we have included an estimate of how these payments will change in aggregate for 2016/17 as part of our cost uplifts.

Figure 2: Breakdown of the tariff cost uplift



Source: DH, with Monitor calculations

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

4.2.1. Inflation in operating costs

129. The categories of operational costs are:

   a. pay costs

   b. drugs costs

   c. other operating costs.

Pay

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

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

   a. Pay settlements, which are the increase in the unit cost of labour reflected in pay awards for the NHS.

   b. Pay drift and staff group mix, which is the movement in the average unit cost of labour due to changes in the overall staff mix (eg the relative proportions of senior and junior staff, or the relative proportions of specialist and non-specialist staff). Pay drift also includes changes to the amount of overtime and other allowances paid to staff.

   c. Pensions, which takes account of changes to the cost of pension provision and results from a revaluation of required NHS pension contributions.

132. We are using DH's central estimates for these components. DH maintains the most accurate and detailed records of labour costs in the NHS, and is directly involved in pay negotiations.

133. The pay award is in-line with public sector pay policy announced in the summer budged which is 1%. The 1% pay award assumption is a limit to the average pay award set by HMT. A greater increase for lower paid staff would have to be offset by a lower increase for higher paid staff.

134. The pay drift inflation rate is 2.4%. Of this, 1.8% is the rate of pension including contracted out employer national insurance contribution rates. As a result, the pay drift is higher than recent years. Staff group mix effect is -0.04% which reflects expectations of skill mix decisions by hundreds of employers in the context of affordability expectations.

135. The current projection of the overall pay inflation rate is 3.3% in 2016/17. This translates into a 2.2% increase in national tariff prices.

Drug costs

136. Drugs cost uplift recognises the expected increase in cost associated with an increase in usage and/or cost of drugs. Although drugs costs are a relatively small component of total provider expenditure (approximately 8.2%), they have historically grown faster than other costs. This has made drugs costs one of the larger cost uplift components in some years.

137. Our approach is the same as previous years which is to differentiate the cost increase due to price increases and remove the increase in costs resulting from activity. This is because providers will be reimbursed for increased drugs usage due to activity through the increase in volumes and therefore payments.

138. To reflect the expected increase in drugs costs, we have used DH's estimate. This estimate is based on long-term trends and DH's expectation of new drugs coming to market, and other drugs that will cease to be provided solely under patent in the coming 12 months. DH has provided us with its best estimate of the increase in drugs unit costs for providers in 2016/17. This figure is 4.5% which translates into a 0.37% cost uplift once the weighting of the increase is taken into consideration.

Other operating costs

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

This translates into an overall cost uplift of 0.34% once the weighting of the increase is taken into consideration.[36]

4.2.2. Clinical Negligence Scheme for Trusts

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

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

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

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

Table 7: CNST tariff impact by HRG subchapter

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

[36] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480585/GDP_Deflators_Autumn_Statement_November_2015_update.csv/preview

[37] CCGs and NHS England are also members of the CNST scheme.

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

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

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

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

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

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

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

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

4.2.4. Service development

148. The final NHS mandate for 2016/17 has been published.[39]

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

[39] https://www.gov.uk/government/publications/nhs-mandate-2016-to-2017

[40] The Mandate to NHS England sets out objectives for the NHS and highlights the areas of health care where the Government expects to see improvements.

4.2.5. Summary of data for cost uplifts

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

Table 8: Cost uplift factors

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

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

4.3. Efficiency factor

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

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

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

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

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

[42] https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201516-engagement-documents

a. discussions with stakeholders

b. econometric modelling and a review of relevant literature

c. assessing the impact of the efficiency factors using financial modelling.

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

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

Decision

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

4.4. Manual adjustments

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

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

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

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

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

a. bariatric surgery

b. endoscopy procedures, including wireless endoscopy

c. some other adjustments to individual prices.

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

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

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

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

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

5. National variations to national prices

162. In some circumstances, it is appropriate to make national adjustments to national prices. For example, adjustments may reflect certain features of cost that the formulation of national prices has not taken into account, or share risk more appropriately among parties.

163. We refer to these nationally determined adjustments as 'national variations' to national prices. We refer to the price, after application of national variations, as the 'nationally determined price'.

164. Specifically, each national variation aims to achieve one of the following:

    a. improve the extent to which the actual prices paid reflect location-specific costs

    b. improve the extent to which the actual prices paid reflect the complexity of patient need

    c. provide incentives for sharing the responsibility for preventing avoidable unplanned hospital stays

    d. share the financial risk appropriately following (or during) a move to new payment approaches.

165. This section sets out the national variations specified in the 2016/17 NTPS.

166. The national variations for 2016/17 have changed from those set out in the 2014/15 NTPS in a number of areas:

    a. Marginal rate emergency rule – activity above the agreed baseline value will be reimbursed at 70 per cent of the standard tariff.

    b. The removal of the variations introduced to support the transition to new payment approaches for maternity care, diagnostic imaging in an outpatient setting, chemotherapy delivery and external-beam radiotherapy. We have removed these variations on the basis that the sector has had sufficient time to adapt to the new payment arrangements.

167. National variations form one important part of an overarching framework, and sit alongside local variations and local modifications. Providers and commissioners should note that:

    a. National variations only apply to services with a national price.

    b. If a commissioner and a provider choose to bundle services that have a mix of national prices and locally determined prices, national variations need not be applied. Instead the rules for local variations apply (see Subsection 6.2).

c. In the case of an application or agreement for a local modification (see Section 6.3), the analysis must reflect all national variations that could alter the price payable for a service (ie it is the price after any national variations have been applied that should be compared with a provider's costs).

d. Where a new service is commissioned that does not have a national price, rules for local price-setting apply (see Section 6.4).

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

a. variations to reflect regional cost differences

b. variations to reflect patient complexity

c. variations to help prevent avoidable hospital stays

d. variations to support transition to new payment approaches.

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

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

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

> A patient attends an NHS trust for a first outpatient attendance, which has a national price of £168.
>
> The NHS trust has an MFF payment index value of 1.0461.
>
> The income that the trust receives from the commissioner for this outpatient attendance is £176 (£168 x 1.0461).

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

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

organisational restructuring (such as dissolution). The 2016/17 MFF index values for each NHS provider can be found in Annex B1.

173. Independent sector providers should adopt the MFF of the NHS trust or NHS foundation trust nearest to the location where the services are being provided.

174. Organisations merging or undergoing other organisational restructuring after 31 March 2016 will not have a new MFF set in-year; any MFF change will be calculated and should apply from 1 April 2017. Providers should notify Monitor by email (pricing@monitor.gov.uk) of any planned changes that might affect the MFF index that we have not identified above.

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

175. National prices in this national tariff are calculated on the basis of average costs. They do not therefore take into account cost differences between providers that arise because some providers serve patients with more complex needs. The purpose of top-up payments for some specialised services is to recognise these cost differences and to improve the extent to which prices paid reflect the actual costs of providing healthcare, when this is not sufficiently differentiated in the Healthcare Resource Group (HRG) design. Only a small number of providers are commissioned to provide such care.

176. Specialised service top-ups have been part of the payment system since 2005/06. The current list of qualifying specialised services, and the design and calculation of specialised top-ups for these services, is informed by research undertaken in 2011 by the Centre for Health Economics (CHE) at the University of York.[46]

177. The levels and coverage of top-up payments for 2016/17 are the same as for 2014/15. These are set out in Table 10 along with the relevant specialised service code flag. With the exception of specialised orthopaedic services, eligibility for top-up payments is limited to specified providers.

Table 10: Top-ups for specialised services

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

SSC= specialised service code

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

178. Annex B1 lists those providers eligible for specialised service top-ups. This list has not changed from that in the 2014/15 national tariff. Annex B1 also lists the top-up trigger codes.

5.3. Variations to help prevent avoidable hospital stays

5.3.1. Marginal rate emergency rule

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

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

    a. lower rates of emergency admissions

    b. acute providers to work with other parties in the local health economy to reduce the demand for emergency care.

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

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

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

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

[48] 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).

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

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

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

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

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

Setting and adjusting the baseline

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

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

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

a. a service reconfiguration at a nearby hospital

b. a change in the local population because of a newly built housing development or retirement community

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

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

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

189. Making local adjustments may therefore be necessary to ensure a balance between maintaining the positive incentives to manage demand and ensuring providers receive sufficient income to provide safe and sustainable emergency care. Baseline values must therefore be set according to 2008/09 activity levels, but where a provider requests a review of the baseline, a joint review must be undertaken involving both the provider(s) and the commissioner(s). Following a review, baseline adjustments must be made where there have been material changes in the patterns of demand for or supply of emergency care in a local health economy, or when material changes are planned for 2016/17.

190. Baseline values (specified in £s) should then be updated to account for material changes that the affected provider cannot directly control. For example, a change in demand at a provider resulting from a reduction of a nearby hospital's A&E department opening hours will be considered a change outside the control of the provider and hence may require an adjustment to the baseline. On the other hand, changes in the number of admissions that result from a reduction in consultant presence in the A&E department will not necessitate an adjustment to the baseline.

191. When assessing supply and demand for emergency admissions, commissioners should consider the factors set out in Table 11.

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

Driver of change	Reason for change	Adjustment necessary?
Change in demand for admissions at a provider	Movement of demand between acute providers, resulting in altered market shares	Yes, if material and off-setting between providers
	Movement of demand between out-of-hospital care and acute care, or between secondary and tertiary providers	Yes, where it reflects a change in commissioning patterns[52]
	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[53]	No, unless this reflects a change in commissioning patterns

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

[53] We recognise that establishing a definitive change to clinical practice may be difficult. We suggest that providers and commissioners examine available data, for example any trends in the casemix

Driver of change	Reason for change	Adjustment necessary?
	Changes in the emergency services commissioned by CCGs (eg designation as trauma centre or hyperacute stroke unit)	Yes, if material
	Changes in the method for coding or counting emergency admissions	Yes, recalculate 2008/09 activity according to new method

192. When calculating baseline values, both increases and decreases in the value of activity should be considered equally according to the criteria in Table 11.

193. Where emergency activity moves from one provider to another in a local health economy (for example, due to service reconfiguration, changing market share or changes in commissioning patterns), the baseline of each provider should be adjusted symmetrically so that, as far as possible, the sum of their baseline values remains constant, all other things being equal.

194. The agreed baseline value (specified in £s) must be explicitly stated in 2016/17 NHS Standard Contracts and in the plans that set out how retained funds are to be invested in managing demand for emergency care. A rationale for the baseline value should also be set out clearly, along with the evidence used to support agreement, for example the support from their local system resilience group.

195. Acute providers or other parties in the local health economy should raise any concerns about baseline agreements with NHS England, through its local offices. Where local consensus cannot be reached, the local NHS England office will provide mediation, in the context of NHS England's CCG assurance role, to ensure CCG plans are consistent with this guidance. Where necessary, Monitor and NHS England will consider enforcing the rules set out in this guidance through their enforcement powers. Where the local NHS England office is the commissioner, the NHS England regional team will provide mediation. In all cases, Monitor must be notified (via pricing@monitor.gov.uk) where concerns have been raised, and whether (and how) plans were changed as a result.

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or age-adjusted conversion rate, admissions patterns by time of day, or changes to staffing levels or patterns (eg use of locums, consultant cover for A&E). Clinical audits and/or insight from the local system resilience group may also help facilitate agreement.

Application of the rule

196. The marginal rate rule is applied individually to each contractual relationship. It is applied to any contract where the value of emergency admissions has increased above the baseline value for that contract.

197. Some providers may have seen an overall reduction in their emergency admissions against their baseline value; this reflects a reduction in admissions in some contracts that is offset by small increases in admissions in other contracts. Such small increases may be due to annual fluctuations in admission numbers over which the provider has limited control. Therefore, small contracts[54] are not subject to the marginal rate rule, provided that the overall value of emergency admissions at the provider has decreased relative to their overall baseline value across all of their contracts.

198. The marginal rate should be applied to the value of a provider's emergency admissions after the application of any other national adjustments for MFF, short-stay emergency spells, long-stay payments, or specialised service top-ups. Where more than one commissioner is involved in a particular contractual relationship, arrangements should be agreed locally according to the payment flows to each commissioner set out in the contract.

199. The marginal rate does not apply to:

a. activity which does not have a national price

b. non-contract activity

c. activity covered by BPTs, with the exception of the BPT that promotes same-day emergency care[55]

d. A&E attendances

e. outpatient appointments

f. contracts with commissioners falling within responsibility of devolved administrations.

5.3.2. Emergency readmissions within 30 days

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

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[54] A small contract is one where the baseline value is less than 5% of the provider's total baseline value across all contracts.

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

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

201. The 30-day readmission rule was introduced in 2011/12 in response to a significant increase in the number of emergency readmissions over the previous decade. The rule provides an incentive for hospitals to reduce avoidable unplanned emergency readmissions within 30 days of discharge. Hospitals may reduce the number of avoidable emergency readmissions by investing in, for example, better discharge planning, more collaborative working and better co-ordination of clinical intervention with community and social care providers.

202. We are retaining this national variation for 2016/17. The rest of this section defines an emergency readmission for the purpose of the readmission rule and sets out how the rule should be applied. Further guidance for commissioners on investing retained funds can be found here.[56]

Definition of an emergency readmission

203. The definition of an emergency readmission is any readmission that:[57]

    a. happens up to 30 days from discharge from initial admission

    b. has an emergency admission method code[58]

    c. has a national price.

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

    a. any that do not have a national price

    b. maternity and childbirth[59]

    c. cancer, chemotherapy and radiotherapy[60]

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

[57] 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.

[58] As defined in the NHS Data Model and Dictionary.

[59] Where the initial admission or readmission is in HRG subchapter NZ (obstetric medicine).

d. patients receiving renal dialysis

e. patients readmitted after an organ transplant

f. young children (under four years old at the time of readmission)

g. patients who are readmitted having self-discharged against clinical advice[61]

h. emergency transfers of an admitted patient from another provider, where the admission at the transferring provider was an initial admission[62]

i. cross-border activity – where the initial admission or readmission is in Northern Ireland, Scotland or Wales.

Application of the rule

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

a. undertake a clinical review of a sample of readmissions. Providers and commissioners are not required to undertake a clinical review for 2016/17 where there continues to be local agreement on the readmissions threshold.

b. set an agreed threshold (informed by the clinical review), above which readmissions will not be reimbursed

c. determine the amount that will not be paid for each readmission above the threshold.

Step 1 – clinical review

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

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

[61] Included in discharge method code 2 in the initial admission.

[62] 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.

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

207. The review team must be clinically led and independent, and reviews must be informed by robust evidence. Relevant clinical staff from the provider trust and primary care services must be included as well as representatives from the commissioning body, local primary care providers and social services. Appropriate consideration should be given to information governance with regard to protecting the confidentiality of patient medical records.[64]

208. For each patient in the sample, the review team should decide whether the readmission could have been avoided through actions that might have been taken by the provider, the primary care team, community health services or social services, or a body contracted to any of these organisations.[65]

209. The aim is not to identify poor quality care in hospitals but to identify actions by any appropriate agency that could have prevented the readmission. The analysis should also look at whether there are particular local problems and promote discussion on how services could be improved, who needs to take action, and what investment should be made.

Step 2 – setting the threshold

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

Step 3 – determining the amount not to be paid

211. The amount that will not be paid for any given readmission above the agreed threshold is the total price associated with the continuous inpatient readmission spell,[66] including any associated unbundled costs, such as critical care or high cost drugs.

212. Where a patient is readmitted to a different provider (from that of initial admission), the second provider must be reimbursed. However, the commissioner will deduct an amount from the first provider. [67]

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

64 Further information can be found on the HSCIC's Information Governance website. http://systems.hscic.gov.uk/infogov

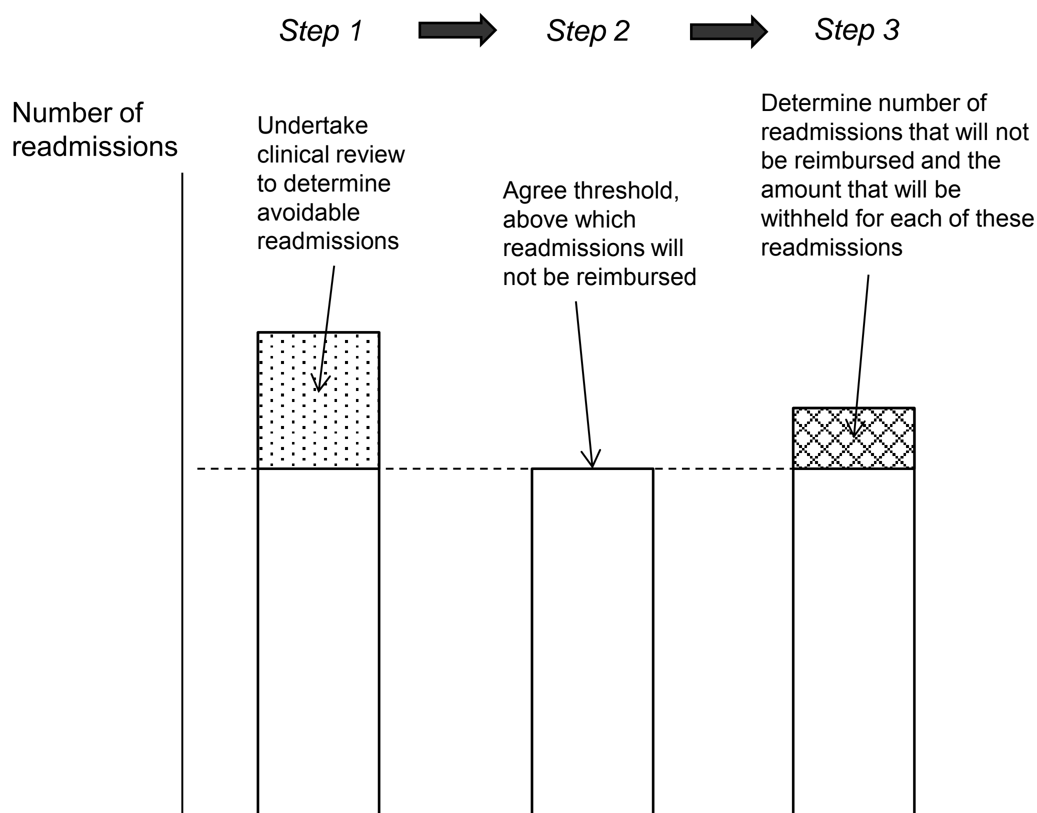
65 The King's Fund paper Avoiding hospital admissions – what does the research evidence say? illustrates some examples of interventions which are more likely and less likely to succeed in reducing readmissions.

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

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

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

Figure 3: Implementing the emergency readmissions rule



5.4. Variations to support transition to new payment approaches

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

a. the maternity pathway currency

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

b. diagnostic imaging in outpatients

c. chemotherapy delivery and external beam radiotherapy.

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

5.4.1. Best practice tariff for primary hip and knee replacements

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

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

a. when recent improvements in patient outcomes are not yet reflected in the nationally available data

b. when providers have identified why they are an outlier on patient reported outcome measures (PROMs) scores and have a credible improvement plan in place, the impact of which is not yet known

c. when a provider has a particularly complex casemix that is not yet appropriately taken into account in the casemix adjustment in PROMs.

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

Recent improvements

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

Planned improvements

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

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

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

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

    a. Headline PROMs scores can be broken down into individual domain scores.
    If required, providers can also request access to individual patient scores through the HSCIC. Providers might look at the questions on which they score badly to see why they are an outlier, for example, those relating to pain management.

    b. Individual patient outcomes might also be compared with patient records to check for complications in surgery or comorbidities that may not be accounted for in the formal casemix adjustment. It would also be sensible to check whether patients attended rehabilitation sessions after being discharged from hospital.

    c. Reviewing the surgical techniques and prostheses used against clinical guidelines and National Joint Registry recommendations is another way providers might try to address poor outcomes. As well as improving the surgical procedure itself, scrutinising the whole care pathway can also improve patient outcomes by ensuring that weakness in another area is not affecting the patient outcomes after surgery.

    d. Providers may also choose to collaborate with those providers that have outcomes significantly above average to learn from their service design. Alternatively, providers can consider conducting a clinical audit. This is a quality improvement process that seeks to improve patient care and outcomes through a systemic review of care against expected criteria.

Casemix

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

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

6. Locally determined prices

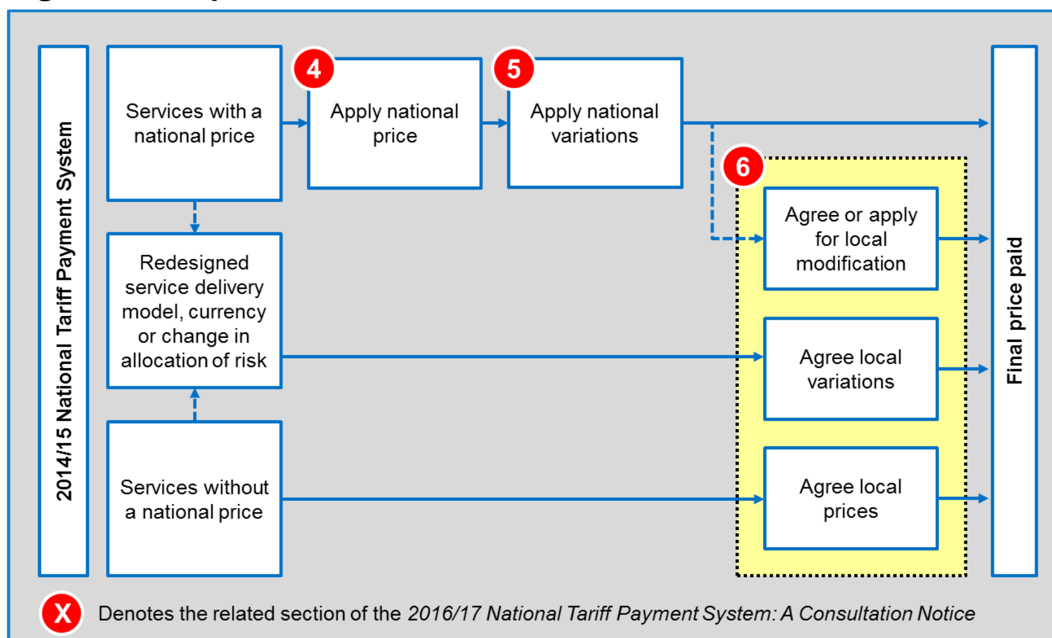
224. Of approximately £70 billion of NHS commissioned activity about half is covered by locally determined prices.

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

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

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

Figure 4: Scope of Section 6 of the national tariff



228. This section is supported by the following annexes:

    a. Annex B1 which lists high cost drugs, devices and procedures.

    b. Annex B2 which provides detail on national currencies for ambulance services as well as nationally specified currencies for acute services with no national price.

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[68] Commissioners have a duty to have regard to such guidance – 2012 Act, section 116(7).

c. Annex B4, the technical guide for mental health clusters.

229. It is also supported by the following documents:

a. *Guidance on locally determined prices for 2016/17* which is supported by:

i. The local variations template (relevant to section 6.2)

ii. The local modifications template and worked example (relevant to section 6.3)

iii. The local prices template (relevant to section 6.4).

Summary of locally determined prices

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

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

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

- Agreements are where a provider and one or more commissioner agree a proposed increase to a national price for a specific service and apply to Monitor for the increase (see Section 6.3.3).

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

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

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

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

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

a. the approach must be in the **best interests of patients**

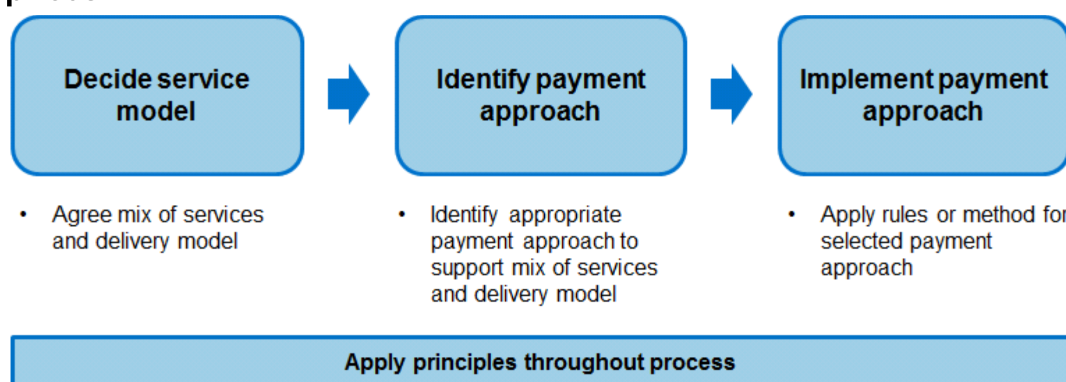
b. the approach must **promote transparency** to improve accountability and encourage the sharing of best practice, and

c. the provider and commissioner(s) must **engage constructively** with each other when trying to agree local payment approaches.

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

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

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



6.1.1. Best interests of patients

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

a. **quality** – how will the agreement maintain or improve the outcomes, patient experience and safety of health care today and in the future?

b. cost effectiveness – how will the agreement make health care more cost effective, without reducing quality, to enable the most effective use of scarce resources for patients today and in the future?

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

c. **innovation** – how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interests of patients today and in the future?

d. **allocation of risk** – Will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?

6.1.2. Transparency

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

a. **accountability** – how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the general public and other stakeholders?

b. **sharing best practice** – how will innovations in service delivery or payment approaches be shared in a way that spreads best practice.

6.1.3. Constructive engagement

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

a. **framework for negotiations** – have the parties agreed a framework for negotiating local variations, modifications and prices that is consistent with the existing guidelines in the NHS Standard Contract?[70]

b. **information sharing** – are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?

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

c. **involvement of clinicians and other stakeholders** – are clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?

d. **short-term and long-term objectives** – are there clearly defined short and long-term strategic objectives for service improvement and delivery agreed before starting price negotiations?

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

6.2. Local variations

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

a. to offer innovative clinical treatments, deliver integrated care pathways or deliver care in new settings

b. to bundle or unbundle existing national currencies to design a new service

c. to design a new integrated service that combines service elements with national and local currencies

d. to support wide-scale reconfiguration and integration of primary, secondary and social care services with payment aligned to patient outcomes.

e. to amend nationally specified currencies or prices to reflect significant differences in casemix compared with the national average

f. to share contracting risks and gains between commissioners and providers to incentivise better care for patients.

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

6.2.1. Required process for agreeing local variations

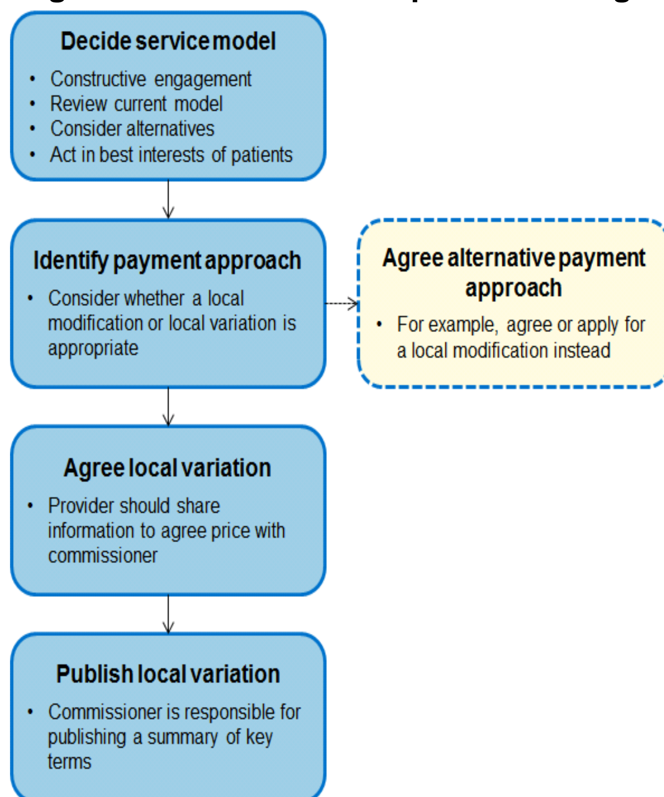
239. Local variations can be agreed between one or more commissioners and one or more providers. Local variations only have effect for the services specified in the agreement, and for the parties to that agreement. We encourage agreements by multiple commissioners, or a lead commissioner acting on behalf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

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

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

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

Figure 6: Overview of the process for agreeing local variations



6.2.2. Rules for local variations

241. For a local variation to be compliant with the national tariff, commissioners and providers must comply with the following rules.[72]

[72] The rules in this section are made pursuant to the 2012 Act, section 116(2).

Rules for local variations

1. The commissioner and provider must apply the principles set out in section 6.1 when agreeing a local variation.

2. The local variation must be documented in the commissioning contract between the commissioner and provider for the service to which the variation relates.[73]

3. The commissioner must use the summary template provided by Monitor when preparing the written statement of the local variation, which must be published as required by the 2012 Act.[74]

4. The commissioner must also submit a written statement of the local variation (using the local variation template) to Monitor. The deadline for submitting the statement is 30 June 2016. For local variations that are agreed after this date, the deadline is 30 days after the agreement.

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

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

6.2.3. Evaluation and sharing of best practice

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

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[73] 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.

[74] As required by the 2012 Act, section 116(3).

[75] See Monitor's Enforcement of the National Tariff. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300865/Enforcement_of_the_national_tariff.pdf

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

245. To determine whether local variations have achieved their desired objectives, and to inform future decision-making, we recommend that commissioners and providers plan to evaluate the success of new payment approaches. We encourage commissioners and providers to share the results of any evaluation processes they complete.

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

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

6.2.4. Publication guidance for local variations

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

248. Under the 2012 Act, commissioners must maintain and publish a written statement of any local variation.[77] Commissioners should publish each statement by 30th June 2016 or if the variation is agreed after this date, within 30 days of the variation agreement. These statements (which can be combined for multiple services) must include details of previously agreed variations for the same services.[78] Commissioners must therefore update the statement if they agree changes to the variations covered by the statement.

249. The rules on local variations (see Section 6.2.2) require a commissioner to use Monitor's template when preparing the written statement and to submit that statement to Monitor. Commissioners should refer to the instructions in the guidance on locally determined prices for information on how to submit a statement for publication.

250. NHS England requires commissioners to include their written statement of each local variation in Schedule 3 of their NHS Standard Contracts.

Requirements for completing a written statement

251. Monitor's requirements for a written statement on a local variation are set out in Monitor's template for local variations.

252. Guidance on local variations is set out in the supporting document *Guidance on locally determined prices for 2016/17*.

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[77] 2012 Act, section 116(3).
[78] 2012 Act, section 116(3)(b).

6.3. Local modifications

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

    a. **Agreements** are where a provider and one or more commissioners agree a proposed increase to a nationally determined price for a specific service (see Section 6.3.3)

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

254. Local modifications differ from local variations in that:

    a. **Local modifications** are subject to approval (in the case of local modification agreements) or grant (in the case of local modification applications) by Monitor.

    b. **Local variations** are not subject to approval or agreement by Monitor but they must comply with the rules outlined in Section 6.2.2.

    c. **Local modifications** can only be used to increase the price for an existing currency or set of currencies.[80]

    d. The methods for determining **local modifications** are distinct from the rules relating to **local variations**.[81]

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

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

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

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

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

one or more specific service without a local modification.[82] If Monitor is not satisfied, we will not approve a local modification agreement or grant a local modification application.

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

Figure 7: Principal differences between local modifications and local variations

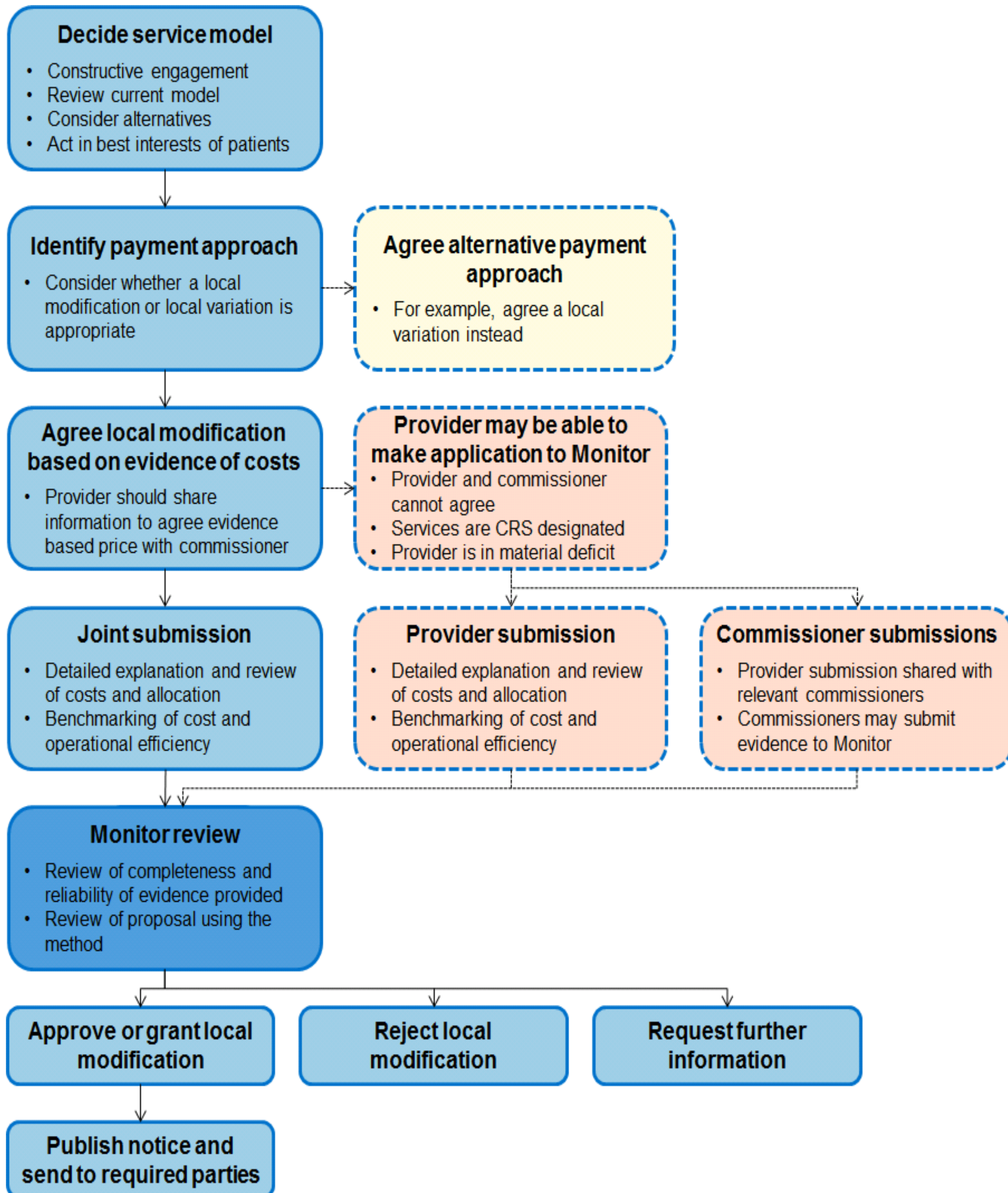
	Policy objective	Criteria	Funding	Examples
Local variations	**Driving better value for patients** The payment system should support clinical best practice, innovation, service redesign and sustainable reconfiguration	**Change in service delivery model or currency** Support improvement to the way specific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

6.3.1. Required process for agreeing local modifications

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

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

Figure 8: Local modification process for commissioners and providers



CRS = commissioner requested service

6.3.2. Method for determining whether services are uneconomic

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

a. Its average cost of providing each service is higher than nationally determined price

b. Its average costs are higher than the nationally determined prices as a result of structural issues that are:

   i. **specific** – the structurally higher costs should only apply to a particular provider or subset of providers and should not be nationally applicable

   ii. **identifiable** – the provider must be able to identify how the structural issues it faces affect the cost of the services

   iii. **non-controllable** – the higher costs should be beyond the direct control of the provider, either currently or in the past[83,84]

   iv. **not reasonably reflected elsewhere** – the costs should not be adjusted for elsewhere in the calculation of national prices, rules or variations, or reflected in payments made under the Sustainability and Transformation Fund

c. It is reasonably efficient when measured against an appropriate group of comparable providers, given the structural issues it faces.[85]

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

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[83] 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.

[84] Monitor considers CNST costs to be controllable and will not consider them to be costs arising from structural issues.

[85] 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.

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

Can other cost factors justify a local modification?

261. Only structurally higher costs which a provider cannot avoid will justify a local modification. Determining whether the provision of a service is uneconomic therefore requires a detailed understanding of why average costs exceed nationally determined prices.[87] It also requires analysis of whether the provider could reduce its costs while still delivering the quality of patient care required.

262. The provider (and, in the case of an agreement, supported by the commissioner) should therefore provide sufficient evidence to enable Monitor to determine whether the service is uneconomic[88]. Where possible, we expect providers to rely on existing information sources, including management and service line reporting. This information should be supported by additional analysis as required. We encourage providers and commissioners to submit evidence that applies to multiple services, in cases where more than one service is affected in the same way by a particular structural issue or issues.

263. Further information on the type of evidence that should be provided is set out in the supporting document *Guidance on locally determined prices for 2016/17.*

Conditions for local modification agreements

264. Under the method for local modification agreements, the following three conditions must be satisfied:

    a. The agreement must specify the services that will be affected, the circumstances or areas in which the modification is to apply, the start date of the local modification and the expected volume of activity for the period of the proposed local modification (which must not exceed the period covered by the national tariff).[89]

    b. The commissioner and provider must be able to demonstrate that it is uneconomic for the provider to provide the relevant NHS services, based on the criteria set out above

[87] 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.

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

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

c. The commissioner and provider must be able to demonstrate that the proposed modification reflects a reasonably efficient cost, given the structural issues faced by the provider.

265. When an agreement covers modifications to multiple services, there may be differences in the level or structure of each modification. It is also possible to propose a modification that is contingent on the volume of activity. For example, a provider and commissioner could agree a modification which involves a higher price increase at lower volumes of activity, to take into account fixed costs associated with providing certain services.

266. For local modification agreements Monitor requires commissioners and providers to prepare joint submissions. Monitor will then decide whether or not to approve the agreement, using the criteria set out above.

267. The terms of a local modification agreement should be included in the relevant commissioning contract (using the NHS Standard Contract where appropriate) once they are agreed between the provider and commissioner. If the terms of a local modification agreement are included in the commissioning contract before the local modification is approved by Monitor, the contract may provide for payment of the modified price pending a decision by Monitor. But if Monitor subsequently decides not to approve the modification, the modification would not have effect and the national price applies. The provider and commissioner must then agree a variation to the commissioning contract to stop the modification, and may agree a mechanism for adjustment and reconciliation in relation to the period before the refusal, or possibly a local variation to the national price.[90]

268. It is important that the cost to providers and commissioners of preparing evidence in support of a local modification agreement does not exceed the expected benefits to patients. As a guideline, we suggest that providers and commissioners should only agree local modifications when the expected increase in revenue for the specified services is greater than £1 million.

269. Monitor may take into account previously agreed local modifications when considering an agreement to extend a local modification, in cases where it can be demonstrated that the underlying issues have not changed.

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

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

6.3.3. Conditions for local modification applications

271. Local modification applications can only be made when a provider has not reached an agreement on a local modification with its commissioner.[91] Under our method, Monitor will only grant applications in cases where the provider has first engaged constructively with its commissioners to consider alternative service delivery models and, if those alternatives are not appropriate, tried to agree a local modification agreement.[92]

272. If an application for a local modification is successful, Monitor will determine the date from which the modification will take effect. In most cases, applications will be effective from the start of the following financial year, subject to any changes in national prices, to allow commissioning budget allocations to take account of decisions.[93] In addition, Monitor will determine the circumstances or locations in which the modified price is to be payable by all commissioners that purchase the specified services from the provider (subject to any restrictions on the circumstances or areas in which the modification applies).

273. To comply with our method for local modification applications, the applicant provider must:

    a. Specify the services affected by the proposed local modification, the circumstances or locations in which the proposed modification is to apply, and the expected volume of activity for each relevant commissioner for the current financial year

    b. Demonstrate that it has first engaged constructively with its commissioners to try to agree alternative means of providing the services at the nationally determined price and, if unsuccessful, has engaged constructively to reach a local modification agreement before submitting an application to Monitor[94]

    ~~c.~~ Demonstrate that the services are commissioner-requested services (CRS)[95] or, in the case of NHS trusts or other providers who are not licensed, the provider cannot reasonably cease to provide the services.

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[91] See the 2012 Act, section 125(1).
[92] Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.
[93] In exceptional cases (and in particular where the delay of the local modification would cause unacceptable risk of harm to patients), Monitor will consider making the modification effective from an earlier date.
[94] Constructive engagement is also required by condition P5 of the Provider Licence, in cases where a provider believes that a local modification is required.
[95] See: 'Guidance for commissioners on ensuring the continuity of health care services; 'Designating commissioner requested services and location specific services', 28 March 2013.

d. Demonstrate that it has a deficit equal to or greater than 4% of revenues at an organisation level in 2015/16 (the previous financial year to an application submitted during 2016/17 for modified prices).

e. Demonstrate that it is uneconomic for it to provide the services required by its commissioners for the purposes of the NHS at the nationally determined prices, based on the criteria set out in Section 6.3.2.

f. Propose a modification to the nationally determined prices of the specified services and be able to demonstrate that the proposed modification reflects a reasonably efficient cost of providing the services, given the structural issues faced by the provider

g. Submit the application to Monitor by 30 September 2016, unless there are exceptional circumstances (for example, where there is a clear and immediate risk to patients).

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

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

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

6.3.4. Publication of local modifications

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

278. The key information published will include:

a. Whether the local modification is an agreement or application

b. The name and location of the provider and commissioner or commissioners covered by the local modification

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

c. A list of the services affected and the changes to their prices as a result of the local modification, including the circumstances or services for which the modification applies (or would have applied)

d. In the case of an approved agreement or granted application, the start date and duration of the local modification

e. An explanation of the structural issues faced by the provider and why a local modification was proposed

f. Any other information that Monitor considers relevant.

6.3.5. Notifications of significant risk

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

[97] 2012 Act, section 126(1) to 126(3).

6.4. Local prices

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

    a. Rules that apply in all cases when a local price is set for services without a national price. These are set out and explained in Section 6.4.1.

    b. Rules that apply only to local price-setting for services with a national currency (but no national price). These are set out and explained in Section 6.4.2.

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

6.4.1. General rules for all services without a national price

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

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

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

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

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

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[98] 2012 Act, section 116(4)(b) and (12) and section 118(5)(b).
[99] The efficiency factor and cost uplift factors under the ETO were -3.5% and 1.9% respectively. This leads to an overall adjustment of -1.6% for 2015/16.

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

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

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

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

  a. commissioners agreeing to fund service development improvements

  b. additional costs being incurred as part of service transformation

  c. taking account of historic efficiencies achieved (eg where there has been a comprehensive service redesign)

  d. comparative information (eg benchmarking) about provider costs and opportunities for efficiency gains

287. These principles apply to both whole year agreements and any adjustments to prices during the course of the year. Monitor will consider taking compliance action where there is evidence of non-compliance with the rules in this section. For further details see the guidance on enforcement of the national tariff.

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

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

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

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

  b. Ambulance services

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[100] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300865/Enforcement_of_the_national_tariff.pdf

c. The following **acute services**

i. specialist rehabilitation (25 currencies based on patient complexity and provider/service type)

ii. critical care – adult and neonatal (13 HRG-based currencies)

iii. HIV adult outpatient services (three currencies based on patient type)

iv. renal transplantation (nine HRG-based currencies)

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

Rule 3:

(a) Where there is a national currency specified for a service, the national currency must be used as the basis for local price-setting for the services covered by those national currencies, unless an alternative payment approach is agreed in accordance with Rule 4 below.

(b) Where a national currency is used as the basis for local price-setting, providers must submit details of the agreed unit prices for those services to Monitor using the standard templates provided by Monitor.

(c) The completed templates must be submitted to Monitor by 30 June 2016.

(d) The national currencies specified for the purposes of these rules are the currencies specified in Annex B2 Section 6.4.4 (mental health services) and section 6.4.5 (ambulance services).

Rule 4:

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

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

(b) The agreement must be documented in the commissioning contract between the commissioner and provider which covers the service in question.

(c) The commissioner must maintain and publish a written statement of the agreement, using the template provided by Monitor, within 30 days of the relevant commissioning contract being signed or in the case of an agreement during the term of an existing contract, the date of the agreement.

(d) The commissioner must have regard to the guidance in Section 6.2.3 when preparing and updating the written statement.

(e) The commissioner must submit the written statement to Monitor.

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

6.4.3. Acute services with no national price

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

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

Acute services without national currencies

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

Local pricing rules: Rule for acute services without national currencies

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

Acute services with national currencies

294. The national currencies for acute services without national prices are set out in Section 6.4.2. Currency specifications and the guidance around using these currencies are set out in annex B2

Local pricing rules: Rule for acute services with national currencies

Rule 6: Providers and commissioners must use the national currencies specified in Annex B2 as the basis for structuring payment for acute services covered by those national currencies, unless an alternative payment approach has been agreed in accordance with Rule 4 in Section 6.4.2

High-cost drugs, devices and listed procedures

295. A number of high-cost drugs, devices and listed procedures are not reimbursed through national prices. Instead, they are subject to local pricing in accordance with the rule below. Annex B1 sets out the updated list of excluded drugs, devices and procedures for the 2016/17 NTPS that are subject to local prices.

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

Rule 7:

(a) As high-cost drugs, devices and listed procedures are not national currencies, Rules 3 and 4 in section 6.4.2, including the requirement to disclose unit prices, do not apply.

(b) Local prices for high-cost drugs, devices or listed procedures must be paid in addition to the relevant national price for the currency covering the core activity. However, the price for the drug, device or procedure must be adjusted to reflect any part of the cost already captured by the national price.

(c) The price agreed should reflect the actual cost to the provider or the nominated supply cost, whichever is lower. The "nominated supply cost" is the cost of the device which would be payable by the provider if the device was supplied in accordance with a requirement to use a supplier or intermediary, or via a framework, specified by the commissioner, pursuant to a notice issued under SC 36.50 of the NHS Standard Contract for 2016/17 (nominated supply arrangements).

(d) As the price agreed should reflect either the actual cost [101] or the nominated supply cost, the requirement to have regard to efficiency and cost uplift factors detailed in Rule 2 does not apply

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

    a. The treatment or intervention was new and not captured in national prices

    b. The design of the currencies have not yet been developed or adjusted for the use of the treatment or intervention

    c. The treatment or intervention was specialist and carried out by a small number of providers and represents a disproportionate cost.

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

[101] Actual cost should reflect the prices paid by the provider less any discounts and rebates which are secured by the provider

298. High-cost drugs, devices and listed procedures meet standard criteria, and we have taken advice from providers, commissioners, the National Institute for Health and Care Excellence (NICE) and other experts to assure which drugs and devices are included on the list.[102] We encourage providers to procure these drugs and devices from suppliers at the most economical price possible. Commissioners may want to incentivise providers to do this by agreeing gain-sharing arrangements with providers.[103]

299. Paragraphs (c) and (d) of the rule deal with the price to be agreed by the commissioner and provider. The price should reflect the lower of the actual cost incurred by the provider, or the cost which would be payable by a provider if they had used a supply or procurement framework nominated by the commissioner under the relevant provision of the NHS Standard Contract. This is a new provision to support the national arrangements for procurement of devices, under which prices may be set by national arrangements rather than local agreements. The commissioner can require the provider to use the national arrangement, and under Rule 7 would only be required to reimburse the applicable price, not any higher price agreed by the provider outside those arrangements.

6.4.4. Mental health services

300. All locally agreed payment arrangements for mental health care must use care clusters to set local prices in 2016/17, unless an alternative payment approach (for example capitation) better meets patient needs. Rollover of historic and poorly specified contracts that are not based on robust and up to date data and evidence are not acceptable.

301. The local payment rules permit providers and commissioners to implement the episodic/year of care or capitated payment approaches in 2016/17(Rule 4). The rules also promote the building blocks relating to robust data collection and use, which are needed to inform evidence-based, patient centred care. Where able, we encourage all sites to implement or shadow our proposed payment approach for 2017/18 during 2016/17.

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[102] Further information about high-cost drugs, devices and procedures may be found online via the High cost drugs, devices and chemotherapy portals.

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

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

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

Local pricing rules: Rules for mental health services

Rule 8

Using the mental health care clusters

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

Rule 9

Local prices for mental health

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

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

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

Rule 10

Mental health reporting requirements

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

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

Quality indicators for mental health

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

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

302. All mental health providers and commissioners must adhere to the rules set out in Sections 6.4.1 (Local prices) and 6.4.2 (General rules for all services without a national price). In addition, all providers and commissioners providing mental health services, covered by the mandatory currencies (care clusters), must comply with Rule 8, 9 and 10.

303. The requirements outlined in Rule 8 and Rule 10 apply in all cases, regardless of the payment approach agreed locally or the degree to which it uses care clusters as the basis for local payment arrangement.

304. Where mental health services are not covered by the currencies, providers and commissioners must adhere to the general rules set out in Section 6.4.1 for all health services not covered by national tariffs (local prices). For clarity, a list of mental health services not captured by the currencies can be found in our mental health guidance, 'Guidance on mental health currencies and payment'.

305. The updated rules covering mental health also include references to the new Mental Health Services Dataset (MHSDS), which replaced the Mental Health and Learning Disabilities Dataset (MHLDDS) in January 2016. Further information on how to access, report and use data this data can be found in our mental Guidance for Mental Health Currencies and Payment.

Compliance and enforcement

306. We are aware that some providers and commissioners are not adhering to the rules at present, and that there may be some confusion in the sector about what is expected. To provide clarity to the sector, in the following sections we provide further guidance for the rules. Further, from 2016, Monitor are undertaking detailed audits and site visits to:

- Ensure compliance with the rules outlined in Section 6.4.1, 6.4.2 and Rules 8, 9 and 10.
- Offer guidance and support to the sector to ensure adherence to the rules.
- Understand sector progress in areas of payment development (e.g. in developing and testing currencies, collecting, reporting and using accurate data for analysis and payment development).

307. Where the rules are not applied by either commissioners or providers, we will address any non-compliance on a case-by-case basis in accordance with Monitor's enforcement policy. This may include formal enforcement action.

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

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

a. **Are in the best interest of patients:** In the context of mental health care, the requirement is to ensure that patients in the local health economy have access to high quality, timely and evidence based care (at a minimum NICE concordant care) that meets their needs. Providers and commissioners can link payment to achievement of agreed outcomes to help ensure care is patient focused and is delivering the right results for patients. Providers and commissioners may also use gain/loss sharing mechanisms, particularly during transitional periods where new baselines for demand and/or costs have not fully been established. This can support stability, continuity and improvement of safe, high quality and effective care for patients. The Guidance on Mental Health Currencies Local Payment Examples and other material to support local payment development for mental health care provides further information on this.

b. **Promotes transparency:** Within the context of mental health, this ensures that contracts clearly outline accountability for delivering services and care, as well as for the outcomes that need to be achieved. A transparent approach to payment development also ensures that data and information is used to understated likely demands for care and associated costs.

c. **Is agreed through constructive engagement between providers and commissioners:** Data and information should also inform development of innovative and effective service designs that meet local care needs and support the objectives set out in the Five Year Forward View. Providers and commissioners should constructively engage with local stakeholders – including clinicians and patients - to (i) understand care needs; (ii) develop service delivery models that meet these needs; and (iii) develop local prices that support the agreed service model. To achieve this it is vital to ensure that accurate data collection, data reporting and data flows are in place. This includes sharing data with clinical staff as well as data sharing between providers, commissioners and other parties. Training may be needed to help staff interpret and analyse data, and data sharing may be facilitated by information sharing agreements, where existing national datasets cannot be used. Providers and commissioners should also actively share best practices where appropriate.

Further details on Rule 8

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

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

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

Further details on Rule 9

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

    a. **Requires that providers and commissioners use the 21 care clusters** (set out in Table 12) as the currencies for agreeing local prices in 2016/17. Additional data and information (eg public health data) should also be used to better understand patient need and the resources required which will help inform local prices.

    b. **Allows providers and commissioners to agree local prices that are based on an alternative payment approach**, if this is in the best interest of patients. This may include, for example, a capitated payment approach. A range of (or combinations of) other payment approaches may also be used. For example, payment arrangements that are linked to achievement of outcomes or implementation of best practice pathways, or approaches that facilitate an increased focus on integrated care. These alternative payment arrangements must be in accordance with Rule 4, and the general local price setting principles outlined in Sections 6.4.1 and 6.4.2. Any payment approach covering care that falls under the care clusters should be informed by care cluster data, as well as other data and information that helps understand patient needs. The Guidance on Mental Health Currencies and Payment and Local Payment Examples provides further information on the different payment models that may be adopted[105]. It remains necessary to comply with Rules 8 and 10 even if a different payment approach is adopted.

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

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

Further details on Rule 10

312. Rule 10 (a) sets out the requirement for all providers to submit data into the MHSDS via the HSCIC. This requirement to all providers regardless of the payment approach they have in place.

313. Rule 10 (b) requires providers to submit the agreed local prices to Monitor by 30 June 2016. This must be submitted using Monitor's standard format. This applies where providers and commissioners use the care clusters as the basis for setting local prices. If an alternative payment arrangement is used (ie where care clusters are not used for setting local prices) then commissioners are required to record the local prices and submit it to Monitor, in accordance with Rule 4.

314. Rule 10 (c) and (d) require providers and commissioners to agree quality indicators for each of the care clusters, which must also be monitored on a quarterly basis. Quality indicators could include outcomes measures and should be aligned to system wide objectives (e.g. Five Year Forward View) and promote high quality, evidence based and timely care that meet patient needs. The Mental Health Guidance on Currencies and Payment provides further information on how providers and commissioners could use both local and national level data to develop quality measures and link them to payment.

6.4.5. Payment rules for ambulances services

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

Ambulance services with national currencies

316. 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.

317. The four national currencies for ambulance services are:

    a. urgent and emergency care calls answered

    b. hear and treat or refer to other services

    c. see and treat or refer to other services

    d. see, treat and convey to hospital

318. The details of these currencies – including how to determine what to include and exclude when applying them – are set out in full in Annex B2. Any services not specified above are not subject to a national ambulance currency.

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

Local pricing rules: Rule for ambulance services

Rule 11

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

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

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

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

Ambulance services without national currencies

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

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

   a. other urgent care services such as: air ambulance; emergency bed services (EBS); GP out of hours; cross-border activity; and single point of access telephone services (e.g. 111)

   b. other patient care services such as: patient transport services, neonatal transfers and patient education

   c. other non-patient care services such as: emergency planning; clinical audit and research units (CARU; chemical biological radiological and nuclear (CBRN); decontamination units; hazardous area response teams (HART); and logistics or courier transport services.

6.4.6. Primary care services

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

    a. providing coordinated care and support for general health problems

    b. helping people maintain good health

    c. referring patients on to more specialist services where necessary.

324. 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

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

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

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

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

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

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

6.4.7. Community services

328. 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.

329. 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.

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

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

[106] These are arrangements made under the NHS Act 2006, Sections 3 or 3A.

7. Payment rules

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

a. billing and payment

b. activity reporting.

7.1. Billing and payment

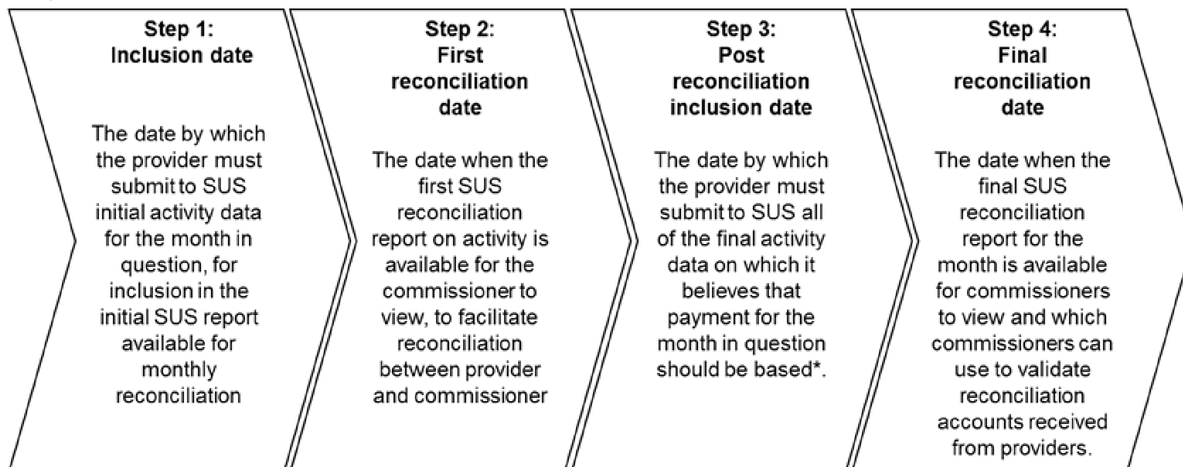
333. Billing and payment must be accurate and prompt, in line with the terms and conditions set out in the NHS Standard Contract. Payments to providers may be reduced or withheld in accordance with provisions for contractual sanctions set out in the NHS Standard Contract (eg sanctions for breach of the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

7.2. Activity reporting

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

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

Figure 9: SUS submission steps



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

[107] 2012 Act, section 116(4)(c).

to be made by the commissioner.

336. The 2016/17 dates for reporting monthly activity and making the reports available will be published on the Health and Social Care Information Centre (HSCIC) website.[108] HSCIC will automatically notify subscribers to its e-bulletin when these dates are announced.

337. NHS England has approval from the Secretary of State to allow CCGs and commissioning support units (CSUs) to process a limited set of personal confidential data when it is absolutely necessary to do so, for invoice validation purposes. This approval is subject to a set of conditions. NHS England has published advice online[109] about these conditions and sets the actions that CCGs, CSUs and providers must take to ensure they act lawfully.

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[108] http://www.hscic.gov.uk/sus/pbrguidance

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

Glossary

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

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

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

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

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

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

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